

103<sup>D</sup> CONGRESS  
1<sup>ST</sup> SESSION

# S. 1579

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

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## IN THE SENATE OF THE UNITED STATES

OCTOBER 21 (legislative day, OCTOBER 13), 1993

Mr. BREAUX (for himself, Mr. DURENBERGER, Mr. LIEBERMAN, and Mr. NUNN) introduced the following bill; which was read twice and referred to the Committee on Finance

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## A BILL

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

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

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

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

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

Section 1. Short title; table of contents.

Sec. 2. Findings; purposes.

Sec. 3. Glossary of certain terms used in titles I and II.

TITLE I—MANAGED COMPETITION IN EMPLOYER-BASED HEALTH PLANS: INCENTIVES TO CONTROL COSTS

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

- Sec. 1001. Uniform tax disincentive to effectively limit deductibility of excess employer health plan expenses.
- Sec. 1002. Increase in deduction for health plan premium expenses of self-employed individuals.
- Sec. 1003. Deduction for health plan premium expenses of individuals.
- Sec. 1004. Exclusion from gross income for contributions by a partnership or S corporation to a health plan covering its partners or shareholders.
- Sec. 1005. Employer obligations.

Subtitle B—Health Plan Purchasing Cooperatives (HPPCs)

- Sec. 1101. Establishment and organization; HPPC areas.
- Sec. 1102. Agreements with accountable health plans (AHPs).
- Sec. 1103. Agreements with small employers.
- Sec. 1104. Enrolling individuals in accountable health plans through a HPPC.
- Sec. 1105. Receipt of premiums.
- Sec. 1106. Coordination among HPPCs.
- Sec. 1107. Complaint process; ombudsman.
- Sec. 1108. Enrollee satisfaction surveys; monitoring enrollee disenrollment.

Subtitle C—Accountable Health Plans (AHPs)

PART 1—REQUIREMENTS FOR ACCOUNTABLE HEALTH PLANS

- Sec. 1201. Registration process; qualifications.
- Sec. 1202. Specified uniform set of effective benefits; reduction in cost-sharing for low-income individuals; quality standards.
- Sec. 1203. Collection and provision of standardized information.
- Sec. 1204. Prohibition of discrimination based on health status for certain conditions; limitation on pre-existing condition exclusions.
- Sec. 1205. Use of standard premiums.
- Sec. 1206. Financial solvency requirements.
- Sec. 1207. Grievance mechanisms; enrollee protections; written policies and procedures respecting advance directives; agent commissions.
- Sec. 1208. Additional requirements of open AHPs.
- Sec. 1209. Coordination of benefits with low-income assistance.
- Sec. 1210. Additional requirement of certain AHPs.
- Sec. 1211. Funding for approved medical residency training programs and physician retraining programs.

PART 2—PREEMPTION OF STATE LAWS FOR ACCOUNTABLE HEALTH PLANS

- Sec. 1221. Preemption from State benefit mandates.
- Sec. 1222. Preemption of State law restrictions on network plans.
- Sec. 1223. Preemption of State laws restricting utilization review programs.

PART 3—CLARIFYING APPLICATION OF FEDERAL ANTITRUST LAWS TO ACCOUNTABLE HEALTH PLANS

- Sec. 1231. Publication of guidelines.

Subtitle D—National Health Board

- Sec. 1301. Establishment of National Health Board.
- Sec. 1302. Specification of uniform set of effective benefits.
- Sec. 1303. Benefits, Evaluations, and Data Standards Board.
- Sec. 1304. Health Plan Standards Board.
- Sec. 1305. Registration of accountable health plans.
- Sec. 1306. Specification of risk-adjustment factors.
- Sec. 1307. National health data system.
- Sec. 1308. Measures of quality of care of specialized centers of care.
- Sec. 1309. Agency for Clinical Evaluations.
- Sec. 1310. Report and recommendations on achieving universal coverage.
- Sec. 1311. Monitoring reinsurance market.
- Sec. 1312. Authorization of appropriations; sunset.

Subtitle E—Managed Competition in Rural and Urban Underserved Areas

PART 1—SPECIAL TREATMENT OF DESIGNATED UNDERSERVED AREAS

- Sec. 1401. Designation of underserved areas.
- Sec. 1402. Special treatment.

PART 2—TRANSITIONAL SUPPORT FOR DEVELOPMENT OF ACCOUNTABLE HEALTH PLANS IN UNDERSERVED AREAS

- Sec. 1411. Technical assistance funding.
- Sec. 1412. Rural development grants.
- Sec. 1413. Migrant health centers.
- Sec. 1414. Community health centers.

PART 3—ESTABLISHMENT OF RURAL EMERGENCY ACCESS CARE HOSPITALS

- Sec. 1421. Rural emergency access care hospitals described.
- Sec. 1422. Coverage of and payment for services.
- Sec. 1423. Effective date.

PART 4—TRANSITIONAL ASSISTANCE FOR SAFETY NET HOSPITALS

- Sec. 1431. Payments to hospitals.
- Sec. 1432. Application for assistance.
- Sec. 1433. Public service responsibilities.
- Sec. 1434. Authorization of appropriations.

Subtitle F—Treatment of Chronically Underserved Areas

- Sec. 1501. Promoting State action.

Subtitle G—Repeal of COBRA Continuation Requirements

- Sec. 1601. Repeal of COBRA continuation requirements.

Subtitle H—Definitions

- Sec. 1701. Definitions.

TITLE II—LOW-INCOME ASSISTANCE FOR HEALTH COVERAGE

Subtitle A—Low-Income Assistance

- Sec. 2001. Eligibility.
- Sec. 2002. Premium assistance.

- Sec. 2003. Cost-sharing assistance.
- Sec. 2004. Assistance for certain items and services.
- Sec. 2005. Computation of base Federal premium amount.
- Sec. 2006. Applications for assistance.
- Sec. 2007. Reconciliation of premium assistance through use of income statements.
- Sec. 2008. Treatment of certain cash assistance recipients.
- Sec. 2009. Definitions.

#### Subtitle B—Long-Term Care Phase-Down Assistance to States

- Sec. 2101. Long-term care phase-down assistance.

#### Subtitle C—Financing

##### PART 1—MEDICARE SAVINGS

- Sec. 2201. Reduction in update for inpatient hospital services.
- Sec. 2202. Reduction in conversion factor for physician fee schedule for non-primary care services.
- Sec. 2203. Reduction in hospital outpatient services through establishment of prospective payment system.
- Sec. 2204. Increase in medicare part B premium for individuals with high income.
- Sec. 2205. Phased-in elimination of medicare hospital disproportionate share adjustment payments.
- Sec. 2206. Reduction in routine cost limits for home health services.
- Sec. 2207. Reduction in routine cost limits for extended care services.
- Sec. 2208. Reductions in payments for hospice services.

##### PART 2—OTHER SAVINGS

- Sec. 2211. Requirement that certain agencies prefund government health benefits contributions for their annuitants.

#### Subtitle D—Repeal of Medicaid Program

- Sec. 2301. Repeal of medicaid program.

### TITLE III—TRAINING AND EDUCATION OF HEALTH CARE PROFESSIONALS

#### Subtitle A—Reform of Federal Funding for Medical Residency Training

- Sec. 3001. Definitions.
- Sec. 3002. Approval of medical residency training positions.
- Sec. 3003. Funding for approved medical residency training programs and physician retraining programs.
- Sec. 3004. Financing.
- Sec. 3005. National Medical Education Fund.
- Sec. 3006. Repeal of separate medical education payments under medicare.

#### Subtitle B—Other Medical Education Grants and Programs

- Sec. 3101. Scholarship and loan repayment programs of National Health Service Corps.
- Sec. 3102. Area health education centers.
- Sec. 3103. Public health and preventive medicine.

- Sec. 3104. Family medicine.
- Sec. 3105. General internal medicine and pediatrics.
- Sec. 3106. Physician assistants.
- Sec. 3107. Allied health project grants and contracts.
- Sec. 3108. Nurse allied health project grants and contracts.
- Sec. 3109. Nurse practitioner and nurse midwife programs.
- Sec. 3110. Use of health care policy and research funds for primary care.

#### TITLE IV—PREVENTIVE HEALTH AND INDIVIDUAL RESPONSIBILITY

##### Subtitle A—Expansion of Public Health Programs

- Sec. 4001. Immunizations against vaccine-preventable diseases.
- Sec. 4002. Prevention, control, and elimination of tuberculosis.
- Sec. 4003. Lead poisoning prevention.
- Sec. 4004. Preventive health measures with respect to breast and cervical cancers.
- Sec. 4005. Office of Disease Prevention and Health Promotion.
- Sec. 4006. Preventive health and health services block grant.
- Sec. 4007. Categorical grants for early intervention regarding acquired immune deficiency syndrome.
- Sec. 4008. Programs of Office of Smoking and Health.

##### Subtitle B—Medicare

##### PART 1—COVERAGE OF PREVENTIVE SERVICES

- Sec. 4101. Coverage of colorectal screening.
- Sec. 4102. Coverage of certain immunizations.
- Sec. 4103. Coverage of well-child care.
- Sec. 4104. Annual screening mammography.
- Sec. 4105. Financing of additional benefits.

##### PART 2—NOTICE OF ADVANCE DIRECTIVE RIGHTS

- Sec. 4111. Providing notice of rights regarding medical care to individuals entering medicare.

#### TITLE V—MALPRACTICE REFORM

##### Subtitle A—Findings; Purpose; Definitions

- Sec. 5001. Findings; purpose.
- Sec. 5002. Definitions.

##### Subtitle B—Grants to States for Alternative Dispute Resolution Systems

- Sec. 5101. Grants to States.
- Sec. 5102. Administration.

##### Subtitle C—Uniform Standards for Malpractice Claims

- Sec. 5201. Applicability.
- Sec. 5202. Treatment of noneconomic and punitive damages.
- Sec. 5203. Periodic payments for future losses.
- Sec. 5204. Uniform statute of limitations.
- Sec. 5205. Special provision for certain obstetric services.

- Sec. 5206. Uniform standard for determining liability in actions based on negligence.  
 Sec. 5207. Jurisdiction of Federal courts.  
 Sec. 5208. Preemption.

Subtitle D—Grants to States for Development of Practice Guidelines

- Sec. 5301. Grants to States.

TITLE VI—PAPERWORK REDUCTION AND ADMINISTRATIVE SIMPLIFICATION

- Sec. 6001. Preemption of State quill pen laws.  
 Sec. 6002. Confidentiality of electronic health care information.  
 Sec. 6003. Standardization for the electronic receipt and transmission of health plan information.  
 Sec. 6004. Use of uniform health claims forms and identification numbers.  
 Sec. 6005. Priority among insurers.  
 Sec. 6006. Furnishing of information among health plans.  
 Sec. 6007. Failure to satisfy certain health plan requirements.  
 Sec. 6008. Definitions.

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

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

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

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

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

14 (C) the Internal Revenue Code not only  
 15 provides no incentives for employees to select  
 16 carefully among competing health plans on the

1 basis of cost, but also provides incentives for  
2 employers and employees to select plans with  
3 greater expenses;

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

8 (E) underwriting practices discriminate  
9 unfairly against individuals in need of health  
10 care.

11 (2) MANAGED COMPETITION.—

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

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

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

1 (b) PURPOSE.—

2 (1) GENERAL OBJECTIVE.—It is the general ob-  
3 jective of this Act to reform the health care market-  
4 place to provide universal access to high quality,  
5 cost-effective care through competitive health plans.

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

11 (3) SPECIFIC MEASURES TO ACHIEVE OBJEC-  
12 TIVES.—In order to—

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

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

23 (C) provide access to coverage, the Act  
24 makes available to all individuals competitively

1 priced accountable health plans regardless of  
2 their employment status;

3 (D) to promote competition based on qual-  
4 ity, the Act provides for the systematic report-  
5 ing and public dissemination of information on  
6 the performance of plans in meeting the clinical  
7 health requirements, functional needs, well-  
8 being, and personal satisfaction of its enrollees;  
9 and

10 (E) improve health care coverage of low-in-  
11 come individuals, the Act offers financial assist-  
12 ance in purchasing accountable health plans  
13 and meeting cost-sharing requirements.

14 **SEC. 3. GLOSSARY OF CERTAIN TERMS USED IN TITLES I**  
15 **AND II.**

16 The following specialized, defined terms are used in  
17 titles I and II of this Act:

18 ACCOUNTABLE HEALTH PLAN; AHP.—The  
19 terms “accountable health plan” and “AHP” are de-  
20 fined in section 1701(b)(1).

21 APPLICABLE FEDERAL ASSISTANCE AMOUNT.—  
22 The term “applicable Federal assistance amount” is  
23 defined in section 2009(c)(1).

1           APPLICABLE           LOW-INCOME           PREMIUM  
2 AMOUNT.—The term “applicable low-income pre-  
3 mium amount” is defined in section 2009(c)(2).

4           BASE FEDERAL PREMIUM AMOUNT.—The “base  
5 Federal premium amount” is defined in section  
6 2005(a)(1).

7           BASE INDIVIDUAL PREMIUM.—The term “base  
8 individual premium” is defined in section  
9 2009(c)(3).

10           BENEFITS, EVALUATIONS, AND DATA STAND-  
11 ARDS BOARD.—The term “Benefits, Evaluations,  
12 and Data Standards Board” refers to the Board es-  
13 tablished under section 1303.

14           BOARD.—The term “Board” is defined in sec-  
15 tion 1701(b)(2).

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

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

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

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

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

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

5 FAMILY ADJUSTED TOTAL INCOME.—The term  
6 “family adjusted total income” is defined in section  
7 2009(b)(1).

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

10 HEALTH PLAN STANDARDS BOARD.—The term  
11 “Health Plan Standards Board” refers to the Board  
12 established under section 1304.

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

15 HPPC; HEALTH PLAN PURCHASING COOPERA-  
16 TIVE.—The terms “health plan purchasing coopera-  
17 tive” and “HPPC” are defined in section  
18 1701(b)(3).

19 INDIVIDUAL RESPONSIBILITY PERCENTAGE.—  
20 The term “individual responsibility percentage” is  
21 defined in section 2009(c)(5).

22 INVESTIGATIONAL TREATMENT.—The term “in-  
23 vestigational treatment” is defined in section  
24 1302(b)(4)(B).

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

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

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

7           MEDICARE-ELIGIBLE INDIVIDUAL.—The term  
8           “medicare-eligible individual” is defined in section  
9           1701(a)(6).

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

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

15          NETWORK PLAN.—The term “network plan” is  
16          defined in section 1208(b)(3)(D) and in section  
17          1222(b)(1).

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

20          PHYSICIAN INCENTIVE PLAN.—The term “phy-  
21          sician incentive plan” is defined in section  
22          1207(b)(2).

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

1           PRE-EXISTING CONDITION.—The term “pre-ex-  
2           isting condition” is defined in section  
3           1204(b)(2)(B)(ii).

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

6           REFERENCE PREMIUM RATE.—The term “ref-  
7           erence premium rate” is defined in section  
8           2009(c)(4).

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

11          SMALL EMPLOYER; LARGE EMPLOYER.—The  
12          terms “small employer” and “large employer” are  
13          defined in section 1701(c)(2).

14          SPECIALIZED CENTER OF CARE.—The term  
15          “specialized center of care” is defined in section  
16          1308(d).

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

20          STATE.—The term “State” is defined in section  
21          1701(c)(5).

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

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

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

4           UTILIZATION REVIEW PROGRAM.—The term  
5 “utilization review program” is defined in section  
6 1223(b).

7           VERY LOW-INCOME INDIVIDUAL.—The term  
8 “very low-income individual” is defined in section  
9 2009(a)(3).

10 **TITLE I—MANAGED COMPETI-**  
11 **TION IN EMPLOYER-BASED**  
12 **HEALTH PLANS: INCENTIVES**  
13 **TO CONTROL COSTS**

14 **Subtitle A—Use of Tax Incentives**  
15 **to Purchase Cost-Effective Plans**

16 **SEC. 1001. UNIFORM TAX DISINCENTIVE TO EFFECTIVELY**  
17 **LIMIT DEDUCTIBILITY OF EXCESS EMPLOYER**  
18 **HEALTH PLAN EXPENSES.**

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

1 **“SEC. 4980C. EMPLOYER HEALTH PLAN EXPENSES IN EX-**  
2 **CESS OF ACCOUNTABLE HEALTH PLAN**  
3 **COSTS.**

4 “(a) GENERAL RULE.—There is hereby imposed a  
5 tax equal to the product of the rate of tax specified in  
6 section 11(b)(1)(C) and the amount of the excess health  
7 plan expenses of any employer.

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

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

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

19 “(A) the expenses are attributable to cov-  
20 erage of the covered individual under an ac-  
21 countable health plan, and

22 “(B) in the case of a small employer, the  
23 expenses are attributable to payment to a  
24 health plan purchasing cooperative for coverage  
25 under an accountable health plan.

1           “(3) LIMIT ON PER INDIVIDUAL CONTRIBU-  
2           TION.—

3           “(A) IN GENERAL.—Health plan expenses  
4           with respect to any covered individual meet the  
5           requirements of this paragraph for any month  
6           only to the extent that the amount of such ex-  
7           penses does not exceed the reference premium  
8           rate (as defined in section 2009(c)(4) of the  
9           Managed Competition Act of 1993) for the  
10          month.

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

1           “(C) TREATMENT OF HEALTH PLANS OUT-  
2           SIDE THE UNITED STATES.—For purposes of  
3           subparagraph (A), in the case of a covered indi-  
4           vidual residing outside the United States, there  
5           shall be substituted for the reference premium  
6           rate such reasonable amounts as the National  
7           Health Board determines to be comparable to  
8           the limit imposed under subparagraph (A) or  
9           subparagraph (B) (if applicable).

10          “(4) REQUIREMENT OF LEVEL CONTRIBU-  
11          TION.—Health plan expenses meet the requirements  
12          of this paragraph for any month only if the amount  
13          of the employer contribution (for a premium class)  
14          does not vary based on the accountable health plan  
15          selected.

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

22          “(d) SPECIAL RULES.—

23                 “(1) TREATMENT OF SELF-INSURED PLANS.—  
24                 In the case of a self-insured health plan, the amount  
25                 of contributions per employee shall be determined

1 for purposes of subsection (b)(3) in accordance with  
2 rules established by the National Health Board  
3 which are based on the principles of section  
4 4980B(f)(4)(B) (as in effect before the date of the  
5 enactment of this Act).

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

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

15 “(f) OTHER DEFINITIONS.—For purposes of this sec-  
16 tion—

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

20 “(2) GROUP HEALTH PLAN.—The term ‘group  
21 health plan’ has the meaning given such term by  
22 section 5000(b)(1), but does not include, as defined  
23 by the National Health Board, health coverage  
24 under a disability or accident policy or under a  
25 workers’ compensation plan.

1           “(3) HEALTH PLAN EXPENSES.—

2                   “(A) IN GENERAL.—The term ‘health plan  
3           expenses’ means employer expenses for any  
4           group health plan, including expenses for pre-  
5           miums as well as payment of deductibles and  
6           coinsurance that would otherwise be applicable.

7                   “(B) EXCLUSION OF CERTAIN DIRECT EX-  
8           PENSES.—Such term does not include expenses  
9           for direct services which are determined by the  
10          National Health Board to be primarily aimed at  
11          workplace health care and health promotion or  
12          related population-based preventive health ac-  
13          tivities.

14                  “(4) SMALL EMPLOYER.—The term ‘small em-  
15          ployer’ means, for a taxable year, an employer that  
16          is a small employer (within the meaning of section  
17          1701(c)(2) of the Managed Competition Act of  
18          1993) for the most recent calendar year ending be-  
19          fore the end of the taxable year.

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

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

“Sec. 4980C. Employer health plan expenses in excess of accountable health plan costs.”.

1 (c) EFFECTIVE DATE.—

2 (1) IN GENERAL.—Except as otherwise pro-  
3 vided in this subsection, the amendments made by  
4 this section shall apply to expenses incurred for the  
5 provision of health services for periods after Decem-  
6 ber 31, 1994.

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

17 **SEC. 1002. INCREASE IN DEDUCTION FOR HEALTH PLAN**  
18 **PREMIUM EXPENSES OF SELF-EMPLOYED IN-**  
19 **DIVIDUALS.**

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

23 (b) MAKING PROVISION PERMANENT.—Subsection  
24 (l) of section 162 of such Code (relating to special rules

1 for health insurance costs of self-employed individuals) is  
2 amended by striking paragraph (6).

3 (c) LIMITATION TO ACCOUNTABLE HEALTH  
4 PLANS.—Paragraph (2) of section 162(l) of such Code is  
5 amended by adding at the end thereof the following new  
6 paragraph:

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

14 (d) EFFECTIVE DATE.—

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

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

22 **SEC. 1003. DEDUCTION FOR HEALTH PLAN PREMIUM EX-**  
23 **PENSES OF INDIVIDUALS.**

24 (a) IN GENERAL.—Section 213 of the Internal Reve-  
25 nue Code of 1986 (relating to medical, dental, etc., ex-

1 penses) is amended by adding at the end the following new  
2 subsection:

3 “(g) SPECIAL RULES FOR HEALTH PLAN PREMIUM  
4 EXPENSES.—

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

10 “(2) LIMITS.—

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

20 “(B) LIMIT TO HPPC PLANS.—

21 “(i) IN GENERAL.—The deduction  
22 under this subsection shall be allowed only  
23 in the case of an individual who obtains  
24 coverage under an accountable health plan

1 through a health plan purchasing coopera-  
2 tive.

3 “(ii) EXCEPTION FOR EMPLOYEES OF  
4 LARGE EMPLOYERS.—Clause (i) shall not  
5 apply to an individual who obtains cov-  
6 erage in an accountable health plan by vir-  
7 tue of the individual’s (or other person’s)  
8 employment by a large employer.

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

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

18 (b) EFFECTIVE DATE.—The amendment made by  
19 subsection (a) shall apply to amounts paid after December  
20 31, 1994, and taxable years ending after such date.

1 **SEC. 1004. EXCLUSION FROM GROSS INCOME FOR CON-**  
2 **TRIBUTIONS BY A PARTNERSHIP OR S COR-**  
3 **PORATION TO A HEALTH PLAN COVERING ITS**  
4 **PARTNERS OR SHAREHOLDERS.**

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

9 “(c) EXCEPTION FOR COVERAGE PROVIDED UNDER  
10 SUBSIDIZED ACCIDENT OR HEALTH PLAN.—This section  
11 shall not apply to coverage under a subsidized accident  
12 or health plan maintained by the S corporation for its em-  
13 ployees.”.

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

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

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

4 **SEC. 1005. EMPLOYER OBLIGATIONS.**

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

7 (1) have in effect an agreement described in  
8 section 1103 with the health plan purchasing cooper-  
9 ative (requiring the offering to employees of cov-  
10 erage through accountable health plans) for the  
11 HPPC area in which the employer has its principal  
12 place of business, and

13 (2) comply with such agreement.

14 (b) OTHER EMPLOYERS.—

15 (1) IN GENERAL.—Each employer that is not a  
16 small employer shall—

17 (A) offer to each employee (in a time and  
18 manner specified by the National Health  
19 Board) enrollment in a qualifying accountable  
20 health plan (as defined in paragraph (3)) both  
21 on an individual basis, and, if applicable and at  
22 the employee's option, on a family basis; and

23 (B) provide, at the option of the employee,  
24 for deduction from wages or other compensa-  
25 tion (in the manner specified in section

1           1103(c)) of amount of any premiums due for  
2           such enrollment (taking into account the  
3           amount of any employer contribution).

4           (2) OPEN ENROLLMENT PERIODS.—For pur-  
5           poses of paragraph (1)(A), the Board shall provide  
6           for—

7                   (A) initial enrollment periods (of not less  
8                   than 30 days) during which newly employed in-  
9                   dividuals are offered enrollment under a quali-  
10                  fying accountable health plan;

11                  (B) an annual open enrollment period (of  
12                  not less than 30 days) in which employees are  
13                  offered enrollment under a qualifying account-  
14                  able health plan (and, if there is a choice  
15                  among such plans, the opportunity to change  
16                  the plan in which the employee is enrolled); and

17                  (C) special enrollment periods during  
18                  which, because of a change in family situation  
19                  (such as marriage, birth or adoption of a child,  
20                  divorce, separation, or death), the employee is  
21                  offered the opportunity to change the type of  
22                  enrollment provided.

23           (3) QUALIFYING ACCOUNTABLE HEALTH  
24           PLAN.—For purposes of this subsection, the term

1 “qualifying accountable health plan” means, with re-  
2 spect to an employee, an accountable health plan—

3 (A) that serves the area in which the em-  
4 ployee resides, and

5 (B) for which the premium charged to the  
6 employee for a premium class does not exceed  
7 (except as provided in paragraph (4)) the pre-  
8 mium of the least expensive accountable health  
9 plan offered to individuals by a health plan pur-  
10 chasing cooperative in the HPPC area in which  
11 the employee resides for that premium class.

12 Nothing in this subsection shall be construed as pre-  
13 venting an employer from offering, or an employee  
14 from electing enrollment in, a health plan that  
15 serves the area in which the employee is employed,  
16 rather than the area in which the employee resides.

17 (4) SPECIAL RULE FOR CERTAIN CLOSED AHPS  
18 ELECTING SPECIAL COMMUNITY RATING.—In the  
19 case of a closed AHP offered to an employee, if the  
20 plan has made an election described in section  
21 1205(b)(3), paragraph (3)(B) shall be applied to the  
22 plan based on the weighted average of premiums de-  
23 termined without regard to age, HPPC area, or both  
24 (as elected under such section), rather than on the  
25 basis of premium class.

1 (c) NONDISCRIMINATION UNDER GROUP HEALTH  
2 PLANS.—

3 (1) APPLICATION OF RULES SIMILAR TO MEDI-  
4 CARE NONDISCRIMINATION RULES.—Subject to  
5 paragraph (2), the provisions of paragraphs (1)(A),  
6 (1)(D), (1)(E), (3)(A), and (3)(C) of section  
7 1862(b) of the Social Security Act shall apply to an  
8 individual eligible for low-income assistance under  
9 subtitle A of title II in the same manner as such  
10 provisions apply to an individual age 65 or over who  
11 is entitled to benefits under title XVIII of such Act  
12 under section 226(a) of such Act.

13 (2) RULES OF APPLICATION.—In applying  
14 paragraph (1) under this Act—

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

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

21 (C) any reference to title XVIII of such  
22 Act is deemed a reference to assistance under  
23 subtitle A of title II of this Act.

24 (d) ENFORCEMENT.—

25 (1) CIVIL MONEY PENALTIES.—

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

6 (B) FAILURE TO OFFER COVERAGE OR  
7 PROVIDE FOR WAGE DEDUCTION.—Failure to  
8 offer coverage or provide for deduction from  
9 wages required under subsection (b)(1) is sub-  
10 ject to a civil monetary penalty (not to exceed  
11 \$500) for each day in which the violation con-  
12 tinues.

13 (C) VIOLATION OF NONDISCRIMINATION  
14 REQUIREMENTS.—Failure to comply with the  
15 requirement of subsection (c) is subject to a  
16 civil monetary penalty (not to exceed \$500) for  
17 each day for each individual with respect to  
18 which the failure occurs.

19 (2) DIRECT ENFORCEMENT.—

20 (A) HPPC AGREEMENT.—An agreement in  
21 effect between a small employer and a HPPC is  
22 directly enforceable by civil action by the HPPC  
23 or by an employee (as a third-party beneficiary  
24 of the agreement). In any such action, if the  
25 HPPC or employee substantially prevails, the

1 HPPC or employee is entitled to reasonable at-  
 2 torneys' fees.

3 (B) OFFER.—The obligation to offer cov-  
 4 erage under subsection (b) with respect to an  
 5 employee is directly enforceable by civil action  
 6 by the employee. In any such action, if the em-  
 7 ployee substantially prevails, the employee is  
 8 entitled to reasonable attorneys' fees.

9 **Subtitle B—Health Plan**  
 10 **Purchasing Cooperatives (HPPCs)**

11 **SEC. 1101. ESTABLISHMENT AND ORGANIZATION; HPPC**  
 12 **AREAS.**

13 (a) HPPC AREAS.—

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

17 (2) ALTERNATIVE, INTRASTATE AREAS.—Each  
 18 State may provide for the division of the State into  
 19 HPPC areas so long as—

20 (A) all portions of each metropolitan sta-  
 21 tistical area in a State are within the same  
 22 HPPC area, and

23 (B) the number of eligible individuals re-  
 24 siding within a HPPC area is not less than  
 25 250,000.

1           (3) ALTERNATIVE, INTERSTATE AREAS.—In ac-  
2           cordance with rules established by the National  
3           Health Board, one or more contiguous States may  
4           provide for the establishment of a HPPC area that  
5           includes adjoining portions of the States so long as  
6           such area, if it includes any part of a metropolitan  
7           statistical area, includes all of such area. In the case  
8           of a HPPC serving a multi-state area, section  
9           1701(c)(2)(C) shall only apply to the area if all the  
10          States encompassed in the area by law agree to the  
11          number to be substituted.

12          (b) ESTABLISHMENT OF HPPCs.—

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

20               (2) INTERSTATE HPPC AREAS.—HPPCs with  
21               respect to interstate areas specified under subsection  
22               (a)(3) shall be established in accordance with rules  
23               of the National Health Board.

24          (c) COOPERATIVE BOARD.—

1           (1) ESTABLISHMENT.—Each HPPC shall be  
2           governed by a Cooperative Board which shall be ini-  
3           tially appointed by the Governor or other chief execu-  
4           tive officer of the State (or as otherwise provided  
5           under State law or by the National Health Board in  
6           the case of a HPPC described in subsection (b)(2)).  
7           The Cooperative Board for a HPPC shall be respon-  
8           sible for ensuring the performance of the duties of  
9           the HPPC under subsection (d).

10          (2) ELECTION.—By not later than January 1,  
11          1996, each HPPC shall provide under State law (or  
12          in the case of a HPPC described in subsection  
13          (b)(2), under rules established by the National  
14          Health Board) for the election of members to the  
15          Cooperative Board from among eligible individuals  
16          who are enrolled in an accountable health plan of-  
17          fered by the HPPC and who do not receive remu-  
18          neration from the HPPC or any such accountable  
19          health plan for any services provided.

20          (3) LIMITATION ON COMPENSATION.—A HPPC  
21          shall not provide compensation to members of the  
22          Cooperative Board other than reimbursement for  
23          reasonable and necessary expenses incurred in the  
24          performance of their duties as members of the Coop-  
25          erative Board.

1 (d) DUTIES OF HPPCs.—

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

4 (A) enter into agreements with accountable  
5 health plans under section 1102;

6 (B) enter into agreements with small em-  
7 ployers under section 1103;

8 (C) offer enrollment and enroll individuals  
9 under accountable health plans, in accordance  
10 with section 1104;

11 (D) charge, receive, and forward adjusted  
12 premiums, in accordance with section 1105, in-  
13 cluding reconciling low-income assistance  
14 among accountable health plans;

15 (E) provide for coordination with other  
16 HPPCs, in accordance with section 1106;

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

20 (G) conduct and analyze surveys of en-  
21 rollee satisfaction and monitor enrollee  
22 disenrollment, in accordance with section 1108;  
23 and

24 (H) carry out other functions provided for  
25 under this title.

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

3           (A) perform any activity (including review,  
4 approval, or enforcement) relating to payment  
5 rates for providers;

6           (B) except as specifically provided under  
7 sections 1102, 1105, or 1106(c), perform any  
8 activity (including review, approval, or enforce-  
9 ment) relating to premium rates for health  
10 plans;

11           (C) perform any activity (including reg-  
12 istration or enforcement) relating to compliance  
13 of accountable health plans with the require-  
14 ments of part 1 of subtitle C (other than as re-  
15 quired to carry out its specific duties under this  
16 subtitle or under section 1305(c)(2));

17           (D) discriminate among such plans, other  
18 than on the basis of the performance of such  
19 plans under this title, as determined in accord-  
20 ance with standards established by the National  
21 Health Board under this title;

22           (E) assume financial risk in relation to any  
23 such plan; or

24           (F) perform other activities identified by  
25 the National Health Board as being inconsist-

1 ent with the performance of its duties under  
2 paragraph (1).

3 (e) PERFORMANCE OF DUTIES.—

4 (1) IN GENERAL.—If the National Health  
5 Board finds that a HPPC is not carrying out its du-  
6 ties as required under subsection (d), the Board  
7 shall notify the Cooperative Board of the HPPC,  
8 and the Governor (or other chief executive officer) of  
9 each State in which the HPPC operates, of such  
10 finding and permit the Board an opportunity to take  
11 such action as may be necessary for the HPPC to  
12 carry out such duties.

13 (2) CORRECTIVE ACTION.—If, after such an op-  
14 portunity, the deficiency has not been corrected, the  
15 National Health Board may—

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

18 (B) take such other action as may be ap-  
19 propriate in order to assure the performance of  
20 such duties.

21 (3) PERFORMANCE CRITERIA.—

22 (A) DEVELOPMENT.—The National Health  
23 Board shall develop criteria relating to HPPC  
24 performance of duties. Such criteria shall in-  
25 clude criteria relating to the following:

1 (i) OVERHEAD.—The HPPC overhead  
2 percentage (computed under section  
3 1105(b)(2)) for the HPPC.

4 (ii) FLOAT.—The average period (de-  
5 scribed in section 1102(d)(2)) between the  
6 HPPC's receipt and payment of funds re-  
7 ceived.

8 (iii) SATISFACTION OF ELIGIBLE INDI-  
9 VIDUALS.—The satisfaction of eligible indi-  
10 viduals with the performance of the HPPC  
11 (as measured under surveys under section  
12 1108).

13 (iv) ENROLLMENT OF AT RISK INDI-  
14 VIDUALS.—The effectiveness of the  
15 HPPC's activities under section  
16 1102(b)(3) in enrolling individuals who are  
17 eligible for low-income assistance or who  
18 reside in medically underserved areas.

19 (B) REPORT.—Each HPPC shall report to  
20 the National Health Board, at such time and in  
21 such manner as the Board specifies, such infor-  
22 mation as the Board may require in order to  
23 evaluate the performance of the HPPC in ac-  
24 cordance with the criteria developed under sub-  
25 paragraph (A).

1 (C) PUBLICATION.—The National Health  
2 Board shall publish annually a report that pro-  
3 vides a comparison of the relative performance  
4 of each HPPC, based on such criteria.

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

9 **SEC. 1102. AGREEMENTS WITH ACCOUNTABLE HEALTH**  
10 **PLANS (AHPS).**

11 (a) AGREEMENTS.—

12 (1) OPEN AHPS.—Each HPPC for a HPPC  
13 area shall enter into an agreement under this section  
14 with each open accountable health plan (described in  
15 section 1701(b)(4)(B)) that serves residents of the  
16 area. Each such agreement under this section shall  
17 include (as specified by the National Health Board)  
18 provisions consistent with the requirements of the  
19 succeeding subsections of this section. A HPPC may  
20 not terminate such an agreement except as provided  
21 in paragraph (3)(A).

22 (2) CLOSED AHPS.—Each HPPC for a HPPC  
23 area shall enter into a special agreement under this  
24 paragraph with each closed AHP that serves resi-  
25 dents of the area, in order to carry out subsection

1 (e). Except as otherwise specifically provided, any  
 2 reference in this Act to an agreement under this sec-  
 3 tion shall not be considered to be a reference to an  
 4 agreement under this paragraph.

5 (3) TERMINATION OF AGREEMENT.—In accord-  
 6 ance with regulations of the National Health  
 7 Board—

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

10 (i) the AHP's registration under part  
 11 1 of subtitle C is revoked, or

12 (ii) the AHP is determined (in accord-  
 13 ance with rules established by the Board)  
 14 substantially to have violated the condi-  
 15 tions of such agreement; and

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

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

22 (b) OFFER OF ENROLLMENT OF INDIVIDUALS.—

23 (1) IN GENERAL.—Under an agreement under  
 24 this section between an AHP and a HPPC, the  
 25 HPPC shall offer, on behalf of the AHP, enrollment

1 in the AHP to eligible individuals (as defined in sec-  
2 tion 1701(a)(1)) at the applicable monthly premium  
3 rates (specified under section 1105(a)).

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

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

10 (B) to other eligible individuals, at such  
11 time (including an annual open enrollment pe-  
12 riod specified by the National Health Board) as  
13 the HPPC shall specify, consistent with section  
14 1104(b).

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

22 (c) RECEIPT OF GROSS PREMIUMS.—

23 (1) IN GENERAL.—Under an agreement under  
24 this section between a HPPC and an AHP, payment  
25 of premiums shall be made, by individuals or em-

1        employers on their behalf, directly to the HPPC for the  
2        benefit of the AHP.

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

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

17       (d) FORWARDING OF ADJUSTED PREMIUMS.—

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

1 (A) the standard premium rate (estab-  
2 lished under section 1205) received for the pre-  
3 mium class, and

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

9 (2) PAYMENTS.—Payments shall be made by  
10 the HPPC under this subsection within a period  
11 (specified by the National Health Board and not to  
12 exceed 3 business days) after the time of receipt of  
13 the premium from the employer of the eligible indi-  
14 vidual or the eligible individual, as the case may be,  
15 based on estimates of applicable risk-adjustment fac-  
16 tors. Subsequent payments shall be adjusted as ap-  
17 propriate to reflect differences between the payments  
18 that were made based on estimates and the pay-  
19 ments that should have been made based on re-  
20 ported (and audited) information.

21 (3) ADJUSTMENTS FOR DIFFERENCES IN  
22 NONPAYMENT RATES.—In accordance with rules es-  
23 tablished by the National Health Board, each agree-  
24 ment between an AHP and a HPPC under this sec-  
25 tion shall provide that, if a HPPC determines that

1 the rates of nonpayment of premiums during grace  
2 periods established under subsection (c)(2) vary ap-  
3 preciably among AHPs, the HPPC shall provide for  
4 such adjustments in the payments made under this  
5 subsection as will place each AHP in the same posi-  
6 tion as if the rates of nonpayment were the same.

7 (e) RECONCILIATION OF LOW-INCOME ASSISTANCE  
8 AMONG ACCOUNTABLE HEALTH PLANS.—

9 (1) IN GENERAL.—Each agreement between an  
10 AHP and a HPPC under this section (including a  
11 special agreement entered into under subsection  
12 (a)(2)) shall provide for such payments from the  
13 AHP to the HPPC, and such payments from the  
14 HPPC to the AHP, as the National Health Board  
15 determines is necessary in order to assure the equi-  
16 table distribution among all AHPs, nationwide, of  
17 reductions in premiums and cost-sharing under sec-  
18 tion 1205(c) and section 1202(c), respectively.

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

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

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

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

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

11 (a) IN GENERAL.—Each HPPC for a HPPC area  
12 shall enter into an agreement under this section with each  
13 small employer that employs individuals in the area. Each  
14 agreement under this section, between a small employer  
15 and a HPPC shall include (as specified by the National  
16 Health Board) provisions consistent with the requirements  
17 specified in the succeeding subsections of this section.

18 (b) FORWARDING INFORMATION ON ELIGIBLE EM-  
19 PLOYEES.—

20 (1) IN GENERAL.—Under an agreement under  
21 this section between a small employer and a HPPC,  
22 the employer must forward to the appropriate  
23 HPPC the name and address (and other identifying  
24 information required by the HPPC) of each em-  
25 ployee (including part-time and seasonal employees).

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

6           (c) PAYROLL DEDUCTION.—

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

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

16                 (B) payment of such amount (including  
17                 any such contribution) to the HPPC.

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

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

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

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

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

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

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

22 **SEC. 1104. ENROLLING INDIVIDUALS IN ACCOUNTABLE**  
23 **HEALTH PLANS THROUGH A HPPC.**

24 (a) OFFER OF ENROLLMENT.—

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

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

12           (b) ENROLLMENT PROCESS.—

13           (1) IN GENERAL.—Each HPPC shall establish  
14 an enrollment (and disenrollment) process in accord-  
15 ance with rules established by the National Health  
16 Board consistent with this subsection.

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

23           (3) GENERAL ENROLLMENT PERIOD.—Each  
24 HPPC shall establish an annual period, of not less  
25 than 30 days, during which eligible individuals may

1 enroll in an AHP or change the AHP in which the  
2 individual is enrolled.

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

5 (A) through marriage, divorce, birth or  
6 adoption of a child, or similar circumstances,  
7 experience a change in family composition, or

8 (B) experience a change in employment  
9 status (including a significant change in the  
10 terms and conditions of employment),

11 each HPPC shall provide for a special enrollment  
12 period in which the individual is permitted to change  
13 the individual or family basis of coverage or the  
14 AHP in which the individual is enrolled. The cir-  
15 cumstances under which such special enrollment pe-  
16 riods are required and the duration of such periods  
17 shall be specified by the National Health Board.

18 (5) TRANSITIONAL ENROLLMENT PERIOD.—  
19 Each HPPC shall provide for a special transitional  
20 enrollment period (during a period beginning in the  
21 Fall of 1994 specified by the National Health  
22 Board) during which eligible individuals may first  
23 enroll.

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

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

10          (c) ANALYSIS AND DISTRIBUTION OF COMPARATIVE  
11 INFORMATION.—

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

21                   (A) to maintain and improve clinical  
22 health, functional status, and well-being, and

23                   (B) to satisfy enrolled individuals.

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

1 (2) DISTRIBUTION OF INFORMATION.—

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

13 (B) ADDITIONAL INFORMATION.—Such in-  
14 formation shall include—

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

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

23 (d) PERIOD OF COVERAGE.—

24 (1) INITIAL ENROLLMENT PERIOD.—In the case  
25 of an eligible individual who enrolls with an AHP

1 through a HPPC during an initial enrollment period,  
2 coverage under the plan shall begin on such date  
3 (not later than the first day of the first month that  
4 begins at least 15 days after the date of enrollment)  
5 as the National Health Board shall specify.

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

12 (3) SPECIAL ENROLLMENT PERIODS.—

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

24 (B) TRANSITIONAL SPECIAL ENROLLMENT  
25 PERIOD.—In the case of an eligible individual

1           who enrolls with an AHP during the transi-  
2           tional special enrollment period described in  
3           subsection (b)(5), coverage under the plan shall  
4           begin on January 1, 1995.

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

12 **SEC. 1105. RECEIPT OF PREMIUMS.**

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

16               (1) the amount of the premium applicable to  
17               the individual under section 1205(a)(1)(B) for such  
18               coverage, and

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

22          (b) HPPC OVERHEAD AMOUNT.—

23               (1) HPPC BUDGET.—Each HPPC shall estab-  
24               lish a budget for each year for each HPPC area in

1 accordance with regulations established by the Na-  
2 tional Health Board.

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

15 (3) HPPC OVERHEAD AMOUNT.—The HPPC  
16 overhead amount for enrollment, whether on an indi-  
17 vidual or family basis, in an AHP for a HPPC area  
18 for a month is equal to the applicable HPPC over-  
19 head percentage (computed under paragraph (2))  
20 multiplied by the weighted average of the standard  
21 premium amounts for premium classes for enroll-  
22 ment on an individual basis under the AHP for the  
23 month (taking into account any reduction in pre-  
24 miums attributable to low-income assistance under  
25 section 2002).

1 **SEC. 1106. COORDINATION AMONG HPPCS.**

2 (a) IN GENERAL.—The National Health Board shall  
3 establish rules consistent with this section for—

4 (1) coordination among HPPCs in cases where  
5 small employers are located in one HPPC area and  
6 their employees reside in a different HPPC area  
7 (and are eligible for enrollment with AHPs located  
8 in the other area), and

9 (2) coordination among HPPCs in the low-in-  
10 come assistance reconciliation processes under sec-  
11 tion 1102(e)(1).

12 The Board shall establish standards for operational soft-  
13 ware in order to promote coordination among HPPCs  
14 under this title.

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

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

20 (A) for providing information to the em-  
21 ployer’s employees on AHPs for areas in which  
22 employees reside;

23 (B)(i) for enrolling employees under the  
24 AHP selected (even if the AHP selected is not  
25 in the same HPPC area as the HPPC) and (ii)  
26 if the AHP chosen is not in the same HPPC

1 area as the HPPC, for forwarding the enroll-  
2 ment information to the HPPC for the area in  
3 which the AHP selected is located; and

4 (C) in the case of premiums to be paid  
5 through payroll deduction, or employer con-  
6 tribution, or both, to receive such premiums  
7 and forward them to the HPPC for the area in  
8 which the AHP selected is located.

9 (2) HPPC FOR EMPLOYEE RESIDENCE.—The  
10 HPPC for the HPPC area in which an employee re-  
11 sides shall be responsible for providing other HPPCs  
12 with information concerning AHPs being offered in  
13 such HPPC area.

14 (c) COORDINATION OF RECONCILIATION OF LOW-IN-  
15 COME ASSISTANCE.—Under the rules established under  
16 subsection (a)(2), the Board shall provide for such pay-  
17 ments among the different HPPCs as the Board deter-  
18 mines is necessary in order to assure the equitable dis-  
19 tribution among AHPs in different HPPC areas of adjust-  
20 ments in premiums and cost-sharing under section  
21 1205(c) and section 1202(c), respectively.

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

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

1 (b) OMBUDSMAN.—

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

3 (A) for the appointment of an ombudsman,  
4 and

5 (B) for a reasonable salary and staff for  
6 the ombudsman.

7 (2) DUTIES AND AUTHORITIES.—Each ombuds-  
8 man shall have the duty and authority to do the fol-  
9 lowing:

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

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

15 (iii) To issue public reports and reports to  
16 the National Health Board on the HPPC's per-  
17 formance of such duties.

18 (B) RELATING TO AHPS.—(i) To inves-  
19 tigate complaints concerning the failure of an  
20 AHP to meet the applicable requirements of  
21 part 1 of subtitle C.

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

24 (iii) To issue public reports and reports to  
25 the National Health Board on any finding that

1 an AHP has failed to meet the applicable re-  
2 quirements of part 1 of subtitle C.

3 (3) ACCESS TO INFORMATION.—The HPPC  
4 shall provide the ombudsman and the ombudsman’s  
5 staff with access to such information as may be nec-  
6 essary to carry out such duties.

7 **SEC. 1108. ENROLLEE SATISFACTION SURVEYS; MONITOR-**  
8 **ING ENROLLEE DISENROLLMENT.**

9 (a) ENROLLEE SATISFACTION SURVEYS.—

10 (1) IN GENERAL.—Each HPPC, using a stand-  
11 ard survey instrument prescribed by the National  
12 Health Board, shall collect information on the satis-  
13 faction of eligible individuals with—

14 (A) the performance of the HPPC, and

15 (B) the performance of the AHP in which  
16 they are enrolled.

17 (2) ANALYSIS.—Each HPPC shall—

18 (A) analyze the information collected under  
19 paragraph (1),

20 (B) submit to the National Health Board  
21 an annual report that summarizes such analy-  
22 sis, and

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

1 (b) MONITORING ENROLLEE DISENROLLMENT.—  
 2 Each HPPC shall monitor enrollee disenrollment from  
 3 AHPs in order to determine whether there is a pattern  
 4 of disenrollment which does not reflect the distribution of  
 5 age, income, health condition, place of residence, and other  
 6 potential risk characteristics of their enrollees. If a HPPC  
 7 determines that such a pattern exists, the HPPC shall  
 8 provide the National Health Board with such information  
 9 on such pattern as the Board may specify and may peti-  
 10 tion under section 1305(c)(2) for the revocation of the reg-  
 11 istration of the AHP.

12 **Subtitle C—Accountable Health**  
 13 **Plans (AHPs)**

14 **PART 1—REQUIREMENTS FOR ACCOUNTABLE**  
 15 **HEALTH PLANS**

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

17 (a) IN GENERAL.—The National Health Board shall  
 18 provide a process whereby a health plan (as defined in sec-  
 19 tion 1701(c)(1)) may be registered with the Board by its  
 20 sponsor as an accountable health plan. Such a registered  
 21 AHP is authorized to allocate its resources (except as oth-  
 22 erwise specifically required under this subtitle) to maxi-  
 23 mize the health of its enrollees.

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

1           (1) provide, in accordance with section 1202,  
2 for coverage of the uniform set of effective benefits  
3 specified by the Board, for adjustments in cost-shar-  
4 ing in the case of low-income individuals, and for  
5 meeting quality standards established by the Board;

6           (2) provide, in accordance with section 1203,  
7 for the collection and provision to the Board and  
8 HPPCs of certain information regarding its enrollees  
9 and provision of services;

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

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

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

17          (6) meet requirements relating to grievance pro-  
18 cedures, physician incentive plans, advance direc-  
19 tives, and agent commissions, in accordance with  
20 section 1207;

21          (7) in the case of an open plan (as defined in  
22 section 1701(b)(4)(B)), meet certain additional re-  
23 quirements under section 1208 (relating to offering  
24 of plans, acceptance of enrollees, and participation

1 as a plan under the medicare program and under  
2 the Federal employees health benefits program);

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

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

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

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

13 (c) **MINIMUM SIZE FOR CLOSED PLANS.**—No plan  
14 may be registered as a closed AHP under this section un-  
15 less the plan covers at least a number of employees greater  
16 than the applicable number of employees specified in or  
17 under section 1701(c)(2).

18 **SEC. 1202. SPECIFIED UNIFORM SET OF EFFECTIVE BENE-**  
19 **FITS; REDUCTION IN COST-SHARING FOR**  
20 **LOW-INCOME INDIVIDUALS; QUALITY STAND-**  
21 **ARDS.**

22 (a) **BENEFITS.**—The National Health Board shall  
23 not accept the registration of a health plan as an AHP  
24 unless, subject to subsection (b), the plan—

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

3           (2) has entered into arrangements with a suffi-  
4 cient number, distribution, and variety of providers  
5 to assure that the uniform set of effective benefits  
6 is—

7                   (A) available and accessible to each en-  
8 rollee, within the area served by the plan, with  
9 reasonable promptness and in a manner which  
10 assures continuity, and

11                   (B) when medically necessary, available  
12 and accessible twenty-four hours a day and  
13 seven days a week,

14 without imposing cost-sharing in excess of the cost-  
15 sharing described in paragraph (4);

16           (3) provides for the application of coverage  
17 standards, with respect to the uniform set of effec-  
18 tive benefits, which are disclosed by the plan to plan  
19 enrollees (in a manner specified by the Board) and  
20 which are consistent with coverage criteria under  
21 section 1302(b) (as interpreted by the Board);

22           (4) if it is a network plan (as defined in section  
23 1222(b)(1)) makes available to nonparticipating pro-  
24 viders, upon request, the criteria used in selecting

1 those providers that are permitted to participate in  
2 the plan;

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

6 (B) does not permit providers participating in  
7 the plan under paragraph (2) to charge for services  
8 included in the uniform set of effective benefits serv-  
9 ices amounts in excess of such cost-sharing; and

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

14 (b) TREATMENT OF ADDITIONAL BENEFITS.—

15 (1) IN GENERAL.—Subject to paragraphs (2)  
16 and (3), subsection (a) shall not be construed as  
17 preventing an AHP from offering benefits in addi-  
18 tion to the uniform set of effective benefits, if such  
19 additional benefits are offered, and priced, sepa-  
20 rately from the benefits described in subsection (a).

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

1 (A) of duplicating the benefits required  
2 under subsection (a), or

3 (B) of reducing the cost-sharing below the  
4 uniform cost-sharing.

5 The National Health Board may file an action, in  
6 any appropriate court, to enjoin an entity (other  
7 than an AHP) that violates this paragraph.

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

15 (d) LIMITATION ON IMPOSITION OF COST-SHAR-  
16 ING.—In order to assure that providers of services for  
17 which benefits are available through an AHP do not im-  
18 pose cost-sharing in excess of that permitted under sub-  
19 section (a)(5), each AHP may not provide payment for  
20 services (other than emergency services) furnished by a  
21 provider with an arrangement described in subsection  
22 (a)(2) to meet the uniform set of effective benefits unless  
23 the provider has agreed (in a manner specified by the Na-  
24 tional Health Board) not to impose cost-sharing in excess  
25 of that so specified.

1 (e) QUALITY STANDARDS.—The National Health  
2 Board shall establish standards relating to the minimum  
3 level of acceptable quality for an AHP’s provision of the  
4 uniform set of effective benefits. In order for a plan to  
5 be registered under this subtitle, the plan must agree to  
6 provide benefits in a manner that complies with such  
7 standards.

8 **SEC. 1203. COLLECTION AND PROVISION OF STANDARD-**  
9 **IZED INFORMATION.**

10 (a) PROVISION OF INFORMATION.—

11 (1) IN GENERAL.—Each AHP must provide the  
12 applicable HPPC and the National Health Board (at  
13 a time, not less frequently than annually, and in an  
14 electronic, standardized form and manner specified  
15 by the Board) such information as the Board deter-  
16 mines to be necessary, consistent with this sub-  
17 section and sections 1104(c) and 1307, to forward  
18 payments to AHPs under section 1102(d) and to  
19 evaluate the performance of the AHP in providing  
20 the uniform set of effective benefits to enrollees in  
21 each HPPC area.

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

1 (A) Information on the characteristics of  
2 enrollees that may affect their need for or use  
3 of health services and the determination of risk-  
4 adjustment factors for enrollee units.

5 (B) Information on the types of treatments  
6 and outcomes of treatments with respect to the  
7 clinical health, functional status, and well-being  
8 of enrollees.

9 (C) Information on health care expendi-  
10 tures, volume and prices of procedures, and use  
11 of specialized centers of care (for which infor-  
12 mation is submitted under section 1308).

13 (D) Information on the flexibility per-  
14 mitted by plans to enrollees in their selection of  
15 providers.

16 (3) SPECIAL TREATMENT.—The Board may  
17 waive the provision of such information under para-  
18 graph (2), or require such other information, as the  
19 Board finds appropriate in the case of a newly es-  
20 tablished AHP for which such information is not  
21 available.

22 (b) CONDITIONING CERTAIN PROVIDER PAY-  
23 MENTS.—

24 (1) IN GENERAL.—In order to assure the collec-  
25 tion of all information required from the direct pro-

1       viders of services for which benefits are available  
2       through an AHP, each AHP may not provide pay-  
3       ment for services (other than emergency services)  
4       furnished by a provider to meet the uniform set of  
5       effective benefits unless the provider has given the  
6       AHP (or has given directly to the National Health  
7       Board and the applicable HPPC) standard informa-  
8       tion (specified by the Board) respecting the services.

9           (2) FORWARDING INFORMATION.—If informa-  
10       tion under paragraph (1) is given to the AHP, the  
11       AHP is responsible for forwarding the information  
12       to the Board and the applicable HPPC.

13       (c) AUDITING.—Each AHP shall provide, in accord-  
14       ance with standards established by the Board, for the au-  
15       diting of information provided under this section.

16       **SEC. 1204. PROHIBITION OF DISCRIMINATION BASED ON**  
17                           **HEALTH STATUS FOR CERTAIN CONDITIONS;**  
18                           **LIMITATION ON PRE-EXISTING CONDITION**  
19                           **EXCLUSIONS.**

20       (a) IN GENERAL.—Except as provided under sub-  
21       section (b), an AHP may not deny, limit, or condition the  
22       coverage under (or benefits of) the plan based on the  
23       health status of an individual, claims experience of an indi-  
24       vidual, receipt of health care by an individual, medical his-  
25       tory of an individual, receipt of public subsidies by an indi-

1 vidual, lack of evidence of insurability of an individual, or  
2 any other characteristic of the individual that may relate  
3 to the need for health care services.

4 (b) TREATMENT OF PREEXISTING CONDITION EX-  
5 CLUSIONS FOR SERVICES.—

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

14 (2) CREDITING OF PREVIOUS COVERAGE.—

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

24 (B) DEFINITIONS.—As used in this para-  
25 graph:

1 (i) PERIOD OF CONTINUOUS COV-  
2 ERAGE.—

3 (I) IN GENERAL.—The term “pe-  
4 riod of continuous coverage” means  
5 the period beginning on the date an  
6 individual is enrolled under an AHP  
7 and ends on the date the individual is  
8 not so enrolled for a continuous period  
9 of more than 3 months.

10 (II) TRANSITIONAL AMNESTY AT  
11 TIME OF INITIAL ENROLLMENT.—For  
12 purposes of this clause, each individ-  
13 ual who enrolls in an AHP before  
14 July 1, 1995, is considered to have  
15 had a period of continuous coverage  
16 during the 6 months ending January  
17 1, 1995.

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

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

5           (4) SPECIAL RULE FOR CERTAIN HEALTH  
6           MAINTENANCE ORGANIZATIONS.—A health mainte-  
7           nance organization that is an AHP shall not be con-  
8           sidered as failing to meet the requirements of sec-  
9           tion 1301 of the Public Health Service Act notwith-  
10          standing that it provides for an exclusion of the type  
11          described in paragraph (1) so long as such exclusion  
12          is applied consistent with the previous provisions of  
13          this subsection.

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

15          (a) STANDARD PREMIUMS FOR OPEN AHPs.—

16               (1) IN GENERAL.—

17                   (A) ESTABLISHMENT.—Subject to sub-  
18                   section (c), each open AHP shall establish a  
19                   standard premium for the uniform set of effec-  
20                   tive benefits within each HPPC area in which  
21                   the plan is offered.

22                   (B) APPLICABLE PREMIUM.—The amount  
23                   of premium applicable for all individuals within  
24                   a premium class (established under paragraph  
25                   (2)) is the standard premium amount multiplied

1 by the premium class factor specified by the  
2 Board for that class under paragraph (2)(B).

3 (C) UNIFORMITY WITHIN A YEAR.—Within  
4 a HPPC area for individuals within a premium  
5 class for months in a calendar year, the stand-  
6 ard premium for all individuals in the class for  
7 each month shall be the same.

8 (2) PREMIUM CLASSES.—

9 (A) IN GENERAL.—The National Health  
10 Board shall establish premium classes—

11 (i) based on types of enrollment (de-  
12 scribed in section 1701(c)(6)), and

13 (ii) within each type of enrollment,  
14 based on the age of the principal enrollee  
15 (or based on the age of another family  
16 member of such enrollee in such cases as  
17 the Board may provide).

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

22 (B) PREMIUM CLASS FACTORS.—

23 (i) IN GENERAL.—For each premium  
24 class established under subparagraph (A),  
25 the National Health Board shall establish

1 a premium class factor that reflects, sub-  
2 ject to clause (ii), the relative actuarial  
3 value of benefits for that class compared to  
4 the actuarial value of benefits for an aver-  
5 age class. The weighted average of the pre-  
6 mium class factors shall be 1. Such pre-  
7 mium class factors shall be computed  
8 based on the actuarial value of benefits for  
9 such population group within the class  
10 (which shall include the population eligible  
11 to enroll with open AHPs through HPPCs)  
12 as the Board determines to be appropriate.

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

23 (3) METHODOLOGY.—The amount of premiums  
24 forwarded to AHPs is adjusted in accordance with  
25 section 1102(d)(1).

1 (b) STANDARD PREMIUMS FOR CLOSED AHPs.—

2 (1) ESTABLISHMENT.—Subject to subsection  
3 (c) and paragraph (3), each closed AHP shall estab-  
4 lish a standard premium for the uniform set of ef-  
5 fective benefits within each HPPC area in which the  
6 plan is offered.

7 (2) APPLICATION BY PREMIUM CLASS.—Subject  
8 to paragraph (3)—

9 (A) the amount of premium applicable for  
10 all individuals within a premium class is the  
11 standard premium amount multiplied by the  
12 premium class factor specified by the Board for  
13 that class under subsection (a)(2)(B), and

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

18 (3) COMMUNITY RATING PERMITTED.—

19 (A) SAME RATES WITHIN TYPE OF EN-  
20 ROLLMENT WITHOUT REGARD TO AGE.—A  
21 closed AHP may elect (in a manner specified by  
22 the National Health Board) to apply this sub-  
23 section on the basis of type of enrollment rather  
24 than premium class. In such case, all references  
25 in this subsection to premium class are deemed

1 a reference to type of enrollment and the ref-  
2 erence to premium class factor (for a type of  
3 enrollment) is the weighted average of such fac-  
4 tors for the plan within the type of enrollment.

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

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

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

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

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

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

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

10                  (2) MODERATELY LOW-INCOME INDIVIDUALS.—

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

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

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

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

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

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

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

11 **SEC. 1206. FINANCIAL SOLVENCY REQUIREMENTS.**

12          (a) SOLVENCY PROTECTION.—

13           (1) FOR INSURED PLANS.—In the case of an  
14          AHP that is an insured plan (as defined by the Na-  
15          tional Health Board) and is issued in a State, in  
16          order for the plan to be registered under this sub-  
17          title the Board must find that the State has estab-  
18          lished satisfactory protection of enrollees with re-  
19          spect to potential insolvency of the plan.

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

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

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

15 (a) EFFECTIVE GRIEVANCE PROCEDURES.—

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

21 (2) ACCESS OF OMBUDSMAN TO INFORMA-  
 22 TION.—Each AHP shall provide the ombudsman,  
 23 appointed under section 1107(b) for the HPPC area  
 24 in which the AHP operates, and the ombudsman's  
 25 staff with access to such information as may be nec-

1        essary for the ombudsman to carry out duties under  
2        such section.

3        (b) RESTRICTION ON CERTAIN PHYSICIAN INCEN-  
4        TIVE PLANS.—

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

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

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

1 would apply to the plan if the plan were an eligible organi-  
2 zation.

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

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

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

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

12 (a) REQUIREMENT OF AGREEMENT WITH HPPC.—

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

18 (b) REQUIREMENT OF OPEN ENROLLMENT.—

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

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

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

7 (A) nonpayment of premiums,

8 (B) fraud or misrepresentation, or

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

13 (3) TREATMENT OF NETWORK PLANS.—

14 (A) GEOGRAPHIC LIMITATIONS.—

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

23 (ii) SERVICE AREAS.—The National  
24 Health Board shall establish standards for  
25 the designation by network plans of service

1 areas in order to prevent discrimination  
2 based on health status of individuals or  
3 their need for health services.

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

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

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

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

1 are not eligible to enroll in another network  
2 plan.

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

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

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

22 (2) EXPANSION OF MEDICARE SELECT PRO-  
23 GRAM.—Subsection (c) of section 4358 of the Omni-  
24 bus Budget Reconciliation Act of 1990 (104 Stat.  
25 1388–137) is amended by striking “only apply in 15

1 States” and all that follows through the end and in-  
2 sserting “on and after January 1, 1992.”.

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

6 (d) PARTICIPATION IN FEHBP.—

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

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

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

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

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

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

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

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

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

17 (1) acceptance of information, electronically,  
18 from the National Health Board on the eligibility of  
19 individuals (and family members) for low-income as-  
20 sistance under subtitle A of title II,

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

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

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

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

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

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

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

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

8 (b) PAYMENT METHOD.—

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

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

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

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

24 (2) a closed AHP, an actuarial equivalent value  
25 (as established in accordance with rules of the  
26 Board, similar to the rules established for purposes

1 of section 4980C(d)(1) of the Internal Revenue Code  
2 of 1986).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 (b) DEFINITIONS.—In this section:

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

19                   (A) which—

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

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

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

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

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

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

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

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

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

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

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

19 **PART 3—CLARIFYING APPLICATION OF FEDERAL**  
20 **ANTITRUST LAWS TO ACCOUNTABLE**  
21 **HEALTH PLANS.**

22 **SEC. 1231. PUBLICATION OF GUIDELINES.**

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

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

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

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

## 15 **Subtitle D—National Health Board**

### 16 **SEC. 1301. ESTABLISHMENT OF NATIONAL HEALTH BOARD.**

17 (a) IN GENERAL.—There is hereby established, as an  
18 independent agency in the Executive Branch, a National  
19 Health Board (in this title referred to as the “Board”).

20 (b) COMPOSITION AND TERMS.—

21 (1) APPOINTMENT.—The Board shall be com-  
22 posed of 5 members appointed by the President by  
23 and with the advice and consent of the Senate. In  
24 appointing members to the Board, the President  
25 shall provide that all members shall demonstrate ex-

1       perience with and knowledge of the health care sys-  
2       tem.

3               (2) CHAIRMAN.—The President shall designate  
4       one of the members to be Chairman of the Board.

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

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

15              (5) OTHER EMPLOYMENT PROHIBITED.—A  
16       member of the Board may not, during the term as  
17       a member, engage in any other business, vocation,  
18       profession, or employment.

19              (6) QUORUM.—Three members of the Board  
20       shall constitute a quorum, except that 2 members  
21       may hold hearings.

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

24              (8) COMPENSATION.—Each member of the  
25       Board shall be entitled to compensation at the rate

1 provided for level II of the Executive Schedule, sub-  
2 ject to such amounts as are provided in advance in  
3 appropriation Acts.

4 (c) PERSONNEL.—

5 (1) IN GENERAL.—The Board shall appoint an  
6 Executive Director and such additional officers and  
7 employees as it considers necessary to carry out its  
8 functions under this Act. Except as otherwise pro-  
9 vided in any other provision of law, such officers and  
10 employees shall be appointed, and their compensa-  
11 tion shall be fixed, in accordance with title 5, United  
12 States Code.

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

17 (d) USE OF U.S. MAIL.—The Board may use the  
18 United States mails in the same manner and under the  
19 same conditions as other departments and agencies of the  
20 United States.

21 **SEC. 1302. SPECIFICATION OF UNIFORM SET OF EFFECTIVE**  
22 **BENEFITS.**

23 (a) SPECIFICATION OF UNIFORM SET OF EFFECTIVE  
24 BENEFITS; CONGRESSIONAL CONSIDERATION.—

1           (1) TRANSMITTAL OF RECOMMENDATIONS TO  
2 CONGRESS.—

3           (A) FOR 1995.—The Board shall transmit  
4 to Congress, by not later than July 1, 1994,  
5 recommendations for the uniform set of effec-  
6 tive benefits to apply under this title for 1995  
7 and, subject to subparagraph (B), subsequent  
8 years.

9           (B) LATER YEARS.—The Board may  
10 transmit to Congress, by not later than July 1  
11 of a subsequent year, recommendations for  
12 changes in the uniform set of effective benefits  
13 to apply under this title for the following year  
14 (and, subject to this subparagraph, subsequent  
15 years).

16           (C) CONGRESSIONAL CONSIDERATION.—

17           (i) IN GENERAL.—Recommendations  
18 transmitted under subparagraph (A) or  
19 (B) shall apply under this title unless a  
20 joint resolution (described in clause (ii))  
21 disapproving such recommendations is en-  
22 acted, in accordance with the provisions of  
23 clause (iii), before the end of the 44-day  
24 period beginning on the date on which  
25 such recommendations were transmitted.

1 For purposes of applying the preceding  
2 sentence and clauses (ii) and (iii), the days  
3 on which either House of Congress is not  
4 in session because of an adjournment of  
5 more than three days to a day certain shall  
6 be excluded in the computation of a period.

7 (ii) JOINT RESOLUTION OF DIS-  
8 APPROVAL.—A joint resolution described in  
9 this clause means only a joint resolution  
10 which is introduced within the 10-day pe-  
11 riod beginning on the date on which the  
12 Board transmits recommendations under  
13 subparagraph (A) or (B) and—

14 (I) which does not have a pre-  
15 amble;

16 (II) the matter after the resolv-  
17 ing clause of which is as follows:  
18 “That Congress disapproves the rec-  
19 ommendations of the National Health  
20 Board concerning the uniform set of  
21 effective benefits as transmitted by  
22 the Board on \_\_\_\_\_”, the  
23 blank space being filled in with the  
24 appropriate date; and

1 (III) the title of which is as fol-  
2 lows: “Joint resolution disapproving  
3 the recommendations of the National  
4 Health Board concerning the uniform  
5 set of effective benefits as transmitted  
6 by the Board on \_\_\_\_\_.”,  
7 the blank space being filled in with  
8 the appropriate date.

9 (iii) PROCEDURES FOR CONSIDER-  
10 ATION OF RESOLUTION OF DIS-  
11 APPROVAL.—Subject to clause (iv), the  
12 provisions of section 2908 (other than sub-  
13 section (a)) of the Defense Base Closure  
14 and Realignment Act of 1990 shall apply  
15 to the consideration of a joint resolution  
16 described in clause (ii) in the same manner  
17 as such provisions apply to a joint resolu-  
18 tion described in section 2908(a) of such  
19 Act.

20 (iv) SPECIAL RULES.—For purposes  
21 of applying clause (iii) with respect to such  
22 provisions—

23 (I) any reference to the Commit-  
24 tee on Armed Services of the House of  
25 Representatives shall be deemed a ref-

1           erence to the Committee on Energy  
2           and Commerce of the House of Rep-  
3           resentatives and any reference to the  
4           Committee on Armed Services of the  
5           Senate shall be deemed a reference to  
6           the Committee on Finance of the Sen-  
7           ate; and

8           (II) any reference to the date on  
9           which the President transmits a re-  
10          port shall be deemed a reference to  
11          the date on which the Board trans-  
12          mits a recommendation under sub-  
13          paragraph (A) or (B).

14          (D) TREATMENT OF DISAPPROVAL.—

15          (i) FOR 1995.—If recommendations  
16          transmitted under subparagraph (A) are  
17          disapproved by joint resolution under sub-  
18          paragraph (C), then the Board shall trans-  
19          mit to Congress, by not later than 15 days  
20          after the date of adoption of the resolution,  
21          recommendations for the uniform set of ef-  
22          fective benefits to apply under this title for  
23          1995 and, subject to subparagraph (B),  
24          subsequent years. The provisions of sub-  
25          paragraph (C) shall apply to such new rec-

1           ommendations in the same manner as they  
2           applied to the recommendations previously  
3           transmitted under subparagraph (A), ex-  
4           cept that any time period specified in such  
5           subparagraph shall be half the period oth-  
6           erwise provided.

7           (ii) FOR SUBSEQUENT YEARS.—If rec-  
8           ommendations transmitted under subpara-  
9           graph (B) are disapproved by joint resolu-  
10          tion under subparagraph (C), then such  
11          recommendations shall not take effect and  
12          the recommendations not previously dis-  
13          approved under this paragraph shall con-  
14          tinue in effect until otherwise changed.

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

17           (A) MEDICALLY APPROPRIATE TREAT-  
18           MENTS.—The uniform set of effective benefits  
19           submitted under paragraph (1) shall include  
20           such categories of health care services that the  
21           Board determines will provide for the delivery  
22           of medically appropriate treatment by AHPs.

23           (B) COVERAGE OF CLINICAL PREVENTIVE  
24           SERVICES.—Such benefits shall include the full  
25           range of effective clinical preventive services

1 (including appropriate screening, counseling,  
2 and immunization and chemoprophylaxis), spec-  
3 ified by the Board, appropriate to age and  
4 other risk factors.

5 (C) COVERAGE OF DIAGNOSTIC SERV-  
6 ICES.—Such benefits shall include a full range  
7 of diagnostic services not covered under sub-  
8 paragraph (B).

9 (D) GUIDELINES.—Nothing in this para-  
10 graph shall prohibit the Board from developing  
11 guidelines that would specify the appropriate  
12 uses of treatment in greater detail.

13 (E) ADDITIONAL COVERAGE.—Nothing in  
14 this paragraph shall be construed as preventing  
15 a plan from providing coverage of treatment  
16 that has not been determined (under subsection  
17 (b)) by the Board to be medically appropriate  
18 for purposes of this paragraph.

19 (3) COST-SHARING.—

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

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

1           tion 1222(b)), the plan may provide for charg-  
 2           ing cost-sharing in excess of the uniform cost-  
 3           sharing under subparagraph (A) in the case of  
 4           services provided by providers that are not par-  
 5           ticipating providers (as defined in such section).

6           (b) CRITERIA FOR DETERMINATION OF MEDICALLY  
 7 APPROPRIATENESS FOR BENEFIT COVERAGE.—

8           (1) IN GENERAL.—An AHP is required to pro-  
 9           vide for coverage of the uniform set of effective ben-  
 10          efits only for treatments and diagnostic procedures  
 11          that are medically appropriate. Subject to the suc-  
 12          ceeding provision of this subsection, for purposes of  
 13          this section, a treatment (as defined in paragraph  
 14          (6)(A)) or diagnostic procedure is considered to be  
 15          “medically appropriate” if the following criteria are  
 16          met (as interpreted by the Board):

17                   (A) TREATMENT OR DIAGNOSIS OF MEDI-  
 18          CAL CONDITION.—

19                   (i) IN GENERAL.—The treatment or  
 20                   diagnostic procedure is for a medical con-  
 21                   dition.

22                   (ii) MEDICAL CONDITION DEFINED.—  
 23                   The term “medical condition” means a dis-  
 24                   ease, illness, injury, or biological or psycho-  
 25                   logical condition or status for which treat-

1           ment is indicated to improve, maintain, or  
2           stabilize a health outcome (as defined in  
3           paragraph (6)(B)) or which, in the absence  
4           of treatment, could lead to an adverse  
5           change in a health outcome.

6           (iii) ADVERSE CHANGE IN HEALTH  
7           OUTCOME DEFINED.—In clause (ii), an ad-  
8           verse change in a health outcome occurs if  
9           there is a biological or psychological  
10          decremental change in a health status or if  
11          the original endowment for a feature lies  
12          outside the normal range.

13          (B) NOT INVESTIGATIONAL.—There must  
14          be sufficient evidence on which to base conclu-  
15          sions about the existence and magnitude of the  
16          change in health outcome resulting from the  
17          treatment or diagnostic procedure compared  
18          with the best available alternative (or with no  
19          treatment or diagnostic procedure if no alter-  
20          native treatment or procedure is available).

21          (C) EFFECTIVE AND SAFE.—The evidence  
22          must demonstrate that the treatment or diag-  
23          nostic procedure can reasonably be expected to  
24          produce the intended health result or provide  
25          intended health information and is safe and the

1 treatment or diagnostic procedure provides a  
2 clinically meaningful benefit with respect to  
3 safety and effectiveness in comparison to other  
4 available alternatives.

5 (2) TREATMENT OR DIAGNOSTIC PROCEDURE  
6 CONSISTENT WITH PRACTICE GUIDELINES.—A treat-  
7 ment or diagnostic procedure that is provided con-  
8 sistent with a practice guideline established by the  
9 Agency for Clinical Evaluations, established under  
10 section 1309, (or its predecessor) is deemed to be  
11 medically appropriate.

12 (3) RELATIONSHIP TO FDA REVIEW.—

13 (A) APPROVED DRUGS, BIOLOGICALS, AND  
14 MEDICAL DEVICES.—

15 (i) DRUGS.—A drug that has been  
16 found to be safe and effective under sec-  
17 tion 505 of the Federal Food, Drug, and  
18 Cosmetic Act is deemed to meet the re-  
19 quirements of paragraphs (1)(B) and  
20 (1)(C) (relating to not investigational and  
21 safety and effectiveness).

22 (ii) BIOLOGICALS.—A biological that  
23 has been found to be safe and effective  
24 under section 351 of the Public Health  
25 Service Act is deemed to meet the require-

1           ments of paragraphs (1)(B) and (1)(C)  
2           (relating to not investigational and safety  
3           and effectiveness).

4           (iii) MEDICAL DEVICES.—A medical  
5           device that is marketed after the provision  
6           of a notice under section 510(k) of the  
7           Federal Food, Drug, and Cosmetic Act or  
8           that has an application for premarket ap-  
9           proval approved under section 515 of such  
10          Act is deemed to meet the requirements of  
11          paragraphs (1)(B) and (1)(C) (relating to  
12          not investigational and safety and effec-  
13          tiveness).

14          (B) OTHER DRUGS, BIOLOGICALS, AND DE-  
15          VICES.—A drug, biological, or medical device  
16          not described in subparagraph (A) shall be con-  
17          sidered to be investigational. Nothing shall pro-  
18          hibit a AHP from covering such drugs,  
19          biologicals, and medical devices, including treat-  
20          ment investigational new drugs (IND).

21          (C) OFF-LABEL USE.—An off-label use for  
22          a drug described in subparagraph (A)(i) is pre-  
23          sumed to meet the requirements of paragraph  
24          (1)(C) if the medical indication for which it is  
25          used is listed in one of the following 3 compen-

1           dia: the American Hospital Formulary Service-  
2           Drug Information, the American Medical Asso-  
3           ciation Drug Evaluations, and the United  
4           States Pharmacopeia-Drug Information.

5           (4) COVERAGE OF INVESTIGATIONAL TREAT-  
6           MENTS IN APPROVED RESEARCH TRIALS.—

7           (A) IN GENERAL.—Coverage of the routine  
8           medical costs (as defined in subparagraph (C))  
9           associated with the delivery of investigational  
10          treatments (as defined in subparagraph (B))  
11          shall be considered to be medically appropriate  
12          only if the treatment is part of an approved re-  
13          search trial (as defined in subparagraph (D)).

14          (B) INVESTIGATIONAL TREATMENT DE-  
15          FINED.—In subparagraph (A), the term “inves-  
16          tigational treatment” means a treatment for  
17          which there is not sufficient evidence to deter-  
18          mine the health outcome of the treatment com-  
19          pared with the best available alternative treat-  
20          ment (or with no treatment if there is no alter-  
21          native treatment).

22          (C) ROUTINE MEDICAL COSTS DEFINED.—  
23          In subparagraph (A), the term “routine medical  
24          costs” means the cost of health services re-  
25          quired to provide treatment according to the de-

1 sign of the trial, except those costs normally  
2 paid for by other funding sources (as defined by  
3 the Board). Such costs do not include the cost  
4 of the investigational agent, devices or proce-  
5 dures themselves, the costs of any nonhealth  
6 services that might be required for a person to  
7 receive the treatment, or the costs of managing  
8 the research.

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

12 (i) conducted for the primary purpose  
13 of determining the safety, effectiveness, ef-  
14 ficacy, or health outcomes of a treatment,  
15 compared with the best available alter-  
16 native treatment, and

17 (ii) approved by the Secretary of  
18 Health and Human Services.

19 A trial is deemed to be approved under clause  
20 (ii) if it is approved by the National Institutes  
21 of Health, the Food and Drug Administration  
22 (through an investigational new drug exemp-  
23 tion), the Department of Veterans Affairs, or  
24 by a qualified nongovernmental research entity

1 (as identified in guidelines issued by one or  
2 more of the National Institutes of Health).

3 (5) DOCUMENTATION.—

4 (A) IN GENERAL.—Each AHP is respon-  
5 sible for maintaining documentary evidence sup-  
6 porting the plan’s decisions to cover or to deny  
7 coverage based on the criteria specified in this  
8 subsection.

9 (B) REFERENCES.—The evidence that may  
10 be used in making such coverage decisions in-  
11 cludes—

- 12 (i) published peer-reviewed literature,  
13 (ii) opinions of medical specialty  
14 groups and other medical experts,  
15 (iii) evidence of general acceptance by  
16 the medical community, and  
17 (iv) recommendations of the Board.

18 (C) DISCLOSURE.—Each AHP shall dis-  
19 close to its members, in a manner specified by  
20 the Board, its coverage decisions and must sub-  
21 mit information on such decisions to the Bene-  
22 fits, Evaluations, and Data Standards Board.

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

1 (A) IN GENERAL.—The term “treatment”  
2 means any health care intervention undertaken,  
3 with respect to a specific indication, to improve,  
4 maintain, or stabilize a health outcome or to  
5 prevent or mitigate an adverse change in a  
6 health outcome.

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

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

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

15 (2) not impose cost-sharing for covered clinical  
16 preventive services,

17 (3) balance the effect of the cost-sharing in re-  
18 ducing premiums and in affecting utilization of ap-  
19 propriate services, and

20 (4) establish a limit on the total cost-sharing  
21 that may be incurred by an individual (or enrollee  
22 unit) in a year.

23 To the extent consistent with the previous provisions, the  
24 Board shall design such cost-sharing in a manner so to

1 maintain overall utilization levels at a level no higher than  
2 current overall utilization levels.

3 (d) AUTHORITY RESPECTING PROVIDERS.—

4 (1) NO AUTHORITY TO RESTRICT USE OF PRO-  
5 VIDERS.—In the case of treatment included in the  
6 uniform set of effective benefits, the Board is not  
7 authorized—

8 (A) to restrict the coverage of such treat-  
9 ment only to, or

10 (B) to require an AHP to provide coverage  
11 of such treatment by,

12 a particular class (or classes) of providers, among  
13 the providers that are legally authorized to provide  
14 such treatment.

15 (2) AUTHORITY WITH RESPECT TO SCOPE OF  
16 PRACTICE OF QUALIFIED PROVIDERS.—A State may  
17 not prohibit or limit the scope of practice of a pro-  
18 vider of health services, with respect to the provision  
19 of the uniform set of effective benefits by an AHP,  
20 to the extent that the Board finds that such prohibi-  
21 tion or limitation restricts the utilization of qualified  
22 providers.

1 **SEC. 1303. BENEFITS, EVALUATIONS, AND DATA STAND-**  
2 **ARDS BOARD.**

3 (a) ESTABLISHMENT.—The Board shall provide for  
4 the initial organization, as a nonprofit corporation in the  
5 District of Columbia, of the Benefits, Evaluations, and  
6 Data Standards Board (in this section referred to as the  
7 “BEDS Board”), under the direction of a board of direc-  
8 tors consisting of 5 directors.

9 (b) APPOINTMENT OF DIRECTORS.—

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

15 (2) CONTINUATION.—The by-laws of the BEDS  
16 Board shall provide for the board of directors subse-  
17 quently to be appointed by the board in a manner  
18 that ensures a broad range of representation of  
19 through groups with an interest in providing and  
20 purchasing health care.

21 (3) TERMS OF DIRECTORS.—The term of each  
22 member of the board of directors shall be for 7  
23 years, except that in order to provide for staggered  
24 terms, the terms of the members initially appointed  
25 shall be for 3, 4, 5, 6, and 7 years. In the case of  
26 a vacancy by death or resignation, the replacement

1 shall be appointed for the remainder of the term. No  
2 individual may serve as a director of the board for  
3 more than 14 years.

4 (c) FUNCTIONS.—

5 (1) IN GENERAL.—The BEDS Board shall  
6 make recommendations to the Board concerning  
7 each of the following:

8 (A) The uniform set of effective benefits.

9 (B) The standards for information to be  
10 provided by AHPs.

11 (C) Auditing standards to ensure the accu-  
12 racy of such information.

13 (D) Aggregate data on coverage decisions  
14 made by AHPs and recommendations for eval-  
15 uations of particular technologies.

16 Before making recommendations described in sub-  
17 paragraphs (B) and (D), the BEDS Board shall  
18 consult with the Agency for Clinical Evaluations re-  
19 garding the need for information in performing its  
20 activities.

21 (2) EVALUATIONS.—The BEDS Board shall  
22 advise the Board on—

23 (A) matters related to the evaluation of  
24 health care services, including information from  
25 clinical and epidemiological studies, and

1 (B) information provided by AHPs, includ-  
2 ing AHP-specific information on clinical health,  
3 functional status, well-being, and plan satisfac-  
4 tion of enrolled individuals.

5 (3) NATIONAL HEALTH DATA SYSTEM.—The  
6 BEDS Board shall provide the Board with its assist-  
7 ance in the development of the standards for the na-  
8 tional health data system under section 1307.

9 (d) FUNDING.—

10 (1) IN GENERAL.—In order to provide funding  
11 for the BEDS Board, the National Health Board  
12 shall establish an annual registration fee for AHPs  
13 which is imposed on a per-covered-individual-basis  
14 and is sufficient, in the aggregate, to provide each  
15 year for not more than the amount specified in para-  
16 graph (2) for the operation of the BEDS Board.

17 (2) AMOUNT OF FUNDS.—The amount specified  
18 in this paragraph for each of fiscal years 1994 and  
19 1995, is \$50,000,000, and, for each succeeding fis-  
20 cal year, is \$25,000,000.

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

22 (a) ESTABLISHMENT.—The Board shall provide for  
23 the initial organization, as a nonprofit corporation in the  
24 District of Columbia, of the Health Plan Standards Board  
25 (in this section referred to as the “Plan Standards

1 Board”), under the direction of a board of directors con-  
2 sisting of 5 directors.

3 (b) APPOINTMENT OF DIRECTORS.—

4 (1) SOLICITATION.—The Board shall solicit  
5 nominations for the initial board of directors of the  
6 Plan Standards Board from organizations that rep-  
7 resent the various groups with an interest in the  
8 health care system and the functions of the Board.

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

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

24 (c) FUNCTIONS.—

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

6           (2) ASSESSMENT OF RISK-ADJUSTMENT FAC-  
7 TORS.—The Plan Standards Board shall provide the  
8 Board with its assessment of the risk-adjustment  
9 factors under section 1306.

10          (d) FUNDING.—In order to provide funding for the  
11 Plan Standards Board, the National Health Board shall  
12 establish an annual registration fee for AHPs which is im-  
13 posed on a per-covered-individual-basis and is sufficient,  
14 in the aggregate, to provide each year for not more than  
15 60 percent of the amount specified in section 1303(d)(2)  
16 for the operation of the Plan Standards Board.

17 **SEC. 1305. REGISTRATION OF ACCOUNTABLE HEALTH**  
18 **PLANS.**

19          (a) IN GENERAL.—The Board shall register those  
20 health plans that meet the standards under part 1 of sub-  
21 title C.

22          (b) TREATMENT OF STATE CERTIFICATION.—If (and  
23 so long as) the Board determines that a State super-  
24 intendent of insurance, State insurance commissioner, or  
25 other State official provides for the imposition of stand-

1 ards that the Board finds are equivalent to the standards  
2 established under part 1 of subtitle C for registration of  
3 a health plan as an AHP, the Board may provide for reg-  
4 istration as AHPs of health plans that such official cer-  
5 tifies as meeting the standards for registration. Nothing  
6 in this subsection shall require a health plan to be certified  
7 by such an official in order to be registered by the Board.

8 (c) REVOCATION OF REGISTRATION.—

9 (1) IN GENERAL.—The Board shall provide for  
10 a process for revocation of such registration in cases  
11 where the Board finds, after notice to the plan and  
12 appropriate due process specified by the Board, that  
13 a health plan no longer substantially meets the  
14 standards for such registration or has failed to com-  
15 ply with a requirement under section 1402(a).

16 (2) INITIATION OF PROCESS.—Such process  
17 may be initiated upon the petition of a HPPC, the  
18 ombudsman for a HPPC, or by the Board itself. If  
19 the process is not initiated by a HPPC or ombuds-  
20 man, the Board shall notify each HPPC involved  
21 that such a process has been initiated. A HPPC may  
22 provide notice to enrollees of an AHP at the time  
23 such a process is initiated with respect to the AHP.

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

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

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

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

8 (b) PROCESS.—

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

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

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

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

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

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

19 (3) SPECIAL RISK-ADJUSTMENT FACTORS FOR  
20 UNDERSERVED AREAS.—The Board shall determine  
21 the special risk-adjustment factors that may be ap-  
22 plied in the case of individuals residing in areas des-  
23 ignated as rural or urban underserved areas under  
24 section 1401.

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

2 (a) STANDARDIZATION OF INFORMATION.—

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

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

12 (b) ANALYSIS OF INFORMATION.—

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

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

20 (3) DISTRIBUTION OF ANALYSES.—The Board  
21 shall distribute the analyses in a form, consistent  
22 with subsection (a)(2), that reports, on a national,  
23 State, and community basis, the levels and trends of  
24 health care expenditures, the rates and trends in the  
25 provision of individual procedures, and (to the extent  
26 such procedures are priced separately) the price lev-

1       els and rates of price change for such procedures.  
2       The reports shall include both aggregate and per  
3       capita measures for areas and shall include com-  
4       parative data for different areas.

5       (c) DISTRIBUTION OF INFORMATION.—

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

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

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

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

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

5 (3) SPECIAL DISTRIBUTIONS.—The Board may,  
6 whenever it deems appropriate, provide for the dis-  
7 tribution—

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

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

17 (4) ACCESS BY AGENCY FOR HEALTH CARE  
18 POLICY AND RESEARCH.—The Board shall make  
19 available to the Agency for Clinical Evaluations in-  
20 formation obtained under section 1203(a) in a man-  
21 ner consistent with subsection (a)(2).

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

24 (a) COLLECTION OF INFORMATION.—The Board  
25 shall provide a process whereby a specialized center of care

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

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

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

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

19 (3) publish such ratings.

20 (c) USE OF SERVICE MARK FOR SPECIALIZED CEN-  
21 TERS OF CARE.—The Board may establish a service mark  
22 for specialized centers of care the performance of which  
23 has been rated under subsection (b). Such service mark  
24 shall be registrable under the Trademark Act of 1946, and  
25 the Board shall apply for the registration of such service

1 mark under such Act. For purposes of such Act, such serv-  
2 ice mark shall be deemed to be used in commerce. For  
3 purposes of this subsection, the “Trademark Act of 1946”  
4 refers to the Act entitled “An Act to provide for the reg-  
5 istration and protection of trademarks used in commerce,  
6 to carry out the provisions of international conventions,  
7 and for other purposes”, approved July 5, 1946 (15  
8 U.S.C. 1051 and following).

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

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

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

20 (b) APPOINTMENT OF ADMINISTRATOR.—There shall  
21 be at the head of the Agency an official to be known as  
22 the Administrator for Clinical Evaluations (in this section  
23 referred to as the “Administrator”). The Administrator  
24 shall be appointed by the President, by and with the advice  
25 and consent of the Senate.

1 (c) DUTIES.—

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

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

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

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

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

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

22 (A) set priorities for the research commu-  
23 nity to strengthen the research base;

24 (B) support research and evaluation (both  
25 on a contract and investigator-initiated basis)

1 on medical effectiveness through technology as-  
2 sessment, consensus development, outcomes re-  
3 search practice guidelines, and other appro-  
4 priate activities;

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

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

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

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

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

1 the Administrator's responsibilities, as may be ap-  
2 propriate.

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

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

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

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

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

3 (a) **FACTORS AFFECTING COVERAGE.**—

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

18 (2) **REPORT.**—By not later than April 1 of each  
19 year (beginning with 1996), the Board shall submit  
20 to Congress a report analyzing the information col-  
21 lected under paragraph (1). Such report shall in-  
22 clude an description of the primary factors contrib-  
23 uting to lack of coverage of identifiable groups of eli-  
24 gible individuals.

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

1           (1) IN GENERAL.—By not later than January  
2           1, 1997, the Board shall submit to Congress rec-  
3           ommendations on the feasibility, cost-effectiveness,  
4           and the economic impact of using different voluntary  
5           and other methods for increasing the coverage of eli-  
6           gible individuals.

7           (2) INDIVIDUAL MANDATE.—The Board shall  
8           specifically make recommendations under paragraph  
9           (1) regarding establishing a requirement that all eli-  
10          gible individuals obtain health coverage through en-  
11          rollment with an AHP.

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

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

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

19          **SEC. 1311. MONITORING REINSURANCE MARKET.**

20               (a) IN GENERAL.—The Board shall monitor the rein-  
21               surance market for AHPs.

22               (b) PERIODIC REPORTS.—The Board shall periodi-  
23               cally report to Congress respecting the availability of rein-  
24               surance for AHPs at reasonable rates and the impact of

1 such availability on the establishment of new plans and  
2 on the financial solvency of current plans.

3 **SEC. 1312. AUTHORIZATION OF APPROPRIATIONS; SUNSET.**

4 (a) AUTHORIZATION OF APPROPRIATIONS.—There  
5 are authorized to be appropriated to the National Health  
6 Board for each of fiscal years 1994 through 2000 such  
7 sums as may be necessary to carry out activities under  
8 this Act.

9 (b) SUNSET.—Unless otherwise provided by law, the  
10 National Health Board shall terminate on December 31,  
11 1999.

12 **Subtitle E—Managed Competition**  
13 **in Rural and Urban Under-**  
14 **served Areas**

15 **PART 1—SPECIAL TREATMENT OF DESIGNATED**  
16 **UNDERSERVED AREAS**

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

18 (a) IN GENERAL.—The Governor of any State may,  
19 subject to subsection (b), designate rural and urban areas  
20 of a State as underserved areas for purposes of this part.  
21 In designating such areas, the Governor shall take into  
22 account—

23 (1) financial and geographic access to AHPs by  
24 residents of such areas, and

1           (2) the availability, adequacy, and quality of  
2           qualified providers and health care facilities in such  
3           areas.

4           (b) REVIEW BY BOARD.—No designation under sub-  
5           section (a) shall take effect under this subsection unless  
6           the Board—

7           (1) has been notified of the proposed designa-  
8           tion, and

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

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

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

21          **SEC. 1402. SPECIAL TREATMENT.**

22          (a) INCLUSION IN PLAN SERVICE AREA.—The  
23          HPPC serving an area designated under section 1401 may  
24          require AHPs, offered by the HPPC and with a service  
25          area adjoining such area, to include the area as part of

1 their service area. The Board may revoke under section  
2 1305(c) registration of an AHP that fails to comply with  
3 such requirement.

4 (b) APPLICATION OF SPECIAL RISK ADJUSTMENT  
5 FACTORS.—In accordance with rules established by the  
6 Board, for eligible individuals residing in an area des-  
7 ignated under section 1401 and enrolled with an AHP,  
8 the HPPC may apply special risk-adjustment factors (de-  
9 termined under section 1306(b)(3)) in order to increase  
10 the compensation available to AHPs serving such individ-  
11 uals.

12 (c) DIRECT STATE SUBSIDIES.—The HPPC shall in-  
13 crease the amount of the payments made to AHPs serving  
14 individuals residing in an area designated under section  
15 1401 by such amounts as the State makes available for  
16 this purpose.

17 (d) TECHNICAL ASSISTANCE IN ANTITRUST MAT-  
18 TERS.—The Department of Justice shall provide ongoing  
19 technical assistance to organizations in relation to the ap-  
20 plication of the Federal antitrust laws to the establishment  
21 of an AHP in an area designated under section 1401.  
22 Such assistance shall be in addition to the review process  
23 provided under section 1231(b).

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

4 **SEC. 1411. TECHNICAL ASSISTANCE FUNDING.**

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

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

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

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

20 (3) assistance in coordinating arrangements for  
21 tertiary care;

22 (4) assistance in recruitment and retention of  
23 health care professionals; and

24 (5) assistance in coordinating the delivery of  
25 emergency services with the provision of services by  
26 an AHP.

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

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

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

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

17 **SEC. 1412. RURAL DEVELOPMENT GRANTS.**

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

22 (b) ELIGIBLE ENTITIES.—

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

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

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

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

11 (c) USE OF FUNDS.—

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

15 (A) For development and implementation.

16 (B) For information systems, including  
17 telecommunications.

18 (C) For meeting solvency requirements for  
19 an AHP.

20 (D) For recruiting health care providers.

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

24 (A) For a telecommunications system un-  
25 less such system is coordinated with, and does

1 not duplicate, such a system existing in the  
2 area.

3 (B) For construction or remodeling of  
4 health care facilities.

5 (d) APPLICATION.—

6 (1) IN GENERAL.—No financial assistance shall  
7 be provided under this section to an entity unless  
8 the entity has submitted to the Secretary, in a time  
9 and manner specified by the Secretary, and had ap-  
10 proved by the Secretary an application.

11 (2) INFORMATION TO BE INCLUDED.—Each  
12 such application shall include—

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

15 (B) a plan for providing the continuum of  
16 services included in the uniform set of effective  
17 benefits, and

18 (C) a description of how the proposed  
19 AHP will utilize existing health care facilities in  
20 a manner that avoids unnecessary duplication.

21 (e) AUTHORIZATION OF APPROPRIATIONS.—

22 (1) IN GENERAL.—There are authorized to be  
23 appropriated \$75,000,000 for each of fiscal years  
24 1995 through 1999 to carry out this section.

1 Amounts appropriated under this section shall be  
2 available until expended.

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

9 (A) The rural health transition grant pro-  
10 gram (under section 4005(e) of the Omnibus  
11 Budget Reconciliation Act of 1987).

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

17 **SEC. 1413. MIGRANT HEALTH CENTERS.**

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

20 (1) in paragraph (1)(A), by striking “through  
21 1994” and inserting “through 1999”,

22 (2) in paragraph (2)(A), by striking “through  
23 1994” and inserting “through 1999”, and

1           (3) by redesignating paragraph (3) as para-  
2           graph (4) and by inserting after paragraph (2) the  
3           following new paragraph:

4           “(3)(A) For the purpose of carrying out subpara-  
5           graph (B), there are authorized to be appropriated  
6           \$11,500,000 for each of the fiscal years 1995 through  
7           1999.

8           “(B) The Secretary may make grants to migrant  
9           health centers for the purpose of assisting such centers  
10          in integrating with AHPs and in providing (and coordinat-  
11          ing the provision of) the uniform set of effective benefits  
12          under such a plan.”.

13   **SEC. 1414. COMMUNITY HEALTH CENTERS.**

14          Section 330(g) of the Public Health Service Act (42  
15          U.S.C. 254c(g)) is amended—

16               (1) in paragraph (1)(A), by striking “through  
17               1994” and inserting “through 1999”,

18               (2) in paragraph (2)(A), by striking “through  
19               1994” and inserting “through 1999”, and

20               (3) by redesignating paragraph (3) as para-  
21               graph (4) and by inserting after paragraph (2) the  
22               following new paragraph:

23               “(3)(A) For the purpose of carrying out subpara-  
24               graph (B), there are authorized to be appropriated

1 \$88,500,000 for each of the fiscal years 1995 through  
2 1999.

3 “(B) The Secretary may make grants to community  
4 health centers for the purpose of assisting such centers  
5 in developing and integrating with accountable health  
6 plans and in providing (and coordinating the provision of)  
7 the uniform set of effective benefits under such a plan.”.

8 **PART 3—ESTABLISHMENT OF RURAL**

9 **EMERGENCY ACCESS CARE HOSPITALS**

10 **SEC. 1421. RURAL EMERGENCY ACCESS CARE HOSPITALS**

11 **DESCRIBED.**

12 Section 1861 of the Social Security Act (42 U.S.C.  
13 1395x) is amended by adding at the end the following new  
14 subsection:

15 “Rural Emergency Access Care Hospital; Rural  
16 Emergency Access Care Hospital Services

17 “(oo)(1) The term ‘rural emergency access care hos-  
18 pital’ means, for a fiscal year, a facility with respect to  
19 which the Secretary finds the following:

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

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

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

6           “(D) The facility has entered into (or plans to  
7 enter into) an agreement with a hospital with a par-  
8 ticipation agreement in effect under section 1866(a),  
9 and under such agreement the hospital shall accept  
10 patients transferred to the hospital from the facility  
11 and receive data from and transmit data to the facil-  
12 ity.

13           “(E) There is a practitioner who is qualified to  
14 provide advanced cardiac life support services (as de-  
15 termined by the State in which the facility is lo-  
16 cated) on-site at the facility on a 24-hour basis.

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

19           “(G) The facility meets such staffing require-  
20 ments as would apply under section 1861(e) to a  
21 hospital located in a rural area, except that—

22                   “(i) the facility need not meet hospital  
23 standards relating to the number of hours dur-  
24 ing a day, or days during a week, in which the  
25 facility must be open, except insofar as the fa-

1 cility is required to provide emergency care on  
2 a 24-hour basis under subparagraphs (E) and  
3 (F) of this paragraph; and

4 “(ii) the facility may provide any services  
5 otherwise required to be provided by a full-time,  
6 on-site dietician, pharmacist, laboratory techni-  
7 cian, medical technologist, or radiological tech-  
8 nologist on a part-time, off-site basis.

9 “(H) The facility meets the requirements appli-  
10 cable to clinics and facilities under subparagraphs  
11 (C) through (J) of paragraph (2) of section  
12 1861(aa) and of clauses (ii) and (iv) of the second  
13 sentence of such paragraph (or, in the case of the  
14 requirements of subparagraph (E), (F), or (J) of  
15 such paragraph, would meet the requirements if any  
16 reference in such subparagraph to a ‘nurse practi-  
17 tioner’ or to ‘nurse practitioners’ was deemed to be  
18 a reference to a ‘nurse practitioner or nurse’ or to  
19 ‘nurse practitioners or nurses’); except that in deter-  
20 mining whether a facility meets the requirements of  
21 this subparagraph, subparagraphs (E) and (F) of  
22 that paragraph shall be applied as if any reference  
23 to a ‘physician’ is a reference to a physician as de-  
24 fined in section 1861(r)(1).

1       “(2) The term ‘rural emergency access care hospital  
2 services’ means medical and other health services fur-  
3 nished by a rural emergency access care hospital.”.

4 **SEC. 1422. COVERAGE OF AND PAYMENT FOR SERVICES.**

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

8           (1) by striking “and” at the end of subpara-  
9 graph (I);

10          (2) by striking the period at the end of sub-  
11 paragraph (J) and inserting “; and”; and

12          (3) by adding at the end the following new sub-  
13 paragraph:

14                   “(K) rural emergency access care hospital  
15 services (as defined in section 1861(o)(2)).”.

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

18           (1) IN GENERAL.—Section 1833(a)(6) of the  
19 Social Security Act (42 U.S.C. 1395l(a)(6)) is  
20 amended by striking “services,” and inserting “serv-  
21 ices and rural emergency access care hospital serv-  
22 ices,”.

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

1 (A) in the heading, by striking “SERV-  
2 ICES” and inserting “SERVICES AND RURAL  
3 EMERGENCY ACCESS CARE HOSPITAL SERV-  
4 ICES”;

5 (B) in paragraph (1), by striking “during  
6 a year before 1993” and inserting “during a  
7 year before the prospective payment system de-  
8 scribed in paragraph (2) is in effect”;

9 (C) in paragraph (1), by adding at the end  
10 the following: “The amount of payment shall be  
11 determined under either method without regard  
12 to the amount of the customary or other  
13 charge.”;

14 (D) in paragraph (2), by striking “Janu-  
15 ary 1, 1993,” and inserting “January 1,  
16 1996,”; and

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

19 “(3) APPLICATION OF METHODS TO PAYMENT  
20 FOR RURAL EMERGENCY ACCESS CARE HOSPITAL  
21 SERVICES.—The amount of payment for rural emer-  
22 gency access care hospital services provided during  
23 a year shall be determined using the applicable  
24 method provided under this subsection for determin-



1 described in section 1923(b)(1) of such  
2 Act; or

3 (ii) is a hospital that the Secretary  
4 otherwise determines to be an appropriate  
5 recipient of assistance under this part on  
6 the basis of the existence of a patient care  
7 operating deficit, a demonstrated inability  
8 to secure or repay financing for a qualify-  
9 ing project on reasonable terms, or such  
10 other criteria as the Secretary considers  
11 appropriate.

12 (B) DEVELOPMENT OF CRITERIA.—For  
13 purposes of subparagraph (A)(ii), with respect  
14 to rural hospitals which are at risk or critical  
15 to health care access, the Prospective Payment  
16 Review Commission, not later than 6 months  
17 after the date of the enactment of this Act,  
18 shall develop criteria to assist the Secretary in  
19 deciding which such hospitals deserve assist-  
20 ance.

21 (2) OWNERSHIP REQUIREMENTS.—In order to  
22 qualify for assistance under this part, a hospital  
23 must—

24 (A) be owned or operated by a unit of  
25 State or local government;

1 (B) be a quasi-public corporation, defined  
2 as a private, nonprofit corporation or public  
3 benefit corporation which is formally granted  
4 one or more governmental powers by legislative  
5 action through (or is otherwise partially funded  
6 by) the State legislature, city or county council;  
7 or

8 (C) be a private nonprofit hospital which  
9 has contracted with, or is otherwise funded by,  
10 a governmental agency to provide health care  
11 services to low income individuals not eligible  
12 for benefits under title XVIII or title XIX of  
13 the Social Security Act, where revenue from  
14 such contracts constitute at least 10 percent of  
15 the hospital's operating revenues over the prior  
16 3 fiscal years.

17 (c) MEETING ADDITIONAL SPECIFIC CRITERIA.—  
18 Hospitals that are generally eligible for assistance under  
19 this part under subsection (b) may apply for the specific  
20 programs described in this part and must meet any addi-  
21 tional criteria for participation in such programs.

22 **SEC. 1432. APPLICATION FOR ASSISTANCE.**

23 (a) IN GENERAL.—No hospital may receive assist-  
24 ance for a project under this part unless the hospital—

1           (1) has filed with the Secretary, in a form and  
2           manner specified by the Secretary an application for  
3           assistance under this part;

4           (2) establishes in its application (for its most  
5           recent cost reporting period) that it meets the cri-  
6           teria for general eligibility under this part;

7           (3) includes a description of the project, includ-  
8           ing the community in which it is located, and de-  
9           scribes utilization and services characteristics of the  
10          project and the hospital, and the patient population  
11          that is to be served;

12          (4) describes the extent to which the project  
13          will include the financial participation of State and  
14          local governments, and all other sources of financing  
15          sought for the project; and

16          (5) establishes, to the satisfaction of the Sec-  
17          retary, that the project meets the additional criteria  
18          for assistance under this part.

19          (b) CRITERIA FOR APPROVAL.—The Secretary shall  
20          determine for each application for assistance under this  
21          part—

22               (1) whether the hospital meets the general eligi-  
23               bility criteria under section 1431(b);

24               (2) whether the hospital meets any additional  
25               eligibility criteria;

1           (3) whether the project for which assistance is  
2           being requested meets the requirements of this part;  
3           and

4           (4) whether funds are available, pursuant to the  
5           limitations of each program, to fully fund the re-  
6           quest for assistance.

7   **SEC. 1433. PUBLIC SERVICE RESPONSIBILITIES.**

8           (a) IN GENERAL.—Any hospital accepting assistance  
9           under this part shall agree—

10           (1) to make the services of the facility or por-  
11           tion thereof to be constructed, acquired, or modern-  
12           ized available to all persons residing in the territorial  
13           area of the applicant; and

14           (2) to provide a significant volume of services to  
15           persons unable to pay therefore, consistent with  
16           other provisions of this Act.

17           (b) ENFORCEMENT.—The Director of the Office of  
18           Civil Rights of the Department of Health and Human  
19           Services shall be given the power to enforce the public  
20           service responsibilities described in this section.

21   **SEC. 1434. AUTHORIZATION OF APPROPRIATIONS.**

22           There is authorized to be appropriated \$50,000,000  
23           for each of the fiscal years 1995 through 1999 to carry  
24           out this part.

1                   **Subtitle F—Treatment of**  
2                   **Chronically Underserved Areas**

3   **SEC. 1501. PROMOTING STATE ACTION.**

4           (a) STANDARDS FOR IDENTIFICATION OF CHRON-  
5   ICALLY UNDERSERVED AREAS.—The National Health  
6   Board shall develop, not later than 2 years after the date  
7   of the enactment of this Act, standards for the identifica-  
8   tion of chronically underserved areas in which the special  
9   treatment provided under subsection (b) may be appro-  
10   priate. Such standards shall be based on—

11           (1) inadequate access in an area to services in-  
12   cluded within the uniform set of effective benefits,

13           (2) insufficient price competition for such serv-  
14   ices in an area, and

15           (3) poor quality of such services in an area.

16   (b) STATE IDENTIFICATION OF AREAS AND PLAN.—  
17   On and after 3 years after the date of the enactment of  
18   this Act, a State may submit to the Board—

19           (1) a finding that an area within the State  
20   meets the standards developed under subsection (a)  
21   to be identified as a chronically underserved area,  
22   and

23           (2) a plan for addressing the problem of health  
24   care delivery in such area.

1 No plan may be submitted under paragraph (2) for an  
2 area unless the plan has been developed in cooperation  
3 with each HPPC serving any portion of the area.

4 (c) CONTENTS OF PLAN.—A plan under subsection  
5 (b)(2) for a chronically underserved area may provide for  
6 the limitation of agreements under section 1102 to a sin-  
7 gle AHP, with such contract awarded on a competitive  
8 basis.

9 (d) REVIEW.—With respect to submissions under  
10 subsection (b), the Board shall review—

11 (1) each finding described in subsection (b)(1),  
12 and

13 (2) each plan submitted under subsection  
14 (b)(2).

15 The Board shall approve or disapprove such a finding and  
16 such a plan within 60 days of the date of its submission  
17 and shall notify the State of its decision. If the Board dis-  
18 approves the finding or the plan, the Board shall provide  
19 the State with the reasons for the disapproval. If the  
20 Board does not act within such period, the Board is  
21 deemed to have approved the finding and the plan.

1           **Subtitle G—Repeal of COBRA**  
2           **Continuation Requirements**

3   **SEC. 1601. REPEAL OF COBRA CONTINUATION REQUIRE-**  
4           **MENTS.**

5           (a) INTERNAL REVENUE CODE PROVISIONS.—

6               (1) IN GENERAL.—Section 4980B of the Inter-  
7           nal Revenue Code of 1986 is repealed.

8               (2) CONFORMING AMENDMENTS.—Section 414  
9           of such Code is amended—

10                   (A) in subsection (n)(3)(C), by striking  
11                   “505, and 4980B” and inserting “and 505”,  
12                   and

13                   (B) in subsection (t)(2), by striking “505,  
14                   or 4980B” and inserting “or 505”.

15           (b) ERISA.—

16               (1) IN GENERAL.—Part 6 of subtitle B of title  
17           I of the Employee Retirement Income Security Act  
18           of 1974 is amended—

19                   (A) by striking sections 601 through 606,  
20                   and

21                   (B) in section 609, as added by section  
22                   4301 of the Omnibus Budget Reconciliation Act  
23                   of 1993, by striking subsection (d).

24               (2) CONFORMING AMENDMENT.—Section  
25           502(c)(1) of such Act (29 U.S.C. 1132(c)(1)) is

1 amended by striking “paragraph (1) or (4) of sec-  
2 tion 606 or”.

3 (c) PUBLIC HEALTH SERVICE ACT.—Title XXII of  
4 the Public Health Service Act is repealed.

5 (d) EFFECTIVE DATE.—The repeals and amend-  
6 ments made by this section shall apply to health plans of  
7 employers as of the January 1, 1995.

8 (e) NOTICE OF BENEFITS.—In the case of continu-  
9 ation coverage which is in effect on January 1, 1995,  
10 under a provision of law repealed by this section, such con-  
11 tinuation may not be discontinued without 30-day notice  
12 to the individual of such discontinuation. Such notice shall  
13 include such information with respect to continuation of  
14 coverage through coverage through a health plan pur-  
15 chasing cooperative as the National Health Board shall  
16 specify.

## 17 **Subtitle H—Definitions**

### 18 **SEC. 1701. DEFINITIONS.**

19 (a) ELIGIBILITY.—In this title and title II:

20 (1) ELIGIBLE INDIVIDUAL.—The term “eligible  
21 individual” means, with respect to a HPPC area, an  
22 individual who—

23 (A) is an eligible employee,

24 (B) is an eligible resident, or

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

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

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

11 (A)(i) is the spouse of the employee or  
12 principal enrollee, or

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

15 (I) an adopted child or recognized  
16 natural child, and

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

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

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

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

8 (4) ELIGIBLE RESIDENT.—

9 (A) IN GENERAL.—The term “eligible resi-  
10 dent” means, with respect to a HPPC area, an  
11 individual who is not an eligible employee, is re-  
12 siding in the area, and is a citizen or national  
13 of the United States, an alien lawfully admitted  
14 for permanent residence, and an alien granted  
15 asylum, admitted as a refugee, or whose depor-  
16 tation has been withheld.

17 (B) EXCLUSION OF CERTAIN INDIVIDUALS  
18 OFFERED COVERAGE THROUGH A LARGE EM-  
19 PLOYER.—

20 (i) IN GENERAL.—The term “eligible  
21 resident” does not include an individual  
22 who—

23 (I) is covered under an AHP pur-  
24 suant to an offer made under section  
25 1005(b)(1)(A), or

1 (II) subject to clause (ii), could  
2 be covered under an AHP as the prin-  
3 cipal enrollee pursuant to such an  
4 offer if such offer had been accepted.

5 (ii) EXCEPTION FOR PART-TIME, SEA-  
6 SONAL, AND TEMPORARY EMPLOYEES.—  
7 Subclause (II) of clause (i) shall not apply  
8 to an individual who is offered coverage  
9 under an AHP by an employer and who is  
10 only a part-time, seasonal, or temporary  
11 employee of that employer. For purposes of  
12 the previous sentence, the term “part-  
13 time” means employment for an average of  
14 less than 25 hours a week on a monthly  
15 basis and an employee who is employed for  
16 more than 8 weeks in a 12-month period  
17 for an employer shall not be considered to  
18 be seasonal or temporary employee.

19 (C) TREATMENT OF MEDICARE BENE-  
20 FICIARIES.—The term “eligible resident” does  
21 not include a medicare-eligible beneficiary.

22 (5) ENROLLEE UNIT.—The term “enrollee  
23 unit” means one unit in the case of coverage on an  
24 individual basis or in the case of coverage on a fam-  
25 ily basis.

1           (6) MEDICARE BENEFICIARY.—The term “med-  
2       icare beneficiary” means an individual who is enti-  
3       tled to benefits under part A of title XVIII of the  
4       Social Security Act, including an individual who is  
5       entitled to such benefits pursuant to an enrollment  
6       under section 1818 or 1818A of such Act.

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

10           (A) is a medicare beneficiary, or

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

14       (b) ABBREVIATIONS.—In this Act, except as other-  
15       wise provided:

16           (1) AHP; ACCOUNTABLE HEALTH PLAN.—The  
17       terms “accountable health plan” and “AHP” mean  
18       a health plan registered with the Board under sec-  
19       tion 1201(a).

20           (2) BOARD.—The term “Board” means the Na-  
21       tional Health Board established under subtitle D.

22           (3) HPPC; HEALTH PLAN PURCHASING COOP-  
23       ERATIVE.—The terms “health plan purchasing coop-  
24       erative” and “HPPC” mean a health plan purchas-  
25       ing cooperative established under subtitle B.

## 1 (4) CLOSED AND OPEN PLANS.—

## 2 (A) CLOSED.—

3 (i) IN GENERAL.—A plan is “closed”  
4 if the plan is limited by structure or law to  
5 one or more large employers.

6 (ii) GRANDFATHER FOR TAFT-HART-  
7 LEY PLANS.—A plan not described in  
8 clause (i) that is maintained pursuant to  
9 one or more collective bargaining agree-  
10 ments between one or more employee orga-  
11 nizations and one or more employers and  
12 that was established as of September 7,  
13 1993, shall be considered to be a closed  
14 plan.

15 (iii) UNIVERSITY PLANS.—Nothing in  
16 this subparagraph shall be construed as  
17 preventing a university from offering en-  
18 rollment, in a closed plan maintained by a  
19 university, to students matriculating at the  
20 university.

21 (iv) SMALL EMPLOYERS.—Subject to  
22 clause (ii), a plan is not a “closed” plan if  
23 the plan was formed by one or more small  
24 employers or for the benefit of employees  
25 of such an employer.

1 (B) OPEN.—A plan is “open” if the plan  
2 is not closed (within the meaning of subpara-  
3 graph (A)).

4 (c) OTHER TERMS.—In this title and titles II and  
5 VI:

6 (1) HEALTH PLAN.—The term “health plan”  
7 means a plan that provides health benefits, whether  
8 through directly, through insurance, or otherwise,  
9 and includes a policy of health insurance, a contract  
10 of a service benefit organization, or a membership  
11 agreement with a health maintenance organization  
12 or other prepaid health plan, and also includes an  
13 employee welfare benefit plan or a multiple employer  
14 welfare plan (as such terms are defined in section 3  
15 of the Employee Retirement Income Security Act of  
16 1974).

17 (2) SMALL EMPLOYER; LARGE EMPLOYER.—

18 (A) IN GENERAL.—Subject to subpara-  
19 graph (B), the term “small employer” means  
20 an employer that normally employed fewer than  
21 101 employees during a typical business day in  
22 the previous year and the term “large em-  
23 ployer” means an employer that is not a small  
24 employer.

1           (B) SPECIAL RULE FOR LARGE EMPLOY-  
2           ERS.—Subject to subparagraph (C), the Board  
3           shall provide a procedure by which, in the case  
4           of an employer that is not a small employer but  
5           normally employs fewer than 101 employees  
6           (or, in the case of a State making an election  
7           described in subparagraph (C)(i), the number of  
8           employees specified under the State law) in a  
9           HPPC area (or other locality identified by the  
10          Board) during a typical business day, the em-  
11          ployer, upon application, would be considered to  
12          be a small employer with respect to such em-  
13          ployees in the HPPC area (or other locality).  
14          Such procedure shall be designed so as to pre-  
15          vent the adverse selection of employees with re-  
16          spect to which the previous sentence is applied.

17          (C) STATE ELECTION.—

18               (i) IN GENERAL.—Subject to section  
19               1101(a)(3) and clause (ii), a State may by  
20               law, with respect to employers in the State,  
21               substitute for “101” in subparagraphs (A)  
22               and (B) any greater number, so long as—

23                       (I) such number is applied uni-  
24                       formly to all employers (other than

1 employers described in clause (ii)) in  
2 a State, and

3 (II) the State demonstrates, to  
4 the satisfaction of the Board, that as  
5 of the time of enactment of the State  
6 law not more than 50 percent of all  
7 employees in the State are employees  
8 of small employers (as determined  
9 based upon such substitution).

10 (ii) EXCEPTION FOR CERTAIN LARGE  
11 MULTI-STATE EMPLOYERS.—Clause (i)  
12 shall not apply to an employer that nor-  
13 mally employed at least 100 employees  
14 during a typical business day in the pre-  
15 vious year in each of at least 2 different  
16 States.

17 (3) PREMIUM CLASS.—The term “premium  
18 class” means a class established under section  
19 1205(a)(2).

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

22 (5) STATE.—The term “State” includes the  
23 District of Columbia, Puerto Rico, the Virgin Is-  
24 lands, Guam, American Samoa, and the Northern  
25 Mariana Islands.

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

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

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

8           (C) Coverage of an individual and one  
9 child.

10           (D) Coverage of an individual and more  
11 than one eligible family member.

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

15           (7) UNIFORM SET OF EFFECTIVE BENEFITS.—

16 The term “uniform set of effective benefits” means,  
17 for a year, such set of benefits as recommended by  
18 the Board under section 1302(a), if not disapproved  
19 under such section.

1 **TITLE II—LOW-INCOME ASSIST-**  
2 **ANCE FOR HEALTH COV-**  
3 **ERAGE.**

4 **Subtitle A—Low-Income Assistance**

5 **SEC. 2001. ELIGIBILITY.**

6 (a) ENROLLEES UNDER ACCOUNTABLE HEALTH  
7 PLANS.—Each low-income individual (as defined in sec-  
8 tion 2009(a)(1)(A)) who is not a medicare-eligible individ-  
9 ual is eligible—

10 (1) for assistance under section 2002(a) with  
11 respect to premiums,

12 (2) for assistance under section 2003(a) with  
13 respect to cost-sharing otherwise imposed by the  
14 plan, and

15 (3) in the case of a very low-income individual,  
16 for assistance under section 2004 with respect to  
17 certain items and services.

18 (b) MEDICARE-ELIGIBLE INDIVIDUALS.—Each medi-  
19 care-eligible individual who is a low-income individual is  
20 eligible—

21 (1) for assistance under section 2002(b) with  
22 premiums under the medicare program, and

23 (2) in the case of a very low-income individual,  
24 for assistance under section 2003(b) with respect to  
25 other medicare cost-sharing and for assistance under

1 section 2004 with respect to certain items and serv-  
2 ices.

3 **SEC. 2002. PREMIUM ASSISTANCE.**

4 (a) IN GENERAL.—

5 (1) VERY LOW-INCOME INDIVIDUALS.—In the  
6 case of a very low-income individual (as defined in  
7 section 2009(a)(3)) who is enrolled in an AHP, the  
8 premium assistance under this section consists of—

9 (A) an adjustment in premiums charged  
10 the individual under the plan, in accordance  
11 with section 1205(c)(1); and

12 (B) payment to the accountable health  
13 plan (on behalf of the individual and family  
14 members) of the applicable Federal assistance  
15 amount (as defined in section 2009(c)(1)) for  
16 enrollment under the plan.

17 (2) MODERATELY LOW-INCOME INDIVIDUALS.—

18 In the case of a moderately low-income individual  
19 (as defined in section 2009(a)(2)) who is enrolled in  
20 an AHP, the premium assistance under this section  
21 consists of—

22 (A) an adjustment in premiums charged  
23 the individual under the plan, in accordance  
24 with section 1205(c)(2); and

1 (B) payment to the accountable health  
2 plan (on behalf of the individual and family  
3 members) of the applicable Federal assistance  
4 amount (as defined in section 2009(c)(1)) for  
5 enrollment under the plan.

6 (b) MEDICARE-ELIGIBLE INDIVIDUALS.—In the case  
7 of a medicare-eligible individual described in section  
8 2001(b), the premium assistance under this subsection  
9 shall consist of payment for premiums imposed under part  
10 A (if any) or part B of title XVIII of the Social Security  
11 Act. Such assistance shall be provided in a manner so that  
12 no such premium amount is deducted from monthly bene-  
13 fits or transfers under section 1818 or 1840 of such Act.

14 **SEC. 2003. COST-SHARING ASSISTANCE.**

15 (a) NOMINAL COST-SHARING FOR LOW-INCOME IN-  
16 DIVIDUALS.—

17 (1) IN GENERAL.—In the case of a low-income  
18 individual described in section 2001(a) who is en-  
19 rolled in an AHP in an enrollee unit, the cost-shar-  
20 ing assistance under this subsection shall consist  
21 of—

22 (A) an accountable health plan's reduction,  
23 in accordance with section 1202(c), in the cost-  
24 sharing otherwise imposed to amounts that are

1 nominal (as specified by the Board, consistent  
2 with paragraph (2)); and

3 (B) payment to the accountable health  
4 plan (on behalf of the individual and family  
5 members) by the Board of the adjusted per en-  
6 rollee cost-sharing assistance amount deter-  
7 mined under paragraph (3).

8 (2) NOMINAL.—In establishing what is “nomi-  
9 nal” for purposes of paragraph (1), the Board shall  
10 consider regulations established to carry out section  
11 1916(a)(3) of the Social Security Act (as in effect  
12 before the date of the enactment of this Act).

13 (3) ADJUSTED PER ENROLLEE COST-SHARING  
14 ASSISTANCE AMOUNT.—

15 (A) IN GENERAL.—For purposes of this  
16 section, the term “adjusted per enrollee cost-  
17 sharing assistance amount” means, for a year,  
18 the product of—

19 (i) the amount determined under sub-  
20 paragraph (B)(i), divided by the number  
21 determined under subparagraph (B)(ii);  
22 and

23 (ii) the premium class assistance fac-  
24 tor established under subparagraph (C).

1 (B) DETERMINATION OF AVERAGE PER  
2 ENROLLEE COST-SHARING AMOUNT.—Before  
3 the beginning of each year the Board shall esti-  
4 mate—

5 (i) the total amount of cost-sharing  
6 assistance to be provided under this section  
7 to enrollee units in the year, and

8 (ii) the average number of enrollee  
9 units (as defined in section 1701(a)(5)) to  
10 be provided such assistance in the year.

11 (C) PREMIUM CLASS ASSISTANCE FAC-  
12 TOR.—The Board shall establish a factor, for  
13 each premium class, that reflects the ratio of  
14 the—

15 (i) the average value of the cost-shar-  
16 ing assistance furnished under this section  
17 to individuals within the premium class, to

18 (ii) the average value of the cost-shar-  
19 ing assistance furnished under this sub-  
20 section to individuals within all the pre-  
21 mium classes.

22 (b) CERTAIN MEDICARE-ELIGIBLE INDIVIDUALS.—  
23 In the case of a very low-income individual described in  
24 section 2001(b), the cost-sharing assistance under this

1 subsection shall consist of payment being made under title  
2 XVIII of the Social Security Act—

3 (1) without regard to coinsurance under such  
4 title (including coinsurance described in section 1813  
5 of such title);

6 (2) without regard to deductibles established  
7 under such title (including those described in section  
8 1813 and section 1833(b) of such title); and

9 (3) as though any reference to “80 percent” in  
10 section 1833(a) of such title were a reference to  
11 “100 percent”.

12 (c) APPROPRIATION TO COVER PART A ASSIST-  
13 ANCE.—Section 1817(a) of the Social Security Act (42  
14 U.S.C. 1395i(a)) is amended by adding at the end the fol-  
15 lowing new sentence: “In addition to the amounts appro-  
16 priated under this subsection, there are hereby appro-  
17 priated to the Trust Fund, out of any moneys in the  
18 Treasury not otherwise appropriated, amounts equivalent  
19 to the reductions in the deductibles and coinsurance estab-  
20 lished under section 1813 effected under section 2003(b)  
21 of the Managed Competition Act of 1993.”.

22 **SEC. 2004. ASSISTANCE FOR CERTAIN ITEMS AND SERV-**  
23 **ICES.**

24 (a) IN GENERAL.—In the case of a very low-income  
25 individual, the special assistance under this section con-

1 sists of payment under this section with respect to items  
2 and services described in subsection (b), subject to sub-  
3 section (c).

4 (b) ITEMS AND SERVICES COVERED.—

5 (1) IN GENERAL.—Subject to paragraph (2),  
6 the items and services described in this subsection  
7 are—

8 (A) prescription drugs,

9 (B) eyeglasses and hearing aids, and

10 (C) such other items and services as the  
11 Board determines were commonly provided to  
12 individuals described in section  
13 1902(a)(10)(A)(i) of the Social Security Act  
14 under State medicaid plans under title XIX of  
15 such Act (as in effect as of the date of the en-  
16 actment of this Act).

17 (2) EXCLUSIONS.—Items and services described  
18 in this subsection shall not include—

19 (A) items and services included in the uni-  
20 form set of effective benefits, and

21 (B) services described in section  
22 2101(c)(1)(A) and similar services.

23 (c) NOMINAL COPAYMENTS.—The Board shall pro-  
24 vide for cost-sharing under this section in an amount that  
25 is nominal (within the meaning of section 1916(a)(3) of

1 the Social Security Act, as in effect as of the date of the  
2 enactment of this Act).

3 (d) PAYMENT RULES.—The Board shall provide for  
4 such rules relating to—

5 (1) qualifications of providers of items and serv-  
6 ices, and

7 (2) use of carriers in the administration of this  
8 section,

9 as may be appropriate to carry out this section.

10 **SEC. 2005. COMPUTATION OF BASE FEDERAL PREMIUM**  
11 **AMOUNT.**

12 (a) FORMULA.—

13 (1) IN GENERAL.—For purposes of this Act,  
14 the “base Federal premium amount” for an individ-  
15 ual residing in a HPPC area is equal to the product  
16 of—

17 (A) reference premium rate (as defined in  
18 section 2009(c)(4)) for the individual, and

19 (B) the national subsidy percentage (com-  
20 puted under paragraph (2)).

21 (2) NATIONAL SUBSIDY PERCENTAGE.—In  
22 paragraph (1)(B), the term “national subsidy per-  
23 centage” means, for a year—

24 (A) the amount specified under subsection

25 (b)(1), divided by

1 (B) the total amount of low-income assist-  
2 ance that would be provided if the national sub-  
3 sidy percentage were equal to 100 percent;  
4 expressed as a percentage.

5 (b) COMPUTATION OF TOTAL FEDERAL AMOUNT  
6 AVAILABLE FOR LOW-INCOME ASSISTANCE.—

7 (1) IN GENERAL.—The amount specified in this  
8 paragraph for a year is—

9 (A) the sum determined under paragraph  
10 (2) for the year, reduced by

11 (B) the total amount of reductions under  
12 paragraph (3) for the year.

13 (2) AVAILABLE FEDERAL FUNDS.—

14 (A) 1995 THROUGH 1999.—The National  
15 Health Board shall compute, in consultation  
16 with the Secretary of Health and Human Serv-  
17 ices and the Director of of the Office of Man-  
18 agement and Budget, before the beginning of  
19 each of years 1995, 1996, 1997, 1998, and  
20 1999, the sum of—

21 (i) the total dollar amount of Federal  
22 financial participation that would have  
23 been payable to States under section 1903  
24 of the Social Security Act (including such  
25 a plan operating under a waiver under sec-

1           tion 1115 of such Act) for calendar quar-  
2           ters during the year, based on their plans  
3           in effect as of the date of the enactment of  
4           this Act, taking into account changes  
5           scheduled to occur in such a plan as of  
6           such date; and

7           (ii) subject to paragraph (4)(A), the  
8           total net amount of additional revenues es-  
9           timated by the Secretary of the Treasury  
10          to be received during the year due to the  
11          amendments made by subtitle A of title I  
12          and subtitle C of this title.

13          (B) AFTER 1999.—The National Health  
14          Board shall compute, in consultation with the  
15          Secretary of Health and Human Services and  
16          the Director of the Office of Management and  
17          Budget, before the beginning of 2000 and each  
18          subsequent year the sum of—

19               (i) the total dollar amount computed  
20               under subparagraph (A)(i) (or this clause)  
21               for the previous year, increased by the per-  
22               centage increase in the gross domestic  
23               product (as determined by the Secretary of  
24               Commerce) for the 4-quarter period ending  
25               in June of the previous year; and

1           (ii) subject to paragraph (4)(A), the  
2           total net amount of additional revenues es-  
3           timated by the Secretary of the Treasury  
4           to be received during the year due to the  
5           amendments made by subtitle A of title I  
6           and subtitle C of this title.

7           (3) REDUCTIONS.—Subject to paragraph  
8           (4)(B), the total amount of reductions described in  
9           this paragraph for a year are the sum of the follow-  
10          ing:

11           (A) LONG-TERM CARE PHASE-DOWN AS-  
12          SISTANCE.—The total amount of long-term care  
13          phase-down assistance to which States are enti-  
14          tled under section 2101 for calendar quarters  
15          during the year.

16           (B) MEDICARE LOW-INCOME ASSIST-  
17          ANCE.—The total amount, estimated by the  
18          Board, of the assistance to be provided under  
19          sections 2002(b) and 2003(b) during the year.

20           (C) COST-SHARING.—The total amount,  
21          estimated by the Board, of the cost-sharing as-  
22          sistance to be provided under section 2003(a)  
23          during the year.

24           (D) SPECIAL LOW-INCOME ASSISTANCE.—  
25          The total amount, estimated by the Board, of

1 the special assistance to be provided under sec-  
2 tion 2004 during the year.

3 (E) GRANTS AND OTHER EXPENDI-  
4 TURES.—In order to provide for grants under  
5 section 2006(g) and additional expenditures  
6 under subtitle E of title I, subtitle B of title  
7 III, subtitle A of title IV, and title V,  
8 \$523,000,000.

9 (4) ADJUSTMENT FOR OVER- AND UNDER-ESTI-  
10 MATES.—

11 (A) FUNDS AVAILABLE.—The amounts de-  
12 termined under subparagraphs (A)(ii) and  
13 (B)(ii) of paragraph (2) for a year shall be in-  
14 creased or decreased by the amount by which  
15 the amount estimated under such respective  
16 subparagraph for the preceding year was below,  
17 or above, the actual amount of revenues for  
18 such year.

19 (B) REDUCTIONS.—The amounts specified  
20 in subparagraphs (A) through (D) of paragraph  
21 (3) for a year shall be increased or decreased  
22 by the amount by which the respective amount  
23 estimated under such subparagraph for the pre-  
24 ceding year was below, or above, the actual

1 amount described in such subparagraph for  
2 such year.

3 **SEC. 2006. APPLICATIONS FOR ASSISTANCE.**

4 (a) IN GENERAL.—Subject to section 2008, any indi-  
5 vidual who seeks assistance under this subtitle (with re-  
6 spect to himself or herself or a family member) shall sub-  
7 mit a written application, by person or mail, to the Board.

8 (b) BASIS FOR DETERMINATION.—Subject to section  
9 2008 and reconciliation under section 2007(b), eligibility  
10 for assistance under this subtitle shall be based on 4 times  
11 the family adjusted total income (as defined in section  
12 2009(b)(1)) during the 3 months preceding the month in  
13 which the application is filed.

14 (c) FORM AND CONTENTS.—An application for as-  
15 sistance under this subtitle shall be in a form and manner  
16 specified by the Board and shall require—

17 (1) the provision of information necessary to  
18 make the determinations described in subsection (b),

19 (2) the provision of information respecting the  
20 AHP in which the individual is enrolled (or is in the  
21 process of enrolling), and

22 (3) the individual to assign rights to assistance  
23 under section 2003 to such plan.

1 Such form also shall include notice that the subsidies  
2 under this subtitle will be made as a direct reduction of  
3 premiums and cost-sharing under the AHP involved.

4 (d) FREQUENCY OF APPLICATIONS.—

5 (1) IN GENERAL.—An application for assistance  
6 under this subtitle may be filed at any time during  
7 the year and may be resubmitted (but, except as  
8 provided in paragraph (3), not more frequently than  
9 once every 3 months) based upon a change of in-  
10 come or family composition.

11 (2) NEED TO REAPPLY.—In the case of an indi-  
12 vidual who—

13 (A) is entitled to assistance under this sub-  
14 title in September of a year, and

15 (B) wishes to remain eligible for assistance  
16 for months beginning with January of the fol-  
17 lowing year,

18 the individual (or a family member) must file with  
19 the Board in October of that preceding year a new  
20 application for assistance. If a new application under  
21 this paragraph is not filed with respect to an individ-  
22 ual, an application for such assistance with respect  
23 to the individual may not be filed during November  
24 or December of that preceding year.

1           (3) CORRECTION OF INCOME.—Nothing in  
2 paragraph (1) shall be construed as preventing an  
3 individual or family from, at any time, submitting an  
4 application to reduce the amount of assistance under  
5 this subtitle based upon an increase in income from  
6 that stated in the previous application.

7           (e) TIMING OF ASSISTANCE.—

8           (1) IN GENERAL.—If an application for assist-  
9 ance under this subtitle is filed—

10                   (A) on or before the 15th day of a month,  
11 assistance under this subtitle shall be available  
12 for premiums for months after such month and,  
13 with respect to the cost-sharing, for expenses  
14 incurred after such month, and, with respect to  
15 special assistance, for items and services fur-  
16 nished after such month; or

17                   (B) after the 15th day of a month, assist-  
18 ance under this subtitle shall be available for  
19 premiums for months after the month following  
20 such month and, with respect to the cost-shar-  
21 ing, for expenses incurred after such following  
22 month, and, with respect to special assistance,  
23 for items and services furnished after such fol-  
24 lowing month.

1           (2) WELFARE RECIPIENTS.—In the case of an  
2 individual or family with respect to whom an appli-  
3 cation for assistance is not required because of sec-  
4 tion 2008, in applying paragraph (1), the date of ap-  
5 proval of aid or benefits described in such section  
6 shall be considered the date of filing of an applica-  
7 tion for assistance under this subtitle.

8           (f) VERIFICATION.—The Board shall provide for ver-  
9 ification, on a sample basis or other basis, of the informa-  
10 tion supplied in applications under this subtitle. This ver-  
11 ification shall be separate from the reconciliation provided  
12 under section 2007.

13           (g) HELP IN COMPLETING APPLICATIONS.—The  
14 Board shall provide, from funds appropriated to carry out  
15 this subtitle, for grants to public or private nonprofit enti-  
16 ties that will make available assistance to individuals and  
17 families in filing applications for assistance under this  
18 subtitle. The Board shall make grants in a manner that  
19 provides such assistance at a variety of sites (such as low-  
20 income housing projects and shelters for homeless individ-  
21 uals) that are readily accessible to individuals and families  
22 eligible for assistance under this subtitle. The total  
23 amount of the funds provided in any fiscal year under  
24 grants under this subsection may not exceed \$10,000,000.

25           (h) PENALTIES FOR INACCURATE INFORMATION.—

1           (1) INTEREST FOR UNDERSTATEMENTS.—Each  
2 individual who knowingly understates income re-  
3 ported in an application for assistance under this  
4 subtitle or otherwise makes a material misrepresen-  
5 tation of information in such an application shall be  
6 liable to the National Health Board for excess pay-  
7 ments made based on such understatement or mis-  
8 representation, and for interest on such excess pay-  
9 ments at a rate specified by the Board.

10           (2) PENALTIES FOR MISREPRESENTATION.—  
11 Each individual who knowingly misrepresents mate-  
12 rial information in an application for assistance  
13 under this subtitle shall be liable to the National  
14 Health board for \$1,000 or, if greater, three times  
15 the excess payments made based on such misrepre-  
16 sentation.

17           (i) FILING OF APPLICATION DEFINED.—Except as  
18 provided in subsection (e)(2), for purposes of this subtitle,  
19 an application under this subtitle is considered to be  
20 “filed” on the date on which the complete application, in-  
21 cluding all documentation required to act on the applica-  
22 tion, has been filed with the Board.

1 **SEC. 2007. RECONCILIATION OF PREMIUM ASSISTANCE**  
2 **THROUGH USE OF INCOME STATEMENTS.**

3 (a) REQUIREMENT FOR FILING OF INCOME STATE-  
4 MENT.—

5 (1) IN GENERAL.—Subject to section 2008, in  
6 the case of a family which is receiving low-income  
7 assistance under this subtitle for any month in a  
8 year, a member of the family shall file with the  
9 Board, by not later than April 15 of the following  
10 year, a statement that verifies the family's total ad-  
11 justed family income for the taxable year ending  
12 during the previous year. Such a statement shall  
13 provide information necessary to determine the fam-  
14 ily adjusted total income during the year and the  
15 number of family members in the family as of the  
16 last day of the year.

17 (2) USE OF INCOME TAX RETURN.—The Board  
18 shall provide a process under which the filing of a  
19 Federal income tax return shall constitute the filing  
20 of a income statement under paragraph (2).

21 (3) EXTENSION.—The Board shall permit the  
22 extension of the filing deadline under paragraph (1)  
23 in such cases as the Board determines to be appro-  
24 priate. The Board shall take into account the exten-  
25 sions permitted for the filing of Federal income tax  
26 returns.

1 (b) RECONCILIATION OF PREMIUM ASSISTANCE  
2 BASED ON ACTUAL INCOME.—Based on and using the in-  
3 come reported in the statement filed under subsection (a)  
4 with respect to a family or individual, subject to section  
5 2008, the Board shall compute the amount of assistance  
6 that should have been provided under section 2002 with  
7 respect to premiums for the family in the year involved.  
8 If the amount of such assistance computed is—

9 (1) greater than the amount of premium assist-  
10 ance provided, the Board shall provide for payment  
11 to the family or individual involved of an amount  
12 equal to the amount of the deficit, or

13 (2) less than the amount of assistance provided,  
14 the Board shall require the family or individual to  
15 pay to the Board (to the credit of the program  
16 under this subtitle) an amount equal to the amount  
17 of the excess payment.

18 (c) DISQUALIFICATION FOR FAILURE TO FILE.—  
19 Subject to section 2008, in the case of any individual with  
20 respect to whom an information statement under sub-  
21 section (a) is required to be filed in a year and that fails  
22 to file such a statement by the deadline specified in such  
23 subsection, the individual is not eligible for assistance  
24 under this subtitle after May 1 of such year. The Board  
25 shall waive the application of this subsection if there is

1 established, to the satisfaction of the Board, good cause  
2 for the failure to file the statement on a timely basis.

3 (d) PENALTIES FOR FALSE INFORMATION.—Any in-  
4 dividual that provides false information in a statement  
5 under subsection (a) is subject to a criminal penalty to  
6 the same extent as a criminal penalty may be imposed  
7 under section 1128B(a) of the Social Security Act with  
8 respect to a person described in clause (ii) of such section.

9 (e) NOTICE OF REQUIREMENT.—The Board shall  
10 provide for written notice, in March of each year, of the  
11 requirement of subsection (a) to each family which re-  
12 ceived assistance under this subtitle in any month during  
13 the preceding year and to which such requirement applies.

14 (f) TRANSMITTAL OF INFORMATION.—The Board of  
15 the Treasury shall transmit annually to the Board such  
16 information relating to the adjusted total income of indi-  
17 viduals for the taxable year ending in the previous year  
18 as may be necessary to verify the reconciliation of assist-  
19 ance under this section.

20 (g) CONSTRUCTION.—Nothing in this section shall be  
21 construed as authorizing reconciliation of assistance pro-  
22 vided with respect to cost-sharing assistance under section  
23 2003 or special assistance under section 2004.

1 **SEC. 2008. TREATMENT OF CERTAIN CASH ASSISTANCE RE-**  
2 **CIPIENTS.**

3 In the case of a family that has been determined to  
4 be eligible for aid under part A or E of title IV of the  
5 Social Security Act or an individual who has been deter-  
6 mined to be eligible for supplemental security income ben-  
7 efits under title XVI of such Act—

8 (1) the family or individual is deemed, without  
9 the need to file an application for assistance under  
10 section 2006, to have adjusted total income below  
11 100 percent of the State-adjusted poverty level for  
12 the State,

13 (2) the family or individual need not file a  
14 statement under section 2007(a), and

15 (3) the assistance received by the family is not  
16 subject to reconciliation under section 2007(b).

17 **SEC. 2009. DEFINITIONS.**

18 (a) **DEFINITIONS RELATING TO LOW-INCOME INDI-**  
19 **VIDUALS.**—In this subtitle:

20 (1) **LOW-INCOME INDIVIDUAL.**—

21 (A) **IN GENERAL.**—The term “low-income  
22 individual” means, in the case of—

23 (i) a medicare-eligible individual resid-  
24 ing in a State, such an individual whose  
25 family adjusted total income (as defined in  
26 subsection (b)(1)) is less than 120 percent

1 of the State-adjusted poverty level for the  
2 State; or

3 (ii) an individual who is not a medi-  
4 care-eligible individual and who resides in  
5 a State, an eligible individual (as defined  
6 in section 1701(a)(1)) whose family ad-  
7 justed total income is less than 200 per-  
8 cent of the State-adjusted poverty level for  
9 the State.

10 (2) MODERATELY LOW-INCOME INDIVIDUAL.—

11 The term “moderately low-income individual” means  
12 a low-income individual (as defined in paragraph  
13 (1)) who is not a very low-income individual (as de-  
14 fined in paragraph (3)).

15 (3) VERY LOW-INCOME INDIVIDUAL.—The term  
16 “very low-income individual” means, with respect to  
17 an individual residing in a State, a low-income indi-  
18 vidual whose family adjusted total income is less  
19 than 100 percent of the State-adjusted poverty level  
20 for the State.

21 (b) DEFINITIONS RELATING TO INCOME AND POV-  
22 ERTY LINE.—In this subtitle:

23 (1) FAMILY ADJUSTED TOTAL INCOME.—The  
24 term “family adjusted total income” means, with re-  
25 spect to an individual, the sum of the modified total

1 income for the individual and all the other eligible  
2 family members.

3 (2) MODIFIED FAMILY INCOME.—The term  
4 “modified family income” means the sum of—

5 (A) the adjusted gross income (as defined  
6 in section 62(a) of the Internal Revenue Code  
7 of 1986) of the taxpayer and family members  
8 for the taxable year determined without regard  
9 to sections 911, 931, and 933 of such Code, de-  
10 termined without the application of paragraphs  
11 (6) and (7) of section 62(a) of such Code and  
12 without the application of section 162(l) of such  
13 Code, plus

14 (B) the interest received or accrued by the  
15 taxpayer and family members during such tax-  
16 able year which is exempt from income, plus

17 (C) the amount of social security benefits  
18 (described in section 86(d) of such Code) which  
19 is not includable in gross income of the tax-  
20 payer and family members under section 86 of  
21 such Code.

22 (3) STATE-ADJUSTED POVERTY LEVEL DE-  
23 FINED.—

24 (A) IN GENERAL.—The term “State-ad-  
25 justed poverty level” means, with respect to an

1 individual resident in a State, the poverty line  
2 (as defined in paragraph (4)) multiplied by the  
3 State adjustment factor (established under sub-  
4 paragraph (B)) for the State.

5 (B) STATE ADJUSTMENT FACTORS.—The  
6 National Health Board shall establish, for each  
7 State, a State adjustment factor that reflects  
8 the relative cost-of-living in the State compared  
9 to the cost-of-living in the continental United  
10 States (including Alaska) and Hawaii. The  
11 weighted average of such factors shall be 1.  
12 Such factors shall be updated annually.

13 (4) POVERTY LINE.—The term “poverty line”  
14 means the income official poverty line as defined by  
15 the Office of Management and Budget, and revised  
16 annually in accordance with section 673(2) of the  
17 Omnibus Budget Reconciliation Act of 1981.

18 (5) FAMILY SIZE.—The family size to be ap-  
19 plied under this subtitle, with respect to family ad-  
20 justed total income, is the number of eligible family  
21 members (as defined in section 1701(a)(3)).

22 (c) DEFINITIONS RELATING TO ASSISTANCE AND  
23 PREMIUM AMOUNTS.—In this Act:

1           (1) APPLICABLE FEDERAL ASSISTANCE  
2 AMOUNT.—The term “applicable Federal assistance  
3 amount” means, with respect to—

4           (A) a very low-income individual, the base  
5 Federal premium amount (as determined under  
6 section 2005(a)(1)), or

7           (B) a moderately low-income individual,  
8 the amount by which (i) the applicable low-in-  
9 come premium amount (as defined in para-  
10 graph (2)), exceeds (ii) the base individual pre-  
11 mium (as defined in paragraph (3)),

12 reduced by the amount of any contribution made by  
13 an employer with respect to coverage of the individ-  
14 ual.

15           (2) APPLICABLE LOW-INCOME PREMIUM  
16 AMOUNT.—The term “applicable low-income pre-  
17 mium amount” means, with respect to a low-income  
18 individual, the base Federal premium amount (deter-  
19 mined under section 2005(a)(1)) plus the product  
20 of—

21           (A) the individual responsibility percentage  
22 (as defined in paragraph (5)), and

23           (B) the amount by which (i) the reference  
24 premium rate (as defined in paragraph (4)), ex-  
25 ceeds (ii) the base Federal premium amount.

1           (3) BASE INDIVIDUAL PREMIUM.—The term  
2 “base individual premium” means, with respect to  
3 an individual, the product of—

4           (A) the individual responsibility percentage  
5 (as defined in paragraph (5)), and

6           (B) the reference premium rate (as defined  
7 in paragraph (4)).

8           (4) REFERENCE PREMIUM RATE.—The term  
9 “reference premium rate” means, with respect to an  
10 individual residing in a HPPC area, the lowest pre-  
11 mium—

12           (A) established by an open AHP which en-  
13 rolls at least such proportion of eligible individ-  
14 uals in the HPPC area as the Board shall  
15 specify, and

16           (B) offered in the area for the premium  
17 class applicable to such individual (including  
18 the HPPC overhead amount established under  
19 section 1105(b)(3)).

20           (5) INDIVIDUAL RESPONSIBILITY PERCENT-  
21 AGE.—The term “individual responsibility percent-  
22 age” means—

23           (A) with respect to a very low-income indi-  
24 vidual, 0 percentage points,

1 (B) with respect to a moderately low-in-  
2 come individual, the number of percentage  
3 points by which the family's family adjusted  
4 total income (expressed as a percent of the ap-  
5 plicable poverty line) exceeds 100 percentage  
6 points, and

7 (C) with respect to any other individual,  
8 100 percentage points.

9 **Subtitle B—Long-Term Care Phase-**  
10 **Down Assistance to States**

11 **SEC. 2101. LONG-TERM CARE PHASE-DOWN ASSISTANCE.**

12 (a) IN GENERAL.—Subject to subsection (b), if the  
13 excess percentage (as defined in subsection (c)(3)) for a  
14 State is greater than 0 percentage points, the State is en-  
15 titled for each calendar quarter in 1995 through 1998 to  
16 payment equal to  $\frac{1}{4}$  of the product of—

17 (A) such excess percentage,

18 (B) the applicable phase-down percentage  
19 for the year, described in subsection (c)(4),  
20 and

21 (C)  $\frac{1}{2}$  of the amount described in sub-  
22 section (c)(1)(B).

23 (b) MAINTENANCE OF EFFORT REQUIRED.—A State  
24 is not eligible for assistance under subsection (a) for a  
25 calendar quarter unless the State provides assurances sat-

1 isfactory to the Board that the State is incurring expenses  
2 (for services described in subsection (c)(1)(A)) in an  
3 amount not less than the sum of—

4 (1) the amount of assistance under subsection  
5 (a), and

6 (2)  $\frac{1}{4}$  of the product of—

7 (A) the State's effective State medicaid  
8 percentage (as defined in subsection (c)(2)),  
9 and

10 (B)  $\frac{1}{2}$  of the amount described in sub-  
11 section (c)(1)(B).

12 (c) DEFINITIONS.—For purposes of this section:

13 (1) LONG-TERM CARE PERCENTAGE.—The  
14 “long-term care percentage” for a State is—

15 (A) the portion of the amount described in  
16 subparagraph (B) that is are attributable to  
17 medical assistance for nursing facility services,  
18 intermediate care facility services for the men-  
19 tally retarded, home health care services, and  
20 home and community-based services, divided by

21 (B) the total amount of Federal and State  
22 expenditures for medical assistance under the  
23 State plan under title XIX of the Social Secu-  
24 rity Act for calendar quarters during fiscal  
25 years 1992 and 1993;

1 expressed as a percentage.

2 (2) EFFECTIVE STATE MEDICAID PERCENT-  
3 AGE.—The “effective State medicaid percentage” for  
4 a State is—

5 (A)(i) the amount described in subpara-  
6 graph (B), reduced by (ii) the sum of the  
7 amount of the Federal financial participation  
8 under section 1903(a) of the Social Security  
9 Act paid to the State for calendar quarters dur-  
10 ing fiscal years 1992 and 1993 and the amount  
11 of health-care related taxes (as defined in sec-  
12 tion 1903(w)(3)(A) of such Act) received by the  
13 State during such fiscal years, divided by

14 (B) the total amount of the Federal and  
15 State expenditures under its plan under title  
16 XIX of the Social Security Act during calendar  
17 quarters in fiscal years 1992 and 1993.

18 (3) EXCESS PERCENTAGE.—The term “excess  
19 percentage” means, for a State, percentage by which  
20 (A) the long-term care percentage (as defined in  
21 paragraph (1)) exceeds (B) 2 percentage points plus  
22 the effective State medicaid percentage (as defined  
23 in paragraph (2)).

24 (4) APPLICABLE PHASE-DOWN PERCENTAGE.—  
25 The “applicable phase-down percentage” for—

- 1 (A) 1995, is 80 percent,  
2 (B) 1996, is 60 percent,  
3 (C) 1997, is 40 percent, and  
4 (D) 1998, is 20 percent.

## 5 **Subtitle C—Financing**

### 6 **PART 1—MEDICARE SAVINGS**

#### 7 **SEC. 2201. REDUCTION IN UPDATE FOR INPATIENT HOS-** 8 **PITAL SERVICES.**

9 (a) PPS HOSPITALS.—Section 1886(b)(3)(B)(i) of  
10 the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)),  
11 as amended by section 13501(a)(1) of the Omnibus Budg-  
12 et Reconciliation Act of 1993 (hereafter in this part re-  
13 ferred to as “OBRA–1993”), is amended—

14 (1) in subclause (XII), by striking “fiscal year  
15 1997, the market basket percentage increase minus  
16 0.5 percentage point” and inserting “each of the fis-  
17 cal years 1997, 1998, and 1999, the market basket  
18 percentage increase minus 2.5 percentage points”;  
19 and

20 (2) in subclause (XIII), by striking “fiscal year  
21 1998” and inserting “fiscal year 2000”.

22 (b) PPS-EXEMPT HOSPITALS.—Section  
23 1886(b)(3)(B)(ii)(V) of such Act (42 U.S.C.  
24 1395ww(b)(3)(B)(ii)(V)), as amended by section

1 13502(a)(1) of OBRA-1993, is amended by striking  
2 “through 1997” and inserting “through 1999”.

3 **SEC. 2202. REDUCTION IN CONVERSION FACTOR FOR PHY-**  
4 **SICIAN FEE SCHEDULE FOR NON-PRIMARY**  
5 **CARE SERVICES.**

6 Section 1848(d)(3)(A) of the Social Security Act (42  
7 U.S.C. 1395w-4(d)(3)(A)), as amended by section  
8 13511(a)(1) of OBRA-1993, is amended—

9 (1) in clause (i), by striking “through (v)” and  
10 inserting “through (vi)”;

11 (2) in clause (vi), by striking “(iv) and (v)” and  
12 inserting “(iv), (v), and (vi)”;

13 (3) by redesignating clause (vi) as clause (vii);  
14 and

15 (4) by inserting after clause (v) the following  
16 new clause:

17 “(vi) ADJUSTMENT IN PERCENTAGE  
18 INCREASE FOR YEARS FROM 1996  
19 THROUGH 1999.—In applying clause (i) for  
20 services furnished during the period begin-  
21 ning January 1, 1996, and ending Decem-  
22 ber 31, 1999, the percentage increase in  
23 the appropriate update index shall be re-  
24 duced by such percent as the Secretary de-  
25 termines will result in a reduction in ag-

1 aggregate payments for physicians' services  
2 under this part during such period of at  
3 least \$6,300,000,000 from the amount of  
4 aggregate payments for such services that  
5 would otherwise have been made during  
6 the period.”.

7 **SEC. 2203. REDUCTION IN HOSPITAL OUTPATIENT SERV-**  
8 **ICES THROUGH ESTABLISHMENT OF PRO-**  
9 **SPECTIVE PAYMENT SYSTEM.**

10 (a) IN GENERAL.—Section 1833(a)(2)(B) of the So-  
11 cial Security Act (42 U.S.C. 1395l(a)(2)(B)) is amended  
12 by striking “section 1886)—” and all that follows and in-  
13 serting the following: “section 1886), an amount equal to  
14 a prospectively determined payment rate established by  
15 the Secretary that provides for payments for such items  
16 and services to be based upon a national rate adjusted  
17 to take into account the relative costs of furnishing such  
18 items and services in various geographic areas, except that  
19 for items and services furnished during cost reporting pe-  
20 riods (or portions thereof) in years beginning with 1995,  
21 such amount shall be equal to 90 percent of the amount  
22 that would otherwise have been determined;”.

23 (b) ESTABLISHMENT OF PROSPECTIVE PAYMENT  
24 SYSTEM.—Not later than July 1, 1994, the Secretary of  
25 Health and Human Services shall establish the prospective

1 payment system for hospital outpatient services necessary  
 2 to carry out section 1833(a)(2)(B) of the Social Security  
 3 Act (as amended by subsection (a)).

4 (c) EFFECTIVE DATE.—The amendment made by  
 5 subsection (a) shall apply to items and services furnished  
 6 on or after January 1, 1995.

7 **SEC. 2204. INCREASE IN MEDICARE PART B PREMIUM FOR**  
 8 **INDIVIDUALS WITH HIGH INCOME.**

9 (a) IN GENERAL.—Subchapter A of chapter 1 of the  
 10 Internal Revenue Code of 1986 is amended by adding at  
 11 the end thereof the following new part:

12 **“PART VIII—MEDICARE PART B PREMIUMS FOR**  
 13 **HIGH-INCOME INDIVIDUALS**

“Sec. 59B. Medicare part B premium tax.

14 **“SEC. 59B. MEDICARE PART B PREMIUM TAX.**

15 “(a) IMPOSITION OF TAX.—In the case of an individ-  
 16 ual to whom this section applies for the taxable year, there  
 17 is hereby imposed (in addition to any other tax imposed  
 18 by this subtitle) a tax for such taxable year equal to the  
 19 aggregate of the Medicare part B premium taxes for each  
 20 of the months during such year that such individual is  
 21 covered by Medicare part B.

22 “(b) INDIVIDUALS TO WHOM SECTION APPLIES.—  
 23 This section shall apply to any individual for any taxable  
 24 year if—

1           “(1) such individual is covered under Medicare  
2 part B for any month during such year, and

3           “(2) the modified adjusted gross income of the  
4 taxpayer for such taxable year exceeds the threshold  
5 amount.

6           “(c) MEDICARE PART B PREMIUM TAX FOR  
7 MONTH.—

8           “(1) IN GENERAL.—The Medicare part B pre-  
9 mium tax for any month is the applicable percentage  
10 (as defined in paragraph (2)) of the amount equal  
11 to the excess of—

12                   “(A) 150 percent of the monthly actuarial  
13 rate for enrollees age 65 and over determined  
14 for that calendar year under section 1839(b) of  
15 the Social Security Act, over

16                   “(B) the total monthly premium under sec-  
17 tion 1839 of the Social Security Act (deter-  
18 mined without regard to subsections (b) and (f)  
19 of section 1839 of such Act).

20           “(2) PHASE-IN OF TAX.—If the modified ad-  
21 justed gross income of the taxpayer for any taxable  
22 years exceeds the threshold amount by—

23                   “(A) less than \$25,000, the applicable per-  
24 centage under this paragraph is  $33\frac{1}{3}$  percent;

1           “(B) at least \$25,000, but less than  
2           \$50,000, the applicable percentage under this  
3           paragraph is  $66\frac{2}{3}$  percent,

4           “(C) at least \$50,000, but less than  
5           \$75,000, the applicable percentage under this  
6           paragraph is  $65/75$  (expressed as a percent), or

7           “(D) at least \$75,000, the applicable per-  
8           centage under this paragraph is 100 percent.

9           “(d) OTHER DEFINITIONS AND SPECIAL RULES.—  
10          For purposes of this section—

11           “(1) THRESHOLD AMOUNT.—The term ‘thresh-  
12          old amount’ means—

13           “(A) except as otherwise provided in this  
14          paragraph, \$75,000,

15           “(B) \$100,000 in the case of a joint re-  
16          turn, and

17           “(C) zero in the case of a taxpayer who—

18           “(i) is married at the close of the tax-  
19          able year but does not file a joint return  
20          for such year, and

21           “(ii) does not live apart from his  
22          spouse at all times during the taxable year.

23           “(2) MODIFIED ADJUSTED GROSS INCOME.—

24          The term ‘modified adjusted gross income’ means  
25          adjusted gross income—

1           “(A) determined without regard to sections  
2           135, 911, 931, and 933, and

3           “(B) increased by the amount of interest  
4           received or accrued by the taxpayer during the  
5           taxable year which is exempt from tax.

6           “(3) MEDICARE PART B COVERAGE.—An indi-  
7           vidual shall be treated as covered under Medicare  
8           part B for any month if a premium is paid under  
9           part B of title XVIII of the Social Security Act for  
10          the coverage of the individual under such part for  
11          the month.

12          “(4) MARRIED INDIVIDUAL.—The determina-  
13          tion of whether an individual is married shall be  
14          made in accordance with section 7703.”.

15          (b) CLERICAL AMENDMENT.—The table of parts for  
16          subchapter A of chapter 1 of such Code is amended by  
17          adding at the end thereof the following new item:

                  “Part VIII. Medicare Part B Premiums For High-Income Indi-  
                  viduals.”.

18          (c) EFFECTIVE DATE.—The amendments made by  
19          this section shall apply to months after December 1993  
20          in taxable years ending after December 31, 1993.

1 **SEC. 2205. PHASED-IN ELIMINATION OF MEDICARE HOS-**  
2 **PITAL DISPROPORTIONATE SHARE ADJUST-**  
3 **MENT PAYMENTS.**

4 Section 1886(d)(5)(F) of the Social Security Act (42  
5 U.S.C. 1395ww(d)(5)(F)) is amended—

6 (1) in clause (i), by inserting “and before Sep-  
7 tember 30, 1998,” after “1986,”;

8 (2) in clause (ii), by striking “The amount of  
9 such payment” and inserting “Subject to clause (ix),  
10 the amount of such payment”; and

11 (3) by adding at the end the following new  
12 clause:

13 “(ix) The amount of the additional payment made  
14 under this paragraph for a discharge shall be equal to—

15 “(I) for discharges occurring during fiscal year  
16 1995, 80 percent of the amount otherwise deter-  
17 mined for the discharge under clause (ii);

18 “(II) for discharges occurring during fiscal year  
19 1996, 60 percent of the amount otherwise deter-  
20 mined for the discharge under clause (ii);

21 “(III) for discharges occurring during fiscal  
22 year 1997, 40 percent of the amount otherwise de-  
23 termined for the discharge under clause (ii); and

24 “(IV) for discharges occurring during fiscal  
25 year 1998, 20 percent of the amount otherwise de-  
26 termined for the discharge under clause (ii).”.

1 **SEC. 2206. REDUCTION IN ROUTINE COST LIMITS FOR**  
2 **HOME HEALTH SERVICES.**

3 Section 1861(v)(1)(L)(i) of the Social Security Act  
4 (42 U.S.C. 1395x(v)(1)(L)(i)) is amended—

5 (1) in subclause (II), by striking “or” at the  
6 end;

7 (2) in subclause (III)—

8 (A) by inserting “and before July 1,  
9 1995,” after “1977,” and

10 (B) by adding “or” at the end; and

11 (3) by inserting after subclause (III) the follow-  
12 ing new subclause:

13 “(IV) July 1, 1995, 103 percent.”

14 **SEC. 2207. REDUCTION IN ROUTINE COST LIMITS FOR EX-**  
15 **TENDED CARE SERVICES.**

16 (a) **IN GENERAL.**—Section 1888(a) of the Social Se-  
17 curity Act (42 U.S.C. 1395yy(a)) is amended by striking  
18 “112 percent” and inserting “102 percent” each place it  
19 appears.

20 (b) **EFFECTIVE DATE.**—The amendments made by  
21 subsection (a) shall apply to cost reporting periods begin-  
22 ning on or after October 1, 1994.

1 **SEC. 2208. REDUCTIONS IN PAYMENTS FOR HOSPICE SERV-**  
2 **ICES.**

3 Section 1814(i)(1)(C)(ii) of the Social Security Act  
4 (42 U.S.C. 1395f(i)(1)(C)(ii)), as amended by section  
5 13504 of OBRA-1993, is amended—

6 (1) in subclause (III), by striking “1.5 percent-  
7 age points” and inserting “2.5 percentage points”;

8 (2) in subclause (IV), by striking “1.5 percent-  
9 age points” and inserting “2.5 percentage points”;

10 (3) in subclause (V), by striking “0.5 percent-  
11 age point” and inserting “1.5 percentage points”  
12 and by striking “and” at the end;

13 (4) by redesignating subclause (VI) as  
14 subclause (VIII); and

15 (5) by inserting after subclause (V) the follow-  
16 ing new subclauses:

17 “(VI) for fiscal year 1998, the market basket  
18 percentage increase for the fiscal year minus 1.0  
19 percentage point;

20 “(VII) for fiscal year 1999, the market basket  
21 percentage increase for the fiscal year minus 1.0  
22 percentage point; and”.

**PART 2—OTHER SAVINGS****SEC. 2211. REQUIREMENT THAT CERTAIN AGENCIES  
PREFUND GOVERNMENT HEALTH BENEFITS  
CONTRIBUTIONS FOR THEIR ANNUITANTS.**

(a) DEFINITIONS.—For the purpose of this section—

(1) the term “agency” means any agency or other instrumentality within the executive branch of the Government, the receipts and disbursements of which are not generally included in the totals of the budget of the United States Government submitted by the President;

(2) the term “health benefits plan” means, with respect to an agency, a health benefits plan, established by or under Federal law, in which employees or annuitants of such agency may participate;

(3) the term “health-benefits coverage” means coverage under a health benefits plan”;

(4) an individual shall be considered to be an “annuitant of an agency” if such individual is entitled to an annuity, under a retirement system established by or under Federal law, by virtue of—

(A) such individual’s service with, and separation from, such agency; or

(B) being the survivor of an annuitant under subparagraph (A) or of an individual who died while employed by such agency; and

1 (5) the term “Office” means the Office of Per-  
2 sonnel Management.

3 (b) PREFUNDING REQUIREMENT.—

4 (1) IN GENERAL.—Effective as of October 1,  
5 1994, each agency (or February 1, 1995, in the case  
6 of the agency with the greatest number of employ-  
7 ees, as determined by the Office) shall be required  
8 to prepay the Government contributions which are  
9 or will be required in connection with providing  
10 health-benefits coverage for annuitants of such agen-  
11 cy.

12 (2) REGULATIONS.—The Office shall prescribe  
13 such regulations as may be necessary to carry out  
14 this section. The regulations shall be designed to en-  
15 sure at least the following:

16 (A) Amounts paid by each agency shall be  
17 sufficient to cover the amounts which would  
18 otherwise be payable by such agency (on a  
19 “pay-as-you-go” basis), on or after the applica-  
20 ble effective date under paragraph (1), on be-  
21 half of—

22 (i) individuals who are annuitants of  
23 the agency as of such effective date; and

24 (ii) individuals who are employed by  
25 the agency as of such effective date, or

1           who become employed by the agency after  
2           such effective date, after such individuals  
3           have become annuitants of the agency (in-  
4           cluding their survivors).

5           (B)(i) For purposes of determining any  
6           amounts payable by an agency—

7                   (I) this section shall be treated as if  
8                   it had taken effect at the beginning of the  
9                   20-year period which ends on the effective  
10                  date applicable under paragraph (1) with  
11                  respect to such agency; and

12                  (II) in addition to any amounts pay-  
13                  able under subparagraph (A), each agency  
14                  shall also be responsible for paying any  
15                  amounts for which it would have been re-  
16                  sponsible, with respect to the 20-year pe-  
17                  riod described in subclause (I), in connec-  
18                  tion with any individuals who are annu-  
19                  itants or employees of the agency as of the  
20                  applicable effective date under paragraph  
21                  (1).

22                  (ii) Any amounts payable under this sub-  
23                  paragraph for periods preceding the applicable  
24                  effective date under paragraph (1) shall be pay-

1           able in equal installments over the 20-year pe-  
2           riod beginning on such effective date.

3           (c) FASB STANDARDS.—Regulations under sub-  
4 section (b) shall be in conformance with the provisions of  
5 standard 106 of the Financial Accounting Standards  
6 Board, issued in December 1990.

7           (d) CLARIFICATION.—Nothing in this section shall be  
8 considered to permit or require duplicative payments on  
9 behalf of any individuals.

10          (e) DRAFT LEGISLATION.—The Office shall prepare  
11 and submit to Congress any draft legislation which may  
12 be necessary in order to carry out this section.

## 13           **Subtitle D—Repeal of Medicaid** 14           **Program**

### 15   **SEC. 2301. REPEAL OF MEDICAID PROGRAM.**

16          (a) IN GENERAL.—Title XIX of the Social Security  
17 Act is repealed.

18          (b) REPORT ON CONFORMING CHANGES.—By not  
19 later than May 1, 1994, the National Health Board shall  
20 submit to Congress a report on—

21               (1) changes in laws that should be made in  
22               order to conform those laws to the repeal in the  
23               medicaid program effected under subsection (a), and

24               (2) the need for any special or transitional pro-  
25               visions that should be made in order to ensure con-

1       tinuous assistance for the medical needs of the med-  
2       icaid population.

3       (c) EFFECTIVE DATE.—The repeal made by sub-  
4       section (a) shall take apply to items and service furnished  
5       on or after January 1, 1995.

6       **TITLE III—TRAINING AND EDU-**  
7       **CATION OF HEALTH CARE**  
8       **PROFESSIONALS**

9       **Subtitle A—Reform of Federal**  
10       **Funding for Medical Residency**  
11       **Training**

12       **SEC. 3001. DEFINITIONS.**

13       In this subtitle, the following definitions shall apply:

14               (1) The term “entry position” means, with re-  
15       spect to a medical residency training program, a po-  
16       sition as a resident in the initial year of study in the  
17       program.

18               (2) The term “Fund” means the National Med-  
19       ical Education Fund established under section 3005.

20               (3) The term “medical residency training pro-  
21       gram” means a residency or other postgraduate  
22       medical training program participation in which may  
23       be counted toward certification in a specialty or sub-  
24       specialty and includes formal postgraduate training

1 programs in geriatric medicine approved by the Na-  
2 tional Health Board.

3 (4) The term “primary care resident” means a  
4 resident enrolled in a medical residency training pro-  
5 gram in family medicine, general internal medicine,  
6 general pediatrics, preventive medicine, geriatric  
7 medicine, or osteopathic general practice.

8 (5) The term “resident” includes any partici-  
9 pant in a medical residency training program (or,  
10 for purposes of section 3003, a physician retraining  
11 program).

12 (6) The term “United States medical graduate”  
13 means a resident who is a graduate of—

14 (A) a school of medicine accredited by the  
15 Liaison Committee on Medical Education of the  
16 American Medical Association (or approved by  
17 such Committee as meeting the standards nec-  
18 essary for such accreditation); or

19 (B) a school of osteopathy accredited by  
20 the American Osteopathic Association (or ap-  
21 proved by such Association as meeting the  
22 standards necessary for such accreditation).

1 **SEC. 3002. APPROVAL OF MEDICAL RESIDENCY TRAINING**  
2 **POSITIONS.**

3 (a) IN GENERAL.—The National Health Board shall  
4 approve a resident training position in a medical residency  
5 training program for purposes of funding under section  
6 3003(a) if—

7 (1) the program submits an application for ap-  
8 proval of the position to the Board (at such time  
9 and in such manner as the Board may require); and

10 (2) the Board determines that the entry posi-  
11 tion relating to such resident training position in the  
12 program has been allocated to the program under  
13 subsection (b).

14 (b) ALLOCATION OF ENTRY POSITIONS AMONG PRO-  
15 GRAMS.—

16 (1) IN GENERAL.—For purposes of subsection  
17 (a)(2), the Board shall establish a process for the al-  
18 location of entry positions among medical residency  
19 training programs consistent with this subsection.

20 (2) TOTAL NUMBER OF FUNDED POSITIONS.—

21 (A) IN GENERAL.—In consultation with ac-  
22 countable health plans, medical societies, and  
23 medical specialty societies, the Board shall de-  
24 termine the appropriate total number of entry  
25 positions that will be allocated to medical resi-  
26 dency training programs under this subsection

1 in the United States for each residency year. In  
2 this subsection, the term “residency year”  
3 means a 12-month period beginning with July  
4 of the year in which the program begins.

5 (B) BASIS FOR TOTAL NUMBER OF ENTRY  
6 POSITIONS.—Subject to subparagraph (C), such  
7 total number of entry positions shall be based  
8 on the need for health care professionals to pro-  
9 vide cost effective health care services in the  
10 United States. In determining such number the  
11 Board shall take into account the population-to-  
12 physician ratio, consistent with demand for  
13 health care services.

14 (C) LIMIT ON TOTAL NUMBER OF ENTRY  
15 POSITIONS.—The total number of entry posi-  
16 tions determined under this paragraph for any  
17 residency year shall not exceed 110 percent of  
18 the number of United States medical graduates  
19 who complete undergraduate medical education  
20 in the previous year.

21 (D) NO APPLICATION TO RESIDENTS WHO  
22 HAVE COMPLETED ANOTHER TRAINING PRO-  
23 GRAM.—The total number determined under  
24 this paragraph shall only apply to residents who  
25 may enroll in a program without having pre-

1           viously completed another medical residency  
2           training program.

3           (3) GENERAL DISTRIBUTION OF POSITIONS  
4           AMONG SPECIALITIES.—

5           (A) IN GENERAL.—In consultation with ac-  
6           countable health plans, medical societies, and  
7           medical specialty societies, the Board shall de-  
8           termine the appropriate distribution of the total  
9           number of entry positions determined under  
10          paragraph (2) among the various medical spe-  
11          cialties.

12          (B) BASIS FOR DISTRIBUTION.—Such dis-  
13          tribution shall be based on the need for health  
14          care professionals in different medical speciali-  
15          ties to provide cost effective health care services  
16          in the United States. In determining such dis-  
17          tribution the Board shall take into account the  
18          population-to-physician ratio with respect to  
19          each medical specialty, consistent with demand  
20          for health care services, and the specific needs  
21          of accountable health plans.

22          (4) ALLOCATION AMONG PROGRAMS.—

23          (A) IN GENERAL.—The Board shall allo-  
24          cate entry positions, distributed among medical

1 specialties under paragraph (3), among specific  
2 medical residency training programs.

3 (B) BASIS FOR ALLOCATION.—Such alloca-  
4 tion shall be based on the recommendations (if  
5 any) submitted by the Accreditation Council for  
6 Graduate Medical Education and the Residency  
7 Review Committees of such Council and the fol-  
8 lowing objectives:

9 (i) Allocating positions among pro-  
10 grams on the basis of quality.

11 (ii) Allocating positions among pro-  
12 grams to avoid an inappropriate geo-  
13 graphic distribution of physicians.

14 (iii) Allocating positions among pro-  
15 grams to assure a sufficient number of  
16 residents in outpatient settings.

17 **SEC. 3003. FUNDING FOR APPROVED MEDICAL RESIDENCY**  
18 **TRAINING PROGRAMS AND PHYSICIAN RE-**  
19 **TRAINING PROGRAMS.**

20 (a) IN GENERAL.—In the case of an entry position  
21 in a medical residency training program that is approved  
22 by the Board under section 3002(a) and in the case of  
23 a entry position in a physician retraining program de-  
24 scribed in subsection (d)(1) for a residency year, the  
25 Board shall provide a payment to the program on the first

1 day of each month of the year from the National Medical  
2 Education Fund established under section 3005 in the  
3 amount determined under subsection (b). This subsection  
4 constitutes budget authority in advance of appropriations  
5 Acts, and represents the obligation of the Federal Govern-  
6 ment to make payments to such programs in accordance  
7 with this subtitle. No payment shall be made under this  
8 subsection for a month before July 1995.

9 (b) PAYMENT AMOUNT.—

10 (1) IN GENERAL.—Subject to subsection (e),  
11 the amount of payment made to an approved medi-  
12 cal residency training program or a physician re-  
13 training program for each approved entry position  
14 for a full-time equivalent resident, shall be equal to  
15 the applicable percentage (as defined in paragraph  
16 (3)) of the base per resident amount established by  
17 the Board for the year under paragraph (2) for that  
18 resident.

19 (2) BASE PER RESIDENT AMOUNT.—The Board  
20 shall establish a base per resident amount for each  
21 year (beginning with 1995) that reflects an appro-  
22 priate measure of the salary and benefits paid to  
23 residents in medical residency training programs  
24 during the year. The Board may vary such amount  
25 for residents to take into account—

1 (A) increases provided in the salaries and  
2 benefits of residents on the basis of the length  
3 of service in the program; and

4 (B) the relative wages and other costs of  
5 goods and services among the various geo-  
6 graphic areas in which such programs are oper-  
7 ated.

8 (3) APPLICABLE PERCENTAGE DEFINED.—In  
9 paragraph (1), the “applicable percentage” with re-  
10 spect to a resident is equal to—

11 (A) 175 percent, in the case of a primary  
12 care resident; and

13 (B) 150 percent, in the case of a resident  
14 who is not a primary care resident.

15 (c) LIMIT ON LENGTH OF SERVICE OF RESIDENT.—

16 (1) IN GENERAL.—No payment shall be made  
17 under subsection (a) for any resident who has com-  
18 pleted 4 years of medical residency training in any  
19 program.

20 (2) EXCEPTION.—Paragraph (1) shall not  
21 apply to a resident enrolled in a physician retraining  
22 program described in subsection (d)(1).

23 (d) FUNDING OF PHYSICIAN RETRAINING PRO-  
24 GRAMS.—

1           (1) PROGRAM DESCRIBED.—A physician re-  
2           training program described in this paragraph is a  
3           program that—

4                   (A) provides training over a period of not  
5           to exceed 2 years for primary care residents for  
6           physicians who have completed training in a  
7           medical residency training program (other than  
8           as a primary care resident); and

9                   (B) meets such other requirements as the  
10          Board (in consultation with the Accreditation  
11          Council for Graduate Medical Education) may  
12          impose.

13          (2) FUNDING FOR PILOT PROGRAMS.—The Na-  
14          tional Health Board shall make payments from the  
15          Fund to assist the development of physician retrain-  
16          ing programs described in paragraph (1).

17          (e) LIMIT ON EXPENDITURES FOR PROGRAMS.—The  
18          amounts otherwise payable under this section shall be re-  
19          duced, in a pro rata manner, to the extent necessary to  
20          assure that the total amount expended by the National  
21          Health Board during a year for payments under this sec-  
22          tion do not exceed the Board's estimate of the amount  
23          of funds available for expenditure from the Fund in the  
24          year.

1 **SEC. 3004. FINANCING.**

2 (a) ASSESSMENT AGAINST PREMIUMS OF ACCOUNT-  
3 ABLE HEALTH PLANS.—For requirement of payment by  
4 accountable health plans to the National Medical Edu-  
5 cation Fund of 1 percent of gross premium receipts, see  
6 section 1211.

7 (b) PAYMENTS FROM MEDICARE.—Title XVIII of  
8 the Social Security Act (42 U.S.C. 1395 et seq.) is amend-  
9 ed by inserting after section 1889 the following new sec-  
10 tion:

11 “PAYMENTS TO NATIONAL MEDICAL EDUCATION FUND

12 “SEC. 1890. (a) ANNUAL PAYMENT REQUIRED.—  
13 For each month (beginning with July 1995), the Secretary  
14 shall make a payment to the National Medical Education  
15 Fund established under section 3005 of the Managed  
16 Competition Act of 1993 in an amount that is equal, for  
17 a month in a fiscal year, to  $\frac{1}{12}$  of 1 percent of the Sec-  
18 retary’s estimate of the total expenditures made by the  
19 Secretary under this title during the preceding fiscal year,  
20 adjusted to the extent of any overpayment or  
21 underpayment which the Secretary determines was made  
22 under this section for any prior fiscal year and with re-  
23 spect to which adjustment has not already been made  
24 under this subsection.

25 “(b) ALLOCATION AMONG TRUST FUNDS.—The Sec-  
26 retary shall provide for an allocation of the payment made

1 under subsection (a) between the Federal Hospital Insur-  
2 ance Trust Fund and the Federal Supplementary Medical  
3 Insurance Trust Fund in a proportion that reasonably re-  
4 flects the proportion of medical education costs of hos-  
5 pitals for which payment was made under this title for  
6 cost reporting periods during fiscal year 1993 that are as-  
7 sociated with the provision of services under part A and  
8 part B.”.

9 **SEC. 3005. NATIONAL MEDICAL EDUCATION FUND.**

10 (a) ESTABLISHMENT.—There is hereby established in  
11 the Treasury of the United States a fund to be known  
12 as the “National Medical Education Fund”, which shall  
13 consist of—

14 (1) amounts paid into the Fund by (or on be-  
15 half of) accountable health plans pursuant to section  
16 1211;

17 (2) amounts paid into the Fund by the Sec-  
18 retary of Health and Human Services under section  
19 1890 of the Social Security Act (as added by section  
20 3004(b)); and

21 (3) such other amounts that may otherwise be  
22 deposited in or appropriated to the Fund.

23 (b) USE OF AMOUNTS IN FUND.—Amounts in the  
24 Fund shall be used by the National Health Board to make

1 payments to medical residency training programs and phy-  
2 sician retraining programs under section 3003(b).

3 (c) MANAGEMENT OF FUND.—

4 (1) IN GENERAL; REPORTS ON OPERATION.—

5 The Secretary of the Treasury shall, in consultation  
6 with the National Health Board, manage the Fund,  
7 and shall report to Congress each year on the finan-  
8 cial condition and the results of the operation of the  
9 Fund during the preceding year and on the expected  
10 condition and operations of the Fund during the  
11 next 5 years.

12 (2) INVESTMENT.—The Secretary of the Treas-  
13 ury shall invest the portion of the Fund that is not,  
14 in the judgment of the Secretary and of the National  
15 Health Board, required to meet current withdrawals.  
16 Any investments of monies in the Fund may be  
17 made only in interest-bearing obligations of the  
18 United States.

19 **SEC. 3006. REPEAL OF SEPARATE MEDICAL EDUCATION**  
20 **PAYMENTS UNDER MEDICARE.**

21 (a) PROHIBITING RECOGNITION OF MEDICAL EDU-  
22 CATION COSTS UNDER PART B.—Section 1861(v)(1) of  
23 the Social Security Act (42 U.S.C. 1395x(v)(1)) is amend-  
24 ed by adding at the end the following new subparagraph:

1       “(T) In determining such reasonable costs, the Sec-  
2 retary may not include any costs incurred by a provider  
3 for graduate medical education.”.

4       (b) REPEAL OF ADJUSTMENT FOR INDIRECT MEDI-  
5 CAL EDUCATION COSTS.—Section 1886(d)(5) of such Act  
6 (42 U.S.C. 1395ww(d)(5)) is amended by striking sub-  
7 paragraph (B).

8       (c) REPEAL OF PAYMENTS FOR DIRECT GRADUATE  
9 MEDICAL EDUCATION COSTS.—Section 1886 of such Act  
10 (42 U.S.C. 1395ww) is amended by striking subsection (h)  
11 and redesignating subsection (i) as subsection (h).

12       (d) CONFORMING AMENDMENTS.—Section 1886(d)  
13 of such Act (42 U.S.C. 1395ww(d)) is amended—

14             (1) in paragraph (3)(C)(ii)—

15                 (A) by inserting “and before October 1,  
16                 1994,” after “September 30, 1986,”; and

17                 (B) by inserting “and on or before Sep-  
18                 tember 30, 1994,” after “October 1, 1986,”;

19             and

20             (2) in paragraph (9)(D), by striking clause (ii)  
21             and redesignating clauses (iii) and (iv) as clauses (ii)  
22             and (iii).

23       (e) EFFECTIVE DATES.—

1           (1) REASONABLE COSTS.—The amendment  
2           made by subsection (a) shall apply to costs incurred  
3           on or after July 1, 1995.

4           (2) INDIRECT MEDICAL EDUCATION ADJUST-  
5           MENT.—The amendments made by subsections (b)  
6           and (d) shall apply to discharges occurring on or  
7           after July 1, 1995.

8           (3) DIRECT MEDICAL EDUCATION.—The  
9           amendment made by subsection (c) shall apply to  
10          portions of cost reporting periods beginning on or  
11          after July 1, 1995.

12                           **Subtitle B—Other Medical**  
13           **Education Grants and Programs**

14   **SEC. 3101. SCHOLARSHIP AND LOAN REPAYMENT PRO-**  
15                           **GRAMS OF NATIONAL HEALTH SERVICE**  
16                           **CORPS.**

17          Section 338H(b)(1) of the Public Health Service Act  
18   (42 U.S.C. 254q(b)(1)) is amended—

19           (1) by striking “and” after “1991,”; and

20           (2) by striking “through 2000.” and inserting  
21          “through 1994, \$150,000,000 for fiscal year 1995,  
22          \$175,000,000 for fiscal year 1996, \$200,000,000 for  
23          fiscal year 1997, \$225,000,000 for fiscal year 1998,  
24          and \$250,000,000 for fiscal year 1999.”.

1 **SEC. 3102. AREA HEALTH EDUCATION CENTERS.**

2 Section 746(i)(1)(A) of the Public Health Service Act  
3 (42 U.S.C. 293j(i)(1)(A)) is amended by striking  
4 “through 1995” and inserting “through 1994 and  
5 \$30,000,000 for each of the fiscal years 1995 through  
6 1999”.

7 **SEC. 3103. PUBLIC HEALTH AND PREVENTIVE MEDICINE.**

8 Section 765(a) of the Public Health Service Act (42  
9 U.S.C. 294c(a)) is amended by striking “through 1995”  
10 and inserting “through 1999”.

11 **SEC. 3104. FAMILY MEDICINE.**

12 Section 747(d)(1) of the Public Health Service Act  
13 (42 U.S.C. 293k(d)(1)) is amended by striking “through  
14 1995” and inserting “through 1999”.

15 **SEC. 3105. GENERAL INTERNAL MEDICINE AND PEDIAT-**  
16 **RICS.**

17 Section 748(c) of the Public Health Service Act (42  
18 U.S.C. 293l(c)) is amended by striking “through 1995”  
19 and inserting “through 1999”.

20 **SEC. 3106. PHYSICIAN ASSISTANTS.**

21 Section 750(d)(1) of the Public Health Service Act  
22 (42 U.S.C. 293n(d)(1)) is amended by striking “through  
23 1995” and inserting “through 1999”.

1 **SEC. 3107. ALLIED HEALTH PROJECT GRANTS AND CON-**  
2 **TRACTS.**

3 Section 767(d) of the Public Health Service Act (42  
4 U.S.C. 294e(d)) is amended by striking “through 1995”  
5 and inserting “through 1999”.

6 **SEC. 3108. NURSE ALLIED HEALTH PROJECT GRANTS AND**  
7 **CONTRACTS.**

8 Section 767(d) of the Public Health Service Act (42  
9 U.S.C. 294e(d)) is amended by striking “through 1995”  
10 and inserting “through 1999”.

11 **SEC. 3109. NURSE PRACTITIONER AND NURSE MIDWIFE**  
12 **PROGRAMS.**

13 Section 822(d) of the Public Health Service Act (42  
14 U.S.C. 296m(d)) is amended by striking “and 1994” and  
15 inserting “through 1999”.

16 **SEC. 3110. USE OF HEALTH CARE POLICY AND RESEARCH**  
17 **FUNDS FOR PRIMARY CARE.**

18 Section 926 of the Public Health Service Act (42  
19 U.S.C. 299c-5), as amended by section 10 of Public Law  
20 102-410 (106 Stat. 2101), is amended by adding at the  
21 end the following subsection:

22 “(f) ALLOCATION REGARDING PRIMARY CARE.—Of  
23 the amounts made available for a fiscal year for carrying  
24 out this title, the Secretary shall obligate not less than  
25 15 percent for carrying out section 902 with respect to  
26 primary care.”.

1 **TITLE IV—PREVENTIVE HEALTH**  
2 **AND INDIVIDUAL RESPON-**  
3 **SIBILITY**

4 **Subtitle A—Expansion of Public**  
5 **Health Programs**

6 **SEC. 4001. IMMUNIZATIONS AGAINST VACCINE-PREVENT-**  
7 **ABLE DISEASES.**

8 Section 317(j)(1)(A) of the Public Health Service Act  
9 (42 U.S.C. 247b(j)(1)(A)) is amended by striking  
10 “through 1995” and inserting “through 1999”.

11 **SEC. 4002. PREVENTION, CONTROL, AND ELIMINATION OF**  
12 **TUBERCULOSIS.**

13 Section 317(j)(2) of the Public Health Service Act  
14 (42 U.S.C. 247b(j)(2)) is amended by striking “through  
15 1995” and inserting “through 1999”.

16 **SEC. 4003. LEAD POISONING PREVENTION.**

17 Section 317A(l)(1) of the Public Health Service Act  
18 (42 U.S.C. 247b-1(l)(1)) is amended by striking “through  
19 1997” and inserting “through 1999”.

20 **SEC. 4004. PREVENTIVE HEALTH MEASURES WITH RE-**  
21 **SPECT TO BREAST AND CERVICAL CANCERS.**

22 Section 1509(a) of the Public Health Service Act (42  
23 U.S.C. 300n-5(a)) is amended—

24 (1) by striking “and” after “1991,” and

1           (2) by striking “1993.” and inserting “1993,  
2           \$100,000,000 for each of the fiscal years 1994  
3           through 1996, and such sums as may be necessary  
4           for each of the fiscal years 1997 through 1999.”.

5 **SEC. 4005. OFFICE OF DISEASE PREVENTION AND HEALTH**  
6 **PROMOTION.**

7           (a) IN GENERAL.—Section 1701(b) of the Public  
8 Health Service Act (42 U.S.C. 300u(b)) is amended by  
9 striking “through 1996” and inserting “through 1999”.

10          (b) PROMOTION OF INDIVIDUAL RESPONSIBILITY.—  
11 Section 1701(a)(11) of such Act (42 U.S.C. 300u(a)(11))  
12 is amended—

13           (1) by striking “and” at the end of subpara-  
14 graph (C),

15           (2) by redesignating subparagraph (D) as sub-  
16 paragraph (E), and

17           (3) by inserting after subparagraph (C) the fol-  
18 lowing new subparagraph:

19                   “(D) promote individual responsibility in  
20                   personal health care and in the use of valuable  
21                   health care resources; and”.

22          (c) MINORITY HEALTH.—Section 1707(f) of such Act  
23 (42 U.S.C. 300u-6(f)) is amended by striking “1993.” and  
24 inserting “1993, \$35,000,000 for each of the fiscal years

1 1994 through 1996, and such sums as may be necessary  
2 for each of the fiscal years 1997 through 1999.”.

3 **SEC. 4006. PREVENTIVE HEALTH AND HEALTH SERVICES**

4 **BLOCK GRANT.**

5 Section 1901(a) of the Public Health Service Act (42  
6 U.S.C. 300w(a)) is amended by striking “through 1997”  
7 and inserting “through 1999”.

8 **SEC. 4007. CATEGORICAL GRANTS FOR EARLY INTERVEN-**

9 **TION REGARDING ACQUIRED IMMUNE DEFICIENCY SYNDROME.**

10 **CIENCY SYNDROME.**

11 Section 2655 of the Public Health Service Act (42  
12 U.S.C. 300ff-55) is amended by striking “through 1995”  
13 and inserting “through 1999”.

14 **SEC. 4008. PROGRAMS OF OFFICE OF SMOKING AND**

15 **HEALTH.**

16 In addition to any other authorization of appropria-  
17 tions that is available for programs of the Centers for Dis-  
18 ease Control regarding the smoking of tobacco products,  
19 there is authorized to be appropriated for such programs  
20 \$10,000,000 for each of the fiscal years 1995 through  
21 1999.

## **Subtitle B—Medicare**

### **PART 1—COVERAGE OF PREVENTIVE SERVICES**

#### **SEC. 4101. COVERAGE OF COLORECTAL SCREENING.**

(a) IN GENERAL.—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by inserting after subsection (c) the following new subsection:

“(d) FREQUENCY AND PAYMENT LIMITS FOR SCREENING FECAL-OCCULT BLOOD TESTS AND SCREENING FLEXIBLE SIGMOIDOSCOPIES.—

“(1) SCREENING FECAL-OCCULT BLOOD TESTS.—

“(A) PAYMENT LIMIT.—In establishing fee schedules under section 1833(h) with respect to screening fecal-occult blood tests provided for the purpose of early detection of colon cancer, except as provided by the Secretary under paragraph (3)(A), the payment amount established for tests performed—

“(i) in 1995 shall not exceed \$5; and

“(ii) in a subsequent year, shall not exceed the limit on the payment amount established under this subsection for such tests for the preceding year, adjusted by the applicable adjustment under section 1833(h) for tests performed in such year.

1           “(B) FREQUENCY LIMIT.—Subject to revision by the Secretary under paragraph (3)(B),  
2           no payment may be made under this part for  
3           a screening fecal-occult blood test provided to  
4           an individual for the purpose of early detection  
5           of colon cancer—  
6

7                   “(i) if the individual is under 50 years  
8                   of age; or

9                   “(ii) if the test is performed within  
10                  the 11 months after a previous screening  
11                  fecal-occult blood test.

12           “(2) SCREENING FLEXIBLE SIGMOIDOS-  
13           COPIES.—

14           “(A) PAYMENT AMOUNT.—The Secretary  
15           shall establish a payment amount under section  
16           1848 with respect to screening flexible  
17           sigmoidoscopies provided for the purpose of  
18           early detection of colon cancer that is consistent  
19           with payment amounts under such section for  
20           similar or related services, except that such  
21           payment amount shall be established without  
22           regard to subsection (a)(2)(A) of such section.

23           “(B) FREQUENCY LIMIT.—Subject to revision by the Secretary under paragraph (3)(B),  
24           no payment may be made under this part for  
25

1 a screening flexible sigmoidoscopy provided to  
2 an individual for the purpose of early detection  
3 of colon cancer—

4 “(i) if the individual is under 50 years  
5 of age; or

6 “(ii) if the procedure is performed  
7 within the 59 months after a previous  
8 screening flexible sigmoidoscopy.

9 “(3) REDUCTIONS IN PAYMENT LIMIT AND RE-  
10 VISION OF FREQUENCY.—

11 “(A) REDUCTIONS IN PAYMENT LIMIT.—

12 The Secretary shall review from time to time  
13 the appropriateness of the amount of the pay-  
14 ment limit established for screening fecal-occult  
15 blood tests under paragraph (1)(A). The Sec-  
16 retary may, with respect to tests performed in  
17 a year after 1997, reduce the amount of such  
18 limit as it applies nationally or in any area to  
19 the amount that the Secretary estimates is re-  
20 quired to assure that such tests of an appro-  
21 priate quality are readily and conveniently  
22 available during the year.

23 “(B) REVISION OF FREQUENCY.—

24 “(i) REVIEW.—The Secretary, in con-  
25 sultation with the Director of the National

1 Cancer Institute, shall review periodically  
2 the appropriate frequency for performing  
3 screening fecal-occult blood tests and  
4 screening flexible sigmoidoscopies based on  
5 age and such other factors as the Sec-  
6 retary believes to be pertinent.

7 “(ii) REVISION OF FREQUENCY.—The  
8 Secretary, taking into consideration the re-  
9 view made under clause (i), may revise  
10 from time to time the frequency with  
11 which such tests and procedures may be  
12 paid for under this subsection, but no such  
13 revision shall apply to tests or procedures  
14 performed before January 1, 1998.

15 “(4) LIMITING CHARGES OF NONPARTICIPATING  
16 PHYSICIANS.—

17 “(A) IN GENERAL.—In the case of a  
18 screening flexible sigmoidoscopy provided to an  
19 individual for the purpose of early detection of  
20 colon cancer for which payment may be made  
21 under this part, if a nonparticipating physician  
22 provides the procedure to an individual enrolled  
23 under this part, the physician may not charge  
24 the individual more than the limiting charge (as

1 defined in subparagraph (B), or, if less, as de-  
2 fined in section 1848(g)(2)).

3 “(B) LIMITING CHARGE DEFINED.—In  
4 subparagraph (A), the term ‘limiting charge’  
5 means 115 percent of the payment limit estab-  
6 lished under paragraph (2)(A).

7 “(C) ENFORCEMENT.—If a physician or  
8 supplier knowing and willfully imposes a charge  
9 in violation of subparagraph (A), the Secretary  
10 may apply sanctions against such physician or  
11 supplier in accordance with section  
12 1842(j)(2).”.

13 (b) CONFORMING AMENDMENTS.—(1) Paragraphs  
14 (1)(D) and (2)(D) of section 1833(a) of such Act (42  
15 U.S.C. 1395l(a)) are each amended by striking “sub-  
16 section (h)(1),” and inserting “subsection (h)(1) or section  
17 1834(d)(1),”.

18 (2) Section 1833(h)(1)(A) of such Act (42 U.S.C.  
19 1395l(h)(1)(A)) is amended by striking “The Secretary”  
20 and inserting “Subject to paragraphs (1) and (3)(A) of  
21 section 1834(d), the Secretary”.

22 (3) Clauses (i) and (ii) of section 1848(a)(2)(A) of  
23 such Act (42 U.S.C. 1395w-4(a)(2)(A)) are each amended  
24 by striking “a service” and inserting “a service (other  
25 than a screening flexible sigmoidoscopy provided to an in-

1 dividual for the purpose of early detection of colon can-  
2 cer)”.  
3

4 (4) Section 1862(a) of such Act (42 U.S.C. 1395y(a))  
5 is amended—

6 (A) in paragraph (1)—

7 (i) in subparagraph (E), by striking “and”  
8 at the end,

9 (ii) in subparagraph (F), by striking the  
10 semicolon at the end and inserting “, and”, and

11 (iii) by adding at the end the following new  
12 subparagraph:

13 “(G) in the case of screening fecal-occult blood  
14 tests and screening flexible sigmoidoscopies provided  
15 for the purpose of early detection of colon cancer,  
16 which are performed more frequently than is covered  
17 under section 1834(d);”; and

18 (B) in paragraph (7), by striking “paragraph  
19 (1)(B) or under paragraph (1)(F)” and inserting  
20 “subparagraphs (B), (F), or (G) of paragraph (1)”.

21 (c) EFFECTIVE DATE.—The amendments made by  
22 this section shall apply to screening fecal-occult blood tests  
23 and screening flexible sigmoidoscopies performed on or  
after January 1, 1995.

1 **SEC. 4102. COVERAGE OF CERTAIN IMMUNIZATIONS.**

2 (a) IN GENERAL.—Section 1861(s)(10) of the Social  
3 Security Act (42 U.S.C. 1395x(s)(10)) is amended—

4 (1) in subparagraph (A)—

5 (A) by striking “, subject to section  
6 4071(b) of the Omnibus Budget Reconciliation  
7 Act of 1987,” and

8 (B) by striking “; and” and inserting a  
9 comma;

10 (2) in subparagraph (B), by striking the semi-  
11 colon at the end and inserting “, and”; and

12 (3) by adding at the end the following new sub-  
13 paragraph:

14 “(C) tetanus-diphtheria booster and its admin-  
15 istration;”.

16 (b) LIMITATION ON FREQUENCY.—Section  
17 1862(a)(1) of such Act (42 U.S.C. 1395y(a)(1)), as  
18 amended by section 4101(b)(4)(A) of this Act, is amend-  
19 ed—

20 (1) in subparagraph (F), by striking “and” at  
21 the end;

22 (2) in subparagraph (G), by striking the semi-  
23 colon at the end and inserting “, and”; and

24 (3) by adding at the end the following new sub-  
25 paragraph:

1           “(H) in the case of an influenza vaccine, which  
2           is administered within the 11 months after a pre-  
3           vious influenza vaccine, and, in the case of a tetanus-diphtheria booster, which is administered within  
4           the 119 months after a previous tetanus-diphtheria  
5           booster;”.

6           (c) CONFORMING AMENDMENT.—Section 1862(a)(7)  
7           of such Act (42 U.S.C. 1395y(a)(7)), as amended by section 4101(b)(4)(B) of this Act, is amended by striking “or  
8           (G)” and inserting “(G), or (H)”.

9           (d) EFFECTIVE DATE.—The amendments made by  
10           this section shall apply to influenza vaccines and tetanus-  
11           diphtheria boosters administered on or after January 1,  
12           1995.

13           **SEC. 4103. COVERAGE OF WELL-CHILD CARE.**

14           (a) IN GENERAL.—Section 1861(s)(2) of the Social  
15           Security Act (42 U.S.C. 1395x(s)(2)), as amended by section 13553(a) of the Omnibus Budget Reconciliation Act  
16           of 1993, is amended—

17           (1) by striking “and” at the end of subpara-  
18           graph (P);

19           (2) by striking the semicolon at the end of sub-  
20           paragraph (Q) and inserting “; and”; and

21           (3) by adding at the end the following new sub-  
22           paragraph:  
23

1           “(R) well-child services (as defined in sub-  
2           section (ll)(1)) provided to an individual entitled to  
3           benefits under this title who is under 7 years of  
4           age;”.

5           (b) SERVICES DEFINED.—Section 1861 of such Act  
6 (42 U.S.C. 1395x) is amended—

7           (1) by redesignating the subsection (jj) added  
8           by section 4156(a)(2) of the Omnibus Budget Rec-  
9           onciliation Act of 1990 as subsection (kk); and

10          (2) by inserting after subsection (kk) (as so re-  
11          designated) the following new subsection:

12                                   “Well-Child Services

13          “(ll)(1) The term ‘well-child services’ means well-  
14          child care, including routine office visits, routine immuni-  
15          zations (including the vaccine itself), routine laboratory  
16          tests, and preventive dental care, provided in accordance  
17          with the periodicity schedule established with respect to  
18          the services under paragraph (2).

19          “(2) The Secretary, in consultation with the Amer-  
20          ican Academy of Pediatrics, the Advisory Committee on  
21          Immunization Practices, and other entities considered ap-  
22          propriate by the Secretary, shall establish a schedule of  
23          periodicity which reflects the appropriate frequency with  
24          which the services referred to in paragraph (1) should be  
25          provided to healthy children.”.

1 (c) CONFORMING AMENDMENTS.—(1) Section  
2 1861(s)(2)(O) of such Act (42 U.S.C. 1395x(s)(2)(O)) is  
3 amended by striking “subsection (jj)” and inserting “sub-  
4 section (kk)”.

5 (2) Section 1862(a)(1) of such Act (42 U.S.C.  
6 1395y(a)(1)), as amended by sections 4101(b)(4)(A) and  
7 4102(b) of this Act, is amended—

8 (A) in subparagraph (G), by striking “and” at  
9 the end;

10 (B) in subparagraph (H), by striking the semi-  
11 colon at the end and inserting “, and”; and

12 (C) by adding at the end the following new sub-  
13 paragraph:

14 “(I) in the case of well-child services, which are  
15 provided more frequently than is provided under the  
16 schedule of periodicity established by the Secretary  
17 under section 1861(ll)(2) for such services;”.

18 (3) Section 1862(a)(7) of such Act (42 U.S.C.  
19 1395y(a)(7)), as amended by sections 4101(b)(4)(B) and  
20 4102(c) of this Act, is amended by striking “or (H)” and  
21 inserting “(H), or (I)”.

22 (d) EFFECTIVE DATE.—The amendments made by  
23 this section shall apply to well-child services provided on  
24 or after January 1, 1995.

1 **SEC. 4104. ANNUAL SCREENING MAMMOGRAPHY.**

2 (a) ANNUAL SCREENING MAMMOGRAPHY FOR  
3 WOMEN OVER AGE 64.—Section 1834(c)(2)(A) of the So-  
4 cial Security Act (42 U.S.C. 1395m(b)(2)(A)) is amend-  
5 ed—

6 (1) in clause (iv), by striking “but under 65  
7 years of age,”, and

8 (2) by striking clause (v).

9 (b) EFFECTIVE DATE.—The amendments made by  
10 subsection (a) shall apply to screening mammography per-  
11 formed on or after January 1, 1995.

12 **SEC. 4105. FINANCING OF ADDITIONAL BENEFITS.**

13 (a) PREMIUM FOR 1995.—Section 1839(e)(1)(B)(v)  
14 of the Social Security Act (42 U.S.C. 1395r(e)(1)(B)(v))  
15 is amended by striking “\$46.10” and inserting “\$47.50”.

16 (b) PREMIUMS FOR 1996–1998.—(1) Section 1839 of  
17 such Act (42 U.S.C. 1395r) is amended by adding at the  
18 end the following new subsection:

19 “(g) Except as provided in subsections (b) and (f),  
20 the monthly premium otherwise determined, without re-  
21 gard to this subsection, for each individual enrolled under  
22 this part shall be increased by \$1.40 for each month in  
23 1996, 1997, and 1998.”.

24 (2) Section 1839 of such Act (42 U.S.C. 1395r) is  
25 amended—

1 (A) in subsection (a)(2), by striking “(b) and  
2 (e)” and inserting “(b), (e), and (g)”,

3 (B) in subsection (a)(3), by striking “subsection  
4 (e)” and inserting “subsections (e) and (g)”, and

5 (C) in subsection (b), by striking “determined  
6 under subsection (a) or (e)” and inserting “other-  
7 wise determined under this section (without regard  
8 to subsection (f))”.

9 **PART 2—NOTICE OF ADVANCE DIRECTIVE**

10 **RIGHTS**

11 **SEC. 4111. PROVIDING NOTICE OF RIGHTS REGARDING**  
12 **MEDICAL CARE TO INDIVIDUALS ENTERING**  
13 **MEDICARE.**

14 (a) IN GENERAL.—Section 1804 of the Social Secu-  
15 rity Act (42 U.S.C. 1395b-2) is amended—

16 (1) in paragraph (2), by striking “and” at the  
17 end;

18 (2) in paragraph (3), by striking the period at  
19 the end and inserting “, and”; and

20 (3) by inserting after paragraph (3) the follow-  
21 ing new paragraph:

22 “(4) a description of an individual’s rights  
23 under State law to make decisions concerning medi-  
24 cal care, including the right to accept or refuse med-  
25 ical or surgical treatment and the right to formulate

1 advance directives (as defined in section  
2 1866(f)(3)).”.

3 (b) EFFECTIVE DATE.—The amendments made by  
4 subsection (a) shall apply to notices provided under section  
5 1804 of the Social Security Act on or after January 1  
6 of the first year beginning after the date of the enactment  
7 of this Act.

8 **TITLE V—MALPRACTICE**  
9 **REFORM**  
10 **Subtitle A—Findings; Purpose;**  
11 **Definitions**

12 **SEC. 5001. FINDINGS; PURPOSE.**

13 (a) FINDINGS.—Congress finds that—

14 (1) the health care and insurance industries are  
15 industries affecting interstate commerce and the  
16 medical malpractice litigation systems existing  
17 throughout the United States affect interstate com-  
18 merce by contributing to the high cost of health care  
19 and premiums for malpractice insurance purchased  
20 by health care providers; and

21 (2) the Federal Government has a major inter-  
22 est in health care as a direct provider of health care  
23 and as a source of payment for health care, and has  
24 a demonstrated interest in assessing the quality of

1 care, access to care, and the costs of care through  
2 the evaluative activities of several Federal agencies.

3 (b) PURPOSE.—It is the purpose of this title to—

4 (1) provide incentives to States to develop alter-  
5 native dispute resolution procedures to attain a more  
6 efficient, expeditious, and equitable resolution of  
7 health care malpractice disputes;

8 (2) enhance general knowledge concerning the  
9 benefits of different forms of alternative dispute res-  
10 olution mechanisms; and

11 (3) establish uniformity and curb excesses in  
12 the State-based medical liability systems through  
13 Federally mandated reforms.

14 **SEC. 5002. DEFINITIONS.**

15 As used in this title:

16 (1) ALTERNATIVE DISPUTE RESOLUTION SYS-  
17 TEM.—The term “alternative dispute resolution sys-  
18 tem” means a system that is enacted or adopted by  
19 a State to resolve medical malpractice claims other  
20 than through a medical malpractice liability action.

21 (2) CLAIMANT.—The term “claimant” means  
22 any person who brings a health care liability action  
23 and, in the case of an individual who is deceased, in-  
24 competent, or a minor, the person on whose behalf  
25 such an action is brought.

1           (3) CLEAR AND CONVINCING EVIDENCE.—The  
2 term “clear and convincing evidence” is that meas-  
3 ure or degree of proof that will produce in the mind  
4 of the trier of fact a firm belief or conviction as to  
5 the truth of the allegations sought to be established,  
6 except that such measure or degree of proof is more  
7 than that required under preponderance of the evi-  
8 dence, but less than that required for proof beyond  
9 a reasonable doubt.

10           (4) ECONOMIC DAMAGES.—The term “economic  
11 damages” means damages paid to compensate an in-  
12 dividual for losses for hospital and other medical ex-  
13 penses, lost wages, lost employment, and other pecu-  
14 niary losses.

15           (5) HEALTH CARE PROFESSIONAL.—The term  
16 “health care professional” means any individual who  
17 provides health care services in a State and who is  
18 required by State law or regulation to be licensed or  
19 certified by the State to provide such services in the  
20 State.

21           (6) HEALTH CARE PROVIDER.—The term  
22 “health care provider” means any organization or  
23 institution that is engaged in the delivery of health  
24 care services in a State that is required by State law  
25 or regulation to be licensed or certified by the State

1 to engage in the delivery of such services in the  
2 State.

3 (7) INJURY.—The term “injury” means any ill-  
4 ness, disease, or other harm that is the subject of  
5 a medical malpractice claim.

6 (8) MEDICAL MALPRACTICE CLAIM.—The term  
7 “medical malpractice claim” means any claim relat-  
8 ing to the provision of (or the failure to provide)  
9 health care services without regard to the theory of  
10 liability asserted, and includes any third-party claim,  
11 cross-claim, counterclaim, or contribution claim in a  
12 medical malpractice liability action.

13 (9) MEDICAL MALPRACTICE LIABILITY AC-  
14 TION.—The term “medical malpractice liability ac-  
15 tion” means any civil action brought pursuant to  
16 State law in which a plaintiff alleges a medical mal-  
17 practice claim against a health care provider or  
18 health care professional.

19 (10) MEDICAL PRODUCT.—The term “medical  
20 product” means a device (as defined in section  
21 201(h) of the Federal Food, Drug, and Cosmetic  
22 Act) or a drug (as defined in section 201(g)(1) of  
23 the Federal Food, Drug, and Cosmetic Act).

24 (11) NONECONOMIC DAMAGES.—The term  
25 “noneconomic damages” means damages paid to

1       compensate an individual for losses for physical and  
2       emotional pain, suffering, inconvenience, physical  
3       impairment, mental anguish, disfigurement, loss of  
4       enjoyment of life, loss of consortium, and other  
5       nonpecuniary losses, but does not include punitive  
6       damages.

7           (12) PUNITIVE DAMAGES.—The term “punitive  
8       damages” means compensation, in addition to com-  
9       pensation for actual harm suffered, that is awarded  
10      for the purpose of punishing a person for conduct  
11      deemed to be malicious, wanton, willful, or exces-  
12      sively reckless.

13          (13) SECRETARY.—The term “Secretary”  
14      means the Secretary of Health and Human Services.

15          (14) STATE.—The term “State” means each of  
16      the several States, the District of Columbia, the  
17      Commonwealth of Puerto Rico, the Virgin Islands,  
18      and Guam.

19   **Subtitle B—Grants to States for Al-**  
20   **ternative Dispute Resolution**  
21   **Systems**

22   **SEC. 5101. GRANTS TO STATES.**

23          (a) IN GENERAL.—The Secretary shall make grants  
24      to States for a 2-year period for the implementation and  
25      evaluation of alternative dispute resolution systems.

1 (b) ELIGIBILITY.—A State is eligible to receive a  
2 grant under this section if the State submits to the Sec-  
3 retary an application at such time, in such form, and con-  
4 taining such information and assurances as the Secretary  
5 may require, including—

6 (1) a description of the alternative dispute reso-  
7 lution system that the State intends to implement  
8 with amounts received under the grant;

9 (2) assurances that the State will comply with  
10 all data gathering requirements promulgated by the  
11 Secretary under section 5102(a); and

12 (3) any information and assurances necessary  
13 to enable the Secretary to determine whether the  
14 State's alternative dispute resolution system meets  
15 the qualification standards for such systems devel-  
16 oped by the Secretary under section 5102(a).

17 (c) NUMBER OF GRANTS.—

18 (1) IN GENERAL.—Except as provided in para-  
19 graph (2), the Secretary shall award not less than  
20 10 grants under this section.

21 (2) EXCEPTION.—Notwithstanding paragraph  
22 (1), the Secretary may award less than 10 grants  
23 under this section if the Secretary determines that  
24 there are an inadequate number of applications sub-

1       mitted that meet the eligibility and approval require-  
2       ments of this section.

3       (d) LIMITATION ON AMOUNT OF GRANT.—The  
4       amount of funds provided to a State under a grant under  
5       this section may not exceed \$5,000,000 during the 2-year  
6       period of the grant.

7       (e) DESIGNATION OF MODEL STATES.—

8           (1) IN GENERAL.—The Secretary shall des-  
9       ignate each State receiving a grant under this sec-  
10      tion as a model alternative dispute resolution State.

11          (2) EXTENSION OF PERIOD OF GRANT.—Upon  
12      application to the Secretary, a State designated  
13      under paragraph (1) shall be eligible for a 2-year ex-  
14      tension of the grant received under this section.

15          (3) DISSEMINATION OF INFORMATION TO  
16      OTHER STATES.—The Secretary shall disseminate  
17      information on the alternative dispute resolution sys-  
18      tems implemented by the States designated under  
19      paragraph (1) to other States, health care profes-  
20      sionals, health care providers, and other interested  
21      parties.

22   **SEC. 5102. ADMINISTRATION.**

23      (a) STANDARDS AND REGULATIONS FOR ALTER-  
24      NATIVE DISPUTE RESOLUTION GRANT PROGRAM.—

1           (1) IN GENERAL.—In consultation with the Di-  
2           rector of the Agency for Health Care Policy and Re-  
3           search, the Secretary shall develop and promulgate  
4           standards and regulations necessary to carry out the  
5           grant program established under section 5101, in-  
6           cluding—

7                   (A) qualification standards for alternative  
8                   dispute resolution systems that States must  
9                   meet in order to receive grants under such sec-  
10                  tion; and

11                  (B) regulations establishing data gathering  
12                  requirements for States receiving grants under  
13                  such section.

14           (2) CRITERIA FOR PROGRAMS.—In developing  
15           qualification standards for alternative dispute resolu-  
16           tion systems under paragraph (1)(A), the Secretary  
17           shall take into account the effectiveness of such sys-  
18           tems in—

19                   (A) supporting access to health care;

20                   (B) encouraging improvements in the qual-  
21                  ity of health care;

22                   (C) enhancing and not impairing the physi-  
23                  cian-patient relationship;

24                   (D) encouraging innovation that leads to  
25                  an improved level of health care;

1 (E) compensating for avoidable medical in-  
2 jury due to provider fault and not compensating  
3 for injury which is unavoidable by standard  
4 medical practice;

5 (F) resolving claims promptly and in  
6 amounts proportional to the injury;

7 (G) providing predictable outcomes; and

8 (H) operating efficiently in terms of finan-  
9 cial costs, professional energies, and govern-  
10 mental processes.

11 (b) TECHNICAL ASSISTANCE.—The Secretary shall  
12 provide States with technical assistance to enable States  
13 to submit applications for grants under section 5101, in-  
14 cluding information on the establishment and operation of  
15 alternative dispute resolution systems.

16 (c) EVALUATION OF ALTERNATIVE DISPUTE RESO-  
17 LUTION SYSTEMS.—Not later than 4 years after awarding  
18 the first grant to a State under section 5101, the Sec-  
19 retary shall prepare and submit to Congress a report de-  
20 scribing and evaluating the alternative dispute resolution  
21 systems implemented by States with funds provided under  
22 such grants, and shall include in the report—

23 (1) information on—

24 (A) the effect of such systems on the cost  
25 of health care within the State,

1 (B) the impact of such systems on the ac-  
2 cess of individuals to health care within the  
3 State, and

4 (C) the effect of such systems on the qual-  
5 ity of health care provided within such State;  
6 and

7 (2) an analysis of the feasibility and desirability  
8 of establishing a national alternative dispute resolu-  
9 tion system.

## 10 **Subtitle C—Uniform Standards for** 11 **Malpractice Claims**

### 12 **SEC. 5201. APPLICABILITY.**

13 Except as provided in section 5208, this subtitle shall  
14 apply to any medical malpractice liability action brought  
15 in a Federal or State court, and to any medical mal-  
16 practice claim subject to an alternative dispute resolution  
17 system, that is initiated on or after January 1, 1995, ex-  
18 cept that this subtitle shall not apply to any action or  
19 claim in which the plaintiff's sole allegation is an allega-  
20 tion of an injury arising from the use of a medical product.

### 21 **SEC. 5202. TREATMENT OF NONECONOMIC AND PUNITIVE** 22 **DAMAGES.**

23 (a) UNITED STATES COMMISSION ON MALPRACTICE  
24 AWARDS.—

1           (1) ESTABLISHMENT.—There is established as  
2 an independent commission in the judicial branch of  
3 the United States the United States Commission on  
4 Malpractice Awards (hereafter in this subtitle re-  
5 ferred to as the “Commission”).

6           (2) MEMBERSHIP.—

7           (A) COMPOSITION.—The Commission shall  
8 consist of 7 voting members, one nonvoting  
9 member, and the Attorney General (or the At-  
10 torney General’s designee), who shall serve as  
11 an ex officio, nonvoting member. Not more than  
12 4 of the members of the Commission shall be  
13 members of the same political party.

14           (B) APPOINTMENT PROCESS.—Each voting  
15 member of the Commission shall be appointed  
16 by the President with the advice and consent of  
17 the Senate not later than March 1, 1994. The  
18 President shall appoint members of the Com-  
19 mission after consultation with representatives  
20 of the following:

21           (i) Attorneys who represent plaintiffs  
22 in medical malpractice liability actions.

23           (ii) Attorneys who represent health  
24 care professionals and health care provid-  
25 ers in medical malpractice liability actions.

1 (iii) Physicians and other health care  
2 professionals and providers.

3 (iv) Individuals who have suffered in-  
4 jury as a result of medical malpractice.

5 (v) Judges who preside over medical  
6 malpractice liability actions.

7 (vi) Medical ethicists.

8 (C) CHAIRPERSON.—The President shall  
9 appoint, with the advice and consent of the  
10 Senate, one of the voting members of the Com-  
11 mission to serve as Chairperson.

12 (3) TERMS OF OFFICE.—

13 (A) INITIAL APPOINTMENT.—The voting  
14 members of the Commission shall be appointed  
15 for 6-year terms, except that the initial terms  
16 of the first members appointed shall be stag-  
17 gered so that—

18 (i) 2 members, including the Chair-  
19 person, serve terms of 6 years;

20 (ii) 3 members serve terms of 4 years;

21 and

22 (iii) 2 members serve terms of 2  
23 years.

24 (B) LIMIT ON NUMBER OF TERMS.—No  
25 voting member may serve more than 2 full

1 terms. A voting member appointed to fill a va-  
2 cancy that occurs before the expiration of the  
3 term for which the member's predecessor was  
4 appointed shall be appointed only for the re-  
5 mainder of such term.

6 (4) COMPENSATION.—

7 (A) CHAIRPERSON.—The Chairperson shall  
8 hold a full-time position and shall be com-  
9 pensated during the term of office at the an-  
10 nual rate at which judges of the United States  
11 courts of appeals are compensated.

12 (B) OTHER VOTING MEMBERS.—The vot-  
13 ing members of the Commission (other than the  
14 Chairperson) shall hold full-time positions until  
15 January 1, 2001, and shall be compensated at  
16 the annual rate at which judges of the United  
17 States courts of appeals are compensated. After  
18 January 1, 2001, such members shall hold  
19 part-time positions and shall be paid at the  
20 daily rate at which judges of the United States  
21 courts of appeals are compensated.

22 (5) DUTY TO PROMULGATE GUIDELINES RE-  
23 LATING TO LIMITS ON NONECONOMIC AND PUNITIVE  
24 DAMAGES.—

1 (A) IN GENERAL.—Not later than Novem-  
2 ber 1, 1994, the Commission shall promulgate  
3 guidelines that provide limits on the amount of  
4 noneconomic damages and the amount of puni-  
5 tive damages that may be awarded with respect  
6 to medical malpractice liability claims. The pur-  
7 pose of the guidelines is to provide certainty  
8 and fairness in malpractice awards and to avoid  
9 unwarranted disparities among health care pro-  
10 viders and health care professionals who have  
11 engaged in similar conduct.

12 (B) FACTORS CONSIDERED.—In promul-  
13 gating guidelines under this subsection, the  
14 Commission shall—

15 (i) vary the limits applicable with re-  
16 spect to various types of claimants and in-  
17 juries on the basis of the status of the  
18 claimant, the severity of the injury that is  
19 the subject of the claim, the nature of the  
20 conduct of the party against whom the  
21 claim is filed, and other factors the Com-  
22 mission considers appropriate; and

23 (ii) examine the most recent available  
24 data on the amount of damages awarded  
25 with respect to such claims.

1 (C) PERIODIC REVISION.—Not less often  
2 than every 2 years after promulgating the ini-  
3 tial guidelines under this subsection, the Com-  
4 mission shall promulgate updated guidelines.

5 (D) NOTICE AND HEARING.—The provi-  
6 sions of section 553 of title 5, United States  
7 Code, shall apply to the promulgation of guide-  
8 lines by the Commission pursuant to this sub-  
9 section.

10 (6) DIRECTOR AND STAFF.—

11 (A) DIRECTOR.—The Commission shall  
12 have a Director who shall be appointed by the  
13 Chairperson (with the approval of the Commis-  
14 sion).

15 (B) STAFF.—With the approval of the  
16 Commission, the Director may appoint such ad-  
17 ditional personnel as the Director considers ap-  
18 propriate.

19 (C) APPLICABILITY OF CERTAIN CIVIL  
20 SERVICE LAWS.—The Director and staff of the  
21 Commission shall be appointed subject to the  
22 provisions of title 5, United States Code, gov-  
23 erning appointments in the competitive service,  
24 and shall be paid in accordance with the provi-  
25 sions of chapter 51 and subchapter III of chap-

1           ter 53 of that title relating to classification and  
2           General Schedule pay rates.

3           (D) EXPERTS AND CONSULTANTS.—With  
4           the approval of the Commission, the Director  
5           may procure temporary and intermittent serv-  
6           ices under section 3109(b) of title 5, United  
7           States Code.

8           (E) STAFF OF FEDERAL AGENCIES.—Upon  
9           request of the Chairperson, the head of any  
10          Federal department or agency may detail, on a  
11          reimbursable basis, any of the personnel of that  
12          department or agency to the Commission to as-  
13          sist it in carrying out its duties under this sub-  
14          section.

15          (7) ANNUAL REPORT.—The Commission shall  
16          report annually to Congress and the President on its  
17          activities.

18          (b) LIMITATION ON NONECONOMIC AND PUNITIVE  
19          DAMAGES.—The amount of noneconomic damages and the  
20          amount of punitive damages that may be awarded to an  
21          individual and the family members of such individual for  
22          losses resulting from an injury which is the subject of a  
23          medical malpractice liability action or claim may not ex-  
24          ceed the limit provided under the applicable guidelines es-

1 tablished by the United States Commission on Malpractice  
2 Awards pursuant to subsection (a).

3 (c) SEVERAL LIABILITY FOR NONECONOMIC DAM-  
4 AGES.—The liability of each defendant for noneconomic  
5 shall be several only and shall not be joint, and each de-  
6 fendant shall be liable only for the amount of noneconomic  
7 damages allocated to the defendant in direct proportion  
8 to the defendant's percentage of responsibility (as deter-  
9 mined by the trier of fact).

10 (d) ALLOCATION OF PUNITIVE DAMAGE AWARDS  
11 FOR PROVIDER LICENSING AND DISCIPLINARY ACTIVI-  
12 TIES.—

13 (1) IN GENERAL.—The total amount of any pu-  
14 nitive damages awarded in a medical malpractice li-  
15 ability action shall be paid to the State in which the  
16 action is brought (or, in a case brought in Federal  
17 court, in the State in which the health care services  
18 that caused the injury that is the subject of the ac-  
19 tion were provided) for the purposes of carrying out  
20 the activities described in paragraph (2).

21 (2) ACTIVITIES DESCRIBED.—A State shall use  
22 amounts paid pursuant to paragraph (1) to carry  
23 out activities to assure the safety and quality of  
24 health care services provided in the State, including  
25 (but not limited to)—

1 (A) licensing or certifying health care pro-  
2 fessionals and health care providers in the  
3 State;

4 (B) implementing health care quality as-  
5 surance programs;

6 (C) carrying out public education programs  
7 to increase awareness of the availability of com-  
8 parative quality information on accountable  
9 health plans; and

10 (D) carrying out programs to reduce mal-  
11 practice-related costs for providers volunteering  
12 to provide services in medically underserved  
13 areas.

14 (3) MAINTENANCE OF EFFORT.—A State shall  
15 use any amounts paid pursuant to paragraph (1) to  
16 supplement and not to replace amounts spent by the  
17 State for the activities described in paragraph (2).

18 **SEC. 5203. PERIODIC PAYMENTS FOR FUTURE LOSSES.**

19 In any medical malpractice liability action in which  
20 the damages awarded for future economic loss exceeds  
21 \$100,000, a defendant may not be required to pay such  
22 damages in a single, lump-sum payment, but may be per-  
23 mitted to make such payments on a periodic basis. The  
24 periods for such payments shall be determined by the

1 court, based upon projections of when such expenses are  
2 likely to be incurred.

3 **SEC. 5204. UNIFORM STATUTE OF LIMITATIONS.**

4 (a) IN GENERAL.—No medical malpractice claim  
5 may be initiated after the expiration of the 2-year period  
6 that begins on the date on which the alleged injury that  
7 is the subject of such claim was discovered or the date  
8 on which such injury should reasonably have been discov-  
9 ered, whichever is earlier.

10 (b) EXCEPTION FOR MINORS.—In the case of an al-  
11 leged injury suffered by a minor who has not attained 6  
12 years of age, a medical malpractice claim may be initiated  
13 after the expiration of the period described in subsection  
14 (a) if the claim is initiated before the minor attains 8  
15 years of age.

16 **SEC. 5205. SPECIAL PROVISION FOR CERTAIN OBSTETRIC**  
17 **SERVICES.**

18 (a) IN GENERAL.—In the case of a medical mal-  
19 practice claim relating to services provided during labor  
20 or the delivery of a baby, if the health care professional  
21 or health care provider against whom the claim is brought  
22 did not previously treat the claimant for the pregnancy,  
23 the trier of fact may not find that such professional or  
24 provider committed malpractice and may not assess dam-

1 ages against such professional or provider unless the mal-  
2 practice is proven by clear and convincing evidence.

3 (b) APPLICABILITY TO GROUP PRACTICES OR  
4 AGREEMENTS AMONG PROVIDERS.—For purposes of sub-  
5 section (a), a health care professional shall be considered  
6 to have previously treated an individual for a pregnancy  
7 if the professional is a member of a group practice whose  
8 members previously treated the individual for the preg-  
9 nancy or is providing services to the individual during  
10 labor or the delivery of a baby pursuant to an agreement  
11 with another professional.

12 **SEC. 5206. UNIFORM STANDARD FOR DETERMINING LIABIL-**  
13 **ITY IN ACTIONS BASED ON NEGLIGENCE.**

14 (a) STANDARD OF REASONABLENESS.—Except as  
15 provided in subsection (b), a defendant in a medical mal-  
16 practice liability action may not be found to have commit-  
17 ted malpractice unless the defendant's conduct at the time  
18 of providing the health care services that are the subject  
19 of the action was not reasonable.

20 (b) ACTIONS BROUGHT UNDER STRICT LIABILITY.—  
21 Subsection (a) shall not apply with respect to a medical  
22 malpractice action if (in accordance with applicable State  
23 law) the theory of liability upon which the action is based  
24 is a theory of strict liability.

1 **SEC. 5207. JURISDICTION OF FEDERAL COURTS.**

2 Nothing in this subtitle shall be construed to estab-  
3 lish jurisdiction over any medical malpractice liability ac-  
4 tion in the district courts of the United States on the basis  
5 of sections 1331 or 1337 of title 28, United States Code.

6 **SEC. 5208. PREEMPTION.**

7 (a) **IN GENERAL.**—This subtitle supersedes any State  
8 law only to the extent that the State law permits the recov-  
9 ery by a claimant or the assessment against a defendant  
10 of a greater amount of damages, establishes a longer pe-  
11 riod during which a medical malpractice claim may be ini-  
12 tiated, or establishes a less strict standard of proof for  
13 determining whether a defendant has committed mal-  
14 practice, than the provisions of this subtitle.

15 (b) **EFFECT ON SOVEREIGN IMMUNITY AND CHOICE**  
16 **OF LAW OR VENUE.**—Nothing in this subtitle shall be con-  
17 strued to—

18 (1) waive or affect any defense of sovereign im-  
19 munity asserted by any State under any provision of  
20 law;

21 (2) waive or affect any defense of sovereign im-  
22 munity asserted by the United States;

23 (3) affect the applicability of any provision of  
24 the Foreign Sovereign Immunities Act of 1976;

1           (4) preempt State choice-of-law rules with re-  
2           spect to claims brought by a foreign nation or a citi-  
3           zen of a foreign nation; or

4           (5) affect the right of any court to transfer  
5           venue or to apply the law of a foreign nation or to  
6           dismiss a claim of a foreign nation or of a citizen  
7           of a foreign nation on the ground in inconvenient  
8           forum.

9           **Subtitle D—Grants to States for**  
10           **Development of Practice Guide-**  
11           **lines**

12           **SEC. 5301. GRANTS TO STATES.**

13           (a) **IN GENERAL.**—The Secretary shall make grants  
14           to States for a 2-year period for the development of medi-  
15           cal practice guidelines that may be applied to resolve medi-  
16           cal malpractice liability claims and actions in the State.

17           (b) **ELIGIBILITY.**—A State is eligible to receive a  
18           grant under this section if the State submits to the Sec-  
19           retary an application at such time, in such form, and con-  
20           taining such information and assurances as the Secretary  
21           may require, including assurances that the State will sub-  
22           mit such periodic reports on the development and applica-  
23           tion of the State’s medical practice guidelines as the Sec-  
24           retary may require.

25           (c) **NUMBER OF GRANTS.**—

1           (1) IN GENERAL.—Except as provided in para-  
2 graph (2), the Secretary shall award not less than  
3 10 grants under this section.

4           (2) EXCEPTION.—Notwithstanding paragraph  
5 (1), the Secretary may award less than 10 grants  
6 under this section if the Secretary determines that  
7 there are an inadequate number of applications sub-  
8 mitted that meet the eligibility and approval require-  
9 ments of this section.

10          (d) LIMITATION ON AMOUNT OF GRANT.—The  
11 amount of funds provided to a State under a grant under  
12 this section may not exceed \$5,000,000 during the 2-year  
13 period of the grant.

14 **TITLE VI—PAPERWORK REDUC-**  
15 **TION AND ADMINISTRATIVE**  
16 **SIMPLIFICATION**

17 **SEC. 6001. PREEMPTION OF STATE QUILL PEN LAWS.**

18          After 1994, no effect shall be given to any provision  
19 of State law that requires medical or health insurance  
20 records (including billing information) to be maintained  
21 in written, rather than electronic, form.

22 **SEC. 6002. CONFIDENTIALITY OF ELECTRONIC HEALTH**  
23 **CARE INFORMATION.**

24          (a) PROMULGATION OF REQUIREMENTS.—

1           (1) IN GENERAL.—The National Health Board  
2 shall promulgate, and may modify from time to  
3 time, requirements to facilitate and ensure the uni-  
4 form, confidential treatment of individually identifi-  
5 able health care information in electronic environ-  
6 ments.

7           (2) ITEMS TO BE INCLUDED.—The require-  
8 ments under this subsection shall—

9                   (A) provide for the preservation of con-  
10 fidentiality and privacy rights in electronic  
11 health care claims processing and payment;

12                   (B) apply to the collection, storage, han-  
13 dling, and transmission of individually identifi-  
14 able health care data (including initial and sub-  
15 sequent disclosures) in electronic form by all ac-  
16 countable health plans, public and private third-  
17 party payers, providers of health care, and all  
18 other entities involved in the transactions;

19                   (C) not apply to public health reporting re-  
20 quired under State or Federal law;

21                   (D) delineate protocols for securing elec-  
22 tronic storage, processing, and transmission of  
23 health care data;

1 (E) specify fair information practices that  
2 assure a proper balance between required dis-  
3 closures and use of data, including—

4 (i) creating a proper balance between  
5 what an individual is expected to divulge to  
6 a record-keeping organization and what the  
7 individual seeks in return,

8 (ii) minimizing the extent to which in-  
9 formation concerning an individual is itself  
10 a source of unfairness in any decision  
11 made on the basis of such information, and

12 (iii) creating and defining obligations  
13 respecting the uses and disclosures that  
14 will be made of recorded information about  
15 an individual;

16 (F) require publication of the existence of  
17 health care data banks;

18 (G) establish appropriate protections for  
19 highly sensitive data (such as data concerning  
20 mental health, substance abuse, and commu-  
21 nicable and genetic diseases);

22 (H) encourage the use of alternative dis-  
23 pute resolution mechanisms (where appro-  
24 priate); and

1 (I) provide for the deletion of information  
2 that is no longer needed to carry out the pur-  
3 pose for which it was collected.

4 (3) CONSULTATION WITH WORKING GROUP.—In  
5 promulgating and modifying requirements under this  
6 subsection, the Board shall consult with a working  
7 group of knowledgeable individuals representing all  
8 interested parties (including third-party payers, pro-  
9 viders, consumers, employers, information managers,  
10 and technical experts).

11 (4) DEADLINE.—The Board shall first promul-  
12 gate requirements under this subsection by not later  
13 than six months after the date of the enactment of  
14 this Act.

15 (b) APPLICATION OF REQUIREMENTS.—

16 (1) STATE ENFORCEMENT OF SIMILAR RE-  
17 QUIREMENTS.—The requirements promulgated  
18 under subsection (a) shall not apply to health care  
19 information in a State if—

20 (A) the State has applied to the National  
21 Health Board for a determination that the  
22 State has in effect a law that provides for the  
23 application of requirements with respect to such  
24 information (and enforcement provisions with  
25 respect to such requirements) consistent with

1           such requirements (and with the enforcement  
2           provisions of subsection (c)), and

3                   (B) the Board determines that the State  
4           has such a law in effect.

5           (2) APPLICATION TO CURRENT INFORMA-  
6           TION.—The National Health Board shall specify the  
7           extent to which (and manner in which) the require-  
8           ments promulgated under subsection (a) apply to in-  
9           formation collected before the effective date of the  
10          requirements.

11          (c) DEFENSE FOR PROPER DISCLOSURES.—An en-  
12         tity that establishes that it has disclosed health care infor-  
13         mation in accordance with the requirements promulgated  
14         under subsection (a) has established a defense in an action  
15         brought for improper disclosure of such information.

16          (d) PENALTIES FOR VIOLATIONS.—An entity that  
17         collects, stores, handles, transmits, or discloses health care  
18         information in violation of the requirements promulgated  
19         under subsection (a) is liable for civil damages, equitable  
20         remedies, and attorneys' fees (if appropriate), in accord-  
21         ance with regulations of the National Health Board.

1 **SEC. 6003. STANDARDIZATION FOR THE ELECTRONIC RE-**  
2 **CEIPT AND TRANSMISSION OF HEALTH PLAN**  
3 **INFORMATION.**

4 (a) GOALS.—The National Health Board shall estab-  
5 lish national goals, and time frameworks, respecting the  
6 progress to be made by the health care industry in elimi-  
7 nating unnecessary paperwork and achieving appropriate  
8 standardization in the areas of electronic receipt and  
9 transmission of health care claims and health plan infor-  
10 mation and eligibility verification (consistent with the re-  
11 quirements promulgated under section 6002(a)).

12 (b) CONTINGENT REQUIREMENTS.—If the Board de-  
13 termines that the health care industry has failed to meet  
14 the goals established under subsection (a) by the deadlines  
15 established by the Board under such subsection, the Board  
16 shall promulgate (and may, from time to time, modify)  
17 standards and requirements concerning the electronic re-  
18 ceipt and transmission of health plan claims forms and  
19 other health plan information.

20 (c) CONSULTATION.—The Board shall conduct activi-  
21 ties under this section in consultation with the Accredited  
22 Standards Committee X-12 of the American National  
23 Standards Institute, insurers, providers, and others.

1 **SEC. 6004. USE OF UNIFORM HEALTH CLAIMS FORMS AND**  
2 **IDENTIFICATION NUMBERS.**

3 (a) GOALS.—The National Health Board shall estab-  
4 lish national goals, and time frameworks, respecting the  
5 progress to be made by the health care industry in achiev-  
6 ing uniformity—

7 (1) in the format and content of basic claims  
8 forms under health plans, and

9 (2) in the use of common identification num-  
10 bers for beneficiaries and providers of health care  
11 items or services under health plans.

12 (b) CONTINGENT REQUIREMENTS.—If the Board de-  
13 termines that the health care industry has failed to meet  
14 the goals established under subsection (a) by the deadlines  
15 established by the Board under such subsection, the Board  
16 shall promulgate (and may, from time to time, modify)  
17 standards and requirements concerning—

18 (1) the format and content of basic claims  
19 forms under health plans, and

20 (2) the common identification numbers to be  
21 used by health plans to identify health plan bene-  
22 ficiaries and health care providers.

23 (c) CONSULTATION.—The Board shall conduct activi-  
24 ties under this section in consultation with the Workgroup  
25 for Electronic Data Interchange and with insurers, provid-  
26 ers, and others.

1 **SEC. 6005. PRIORITY AMONG INSURERS.**

2 (a) GOALS.—The National Health Board shall estab-  
3 lish national goals, and time frameworks, respecting the  
4 progress to be made by the health care industry in achiev-  
5 ing uniformity in the rules for determining the liability  
6 of insurers when benefits are payable under two or more  
7 health plans.

8 (b) CONTINGENT REQUIREMENTS.—If the Board de-  
9 termines that the health care industry has failed to meet  
10 the goals established under subsection (a) by the deadlines  
11 established by the Board under such subsection, the Board  
12 shall promulgate (and may, from time to time, modify)  
13 rules for determining the liability of health plans when  
14 benefits are payable under two or more health plans.

15 (c) CONSULTATION.—The Board shall conduct activi-  
16 ties under this section in consultation with health plans.

17 **SEC. 6006. FURNISHING OF INFORMATION AMONG HEALTH**  
18 **PLANS.**

19 (a) GOALS.—The National Health Board shall estab-  
20 lish national goals, and time frameworks, respecting the  
21 progress to be made by the health care industry in achiev-  
22 ing uniformity in the availability of information among  
23 health plans when benefits are payable under two or more  
24 health plans.

25 (b) CONTINGENT REQUIREMENTS.—If the Board de-  
26 termines that the health care industry has failed to meet

1 the goals established under subsection (a) by the deadlines  
2 established by the Board under such subsection, the Board  
3 shall promulgate (and may, from time to time, modify)  
4 requirements concerning the transfer among health plans  
5 (and annual updating) of appropriate information (which  
6 may include requirements for the use of unique identifiers,  
7 and for the listing of all individuals covered under a health  
8 plan).

9 (c) CONSULTATION.—The Board shall conduct activi-  
10 ties under this section in consultation with health plans.

11 **SEC. 6007. FAILURE TO SATISFY CERTAIN HEALTH PLAN**  
12 **REQUIREMENTS.**

13 (a) IN GENERAL.—Chapter 47 of the Internal Reve-  
14 nue Code of 1986 (relating to taxes on group health plans)  
15 is amended by adding at the end the following new section:

16 **“SEC. 5000A. FAILURE TO SATISFY CERTAIN HEALTH PLAN**  
17 **REQUIREMENTS.**

18 “(a) GENERAL RULE.—There is hereby imposed, on  
19 any administrator of a health plan, a tax on any failure  
20 to comply with an applicable requirement of sections 6003  
21 through 6006 of the Managed Competition Act of 1993.  
22 The National Health Board shall determine whether any  
23 such administrator meets the requirements of those sec-  
24 tions.

1       “(b) AMOUNT OF TAX.—The amount of tax imposed  
2 by subsection (a) for a taxable year in which an adminis-  
3 trator fails to comply with a requirement described in that  
4 subsection shall be equal to \$100 for each such failure.

5       “(c) CONTROLLED GROUPS.—

6           “(1) EMPLOYERS.—In the case of an adminis-  
7 trator that is an employer, for purposes of this sec-  
8 tion all persons that are treated as part of the same  
9 employer (within the meaning of section 414) as the  
10 administrator shall be treated as the same person.

11          “(2) OTHER ADMINISTRATORS.—In the case of  
12 an administrator that is not an employer, for pur-  
13 poses of this section—

14           “(A) CONTROLLED GROUP OF CORPORA-  
15 TIONS.—All corporations which are members of  
16 the same controlled group of corporations shall  
17 be treated as 1 person. For purposes of the pre-  
18 ceding sentence, the term ‘controlled group of  
19 corporations’ has the meaning given to such  
20 term by section 1563(a), except that—

21           “(i) ‘more than 50 percent’ shall be  
22 substituted for ‘at least 80 percent’ each  
23 place it appears in section 1563(a)(1), and

1           “(ii) the determination shall be made  
2           without regard to subsections (a)(4) and  
3           (e)(3)(C) of section 1563.

4           “(B) PARTNERSHIPS, PROPRIETORSHIPS,  
5           ETC., WHICH ARE UNDER COMMON CONTROL.—  
6           Under regulations prescribed by the Secretary,  
7           all trades or businesses (whether or not incor-  
8           porated) which are under common control shall  
9           be treated as 1 person. The regulations pre-  
10          scribed under this subparagraph shall be based  
11          on principles similar to the principles which  
12          apply in the case of subparagraph (A).

13          “(d) LIMITATIONS ON TAX.—

14                 “(1) TAX NOT TO APPLY WHERE FAILURE NOT  
15                 DISCOVERED EXERCISING REASONABLE DILI-  
16                 GENCE.—No tax shall be imposed by subsection (a)  
17                 with respect to any failure for which it is established  
18                 to the satisfaction of the Secretary that the person  
19                 liable for tax did not know, and by exercising rea-  
20                 sonable diligence would not have known, that the  
21                 failure existed.

22                 “(2) TAX NOT TO APPLY TO FAILURES COR-  
23                 RECTED WITHIN 30 DAYS.—No tax shall be imposed  
24                 by subsection (a) on any failure if—

1           “(A) the failure was due to reasonable  
2           cause and not to willful neglect, and

3           “(B) the failure is corrected during the 30-  
4           day period beginning on the 1st date the person  
5           liable for the tax knew, or by exercising reason-  
6           able diligence would have known, that the fail-  
7           ure existed.

8           “(3) WAIVER BY SECRETARY.—In the case of a  
9           failure which is due to reasonable cause and not to  
10          willful neglect, the Secretary may waive part or all  
11          of the tax imposed by subsection (a) to the extent  
12          that the payment of that tax would be excessive rel-  
13          ative to the failure involved.”.

14          (b) NONDEDUCTIBILITY OF TAX.—Paragraph (6) of  
15          section 275(a) of that Code (relating to nondeductibility  
16          of certain taxes) is amended by inserting “47,” after  
17          “46,”.

18          (c) CLERICAL AMENDMENTS.—The table of sections  
19          for chapter 47 of that Code is amended by adding at the  
20          end the following new item:

                  “5000A. Failure to satisfy certain health plan requirements.”.

21       **SEC. 6008. DEFINITIONS.**

22           For purposes of this title—

23           (1) The term “health plan” means any contract  
24           or arrangement under which an entity bears all or  
25           part of the cost of providing health care items and

1 services, including a hospital or medical expense in-  
 2 curred policy or certificate, hospital or medical serv-  
 3 ice plan contract, or health maintenance subscriber  
 4 contract (including any closed accountable health  
 5 plan), but does not include (except for purposes of  
 6 sections 6005 and 6006)—

7 (A) coverage only for accident, dental, vi-  
 8 sion, disability, or long term care, medicare  
 9 supplemental health insurance, or any combina-  
 10 tion thereof,

11 (B) coverage issued as a supplement to li-  
 12 ability insurance,

13 (C) workers' compensation or similar in-  
 14 surance, or

15 (D) automobile medical-payment insur-  
 16 ance.

17 (2) The term "provider" means a physician,  
 18 hospital, pharmacy, laboratory, or other person li-  
 19 censed or otherwise authorized under applicable  
 20 State laws to furnish health care items or services.

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