

103^D CONGRESS
2^D SESSION

S. 1743

To provide Americans with secure, portable health insurance benefits and greater choice of health insurance plans, and for other purposes.

IN THE SENATE OF THE UNITED STATES

NOVEMBER 20 (legislative day, NOVEMBER 2), 1993

Mr. NICKLES (for himself, Mr. HATCH, Mr. MACK, Mr. BENNETT, Mr. BROWN, Mr. BURNS, Mr. COATS, Mr. COCHRAN, Mr. COVERDELL, Mr. CRAIG, Mr. DOLE, Mr. FAIRCLOTH, Mr. GREGG, Mr. HELMS, Mrs. HUTCHISON, Mr. KEMPTHORNE, Mr. LOTT, Mr. LUGAR, Mr. MURKOWSKI, Mr. SIMPSON, Mr. SMITH, Mr. STEVENS, Mr. THURMOND, Mr. WALLOP, and Mr. GRASSLEY) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To provide Americans with secure, portable health insurance benefits and greater choice of health insurance plans, and for other purposes.

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

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

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Consumer Choice Health Security Act of 1994”.

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

- Sec. 1. Short title and table of contents.
- Sec. 2. Purposes.

TITLE I—TAX AND INSURANCE PROVISIONS

Subtitle A—Tax Treatment of Health Care Expenses

- Sec. 101. Refundable health care expenses tax credit.
- Sec. 102. Medical savings accounts.
- Sec. 103. Other tax provisions.

Subtitle B—Insurance Provisions

PART I—FEDERALLY QUALIFIED HEALTH INSURANCE PLAN

- Sec. 111. Federally qualified health insurance plan.
- Sec. 112. Family security benefits package.
- Sec. 113. Rating practices.
- Sec. 114. Guaranteed issue.
- Sec. 115. Guaranteed renewability.

PART II—CERTIFICATION OF FEDERALLY QUALIFIED HEALTH INSURANCE PLANS

- Sec. 117. Establishment of regulatory program for certification of plans.
- Sec. 118. Standards for regulatory programs.

Subtitle C—Employer Provisions

- Sec. 121. General provisions relating to employers.
- Sec. 122. Conversion of non-self-insured plans.
- Sec. 123. Provisions relating to existing self-insured plans.
- Sec. 124. Continuation of employer-provided health coverage required until effective date of new coverage under this Act.
- Sec. 125. Requirements with respect to cashing out employer-sponsored plans.
- Sec. 126. Enforcement.

Subtitle D—Federal Preemption

- Sec. 131. Federal preemption of certain State laws.

Subtitle E—Report

- Sec. 141. Report on health insurance coverage.

TITLE II—MEDICARE AND MEDICAID REFORMS

Subtitle A—Medicare

- Sec. 201. Study of medicare private health insurance program.
- Sec. 202. Elimination of medicare hospital disproportionate share adjustment payments.
- Sec. 203. Reduction in adjustment for indirect medical education.
- Sec. 204. Imposition of copayment on laboratory services.
- Sec. 205. Imposition of copayment for certain home health visits.
- Sec. 206. Imposition of copayment for skilled nursing facility services.
- Sec. 207. Shift payment updates to January for all payment rates under hospital insurance program.

Sec. 208. Acceleration of transition to prospective rates for facility costs in hospital outpatient departments.

Subtitle B—Medicaid

Sec. 211. Cap on Federal payments made for acute medical services under the medicaid program.

Sec. 212. Waivers for the furnishing of acute medical services under the medicaid program.

Sec. 213. Termination of disproportionate share payments.

Sec. 214. Grants for health insurance coverage, acute medical services, preventive care, and disease prevention.

TITLE III—HEALTH CARE LIABILITY REFORM

Sec. 301. Short title.

Sec. 302. Definitions.

Sec. 303. Health care malpractice.

Sec. 304. Health care product liability of manufacturer or seller.

Sec. 305. General provisions relating to health care liability.

Sec. 306. Punitive damages.

Sec. 307. Exceptions.

Sec. 308. Rules of construction.

TITLE IV—ADMINISTRATIVE COST SAVINGS

Subtitle A—Standardization of Claims Processing

Sec. 401. Adoption of data elements, uniform claims, and uniform electronic transmission standards.

Sec. 402. Application of standards.

Sec. 403. Periodic review and revision of standards.

Sec. 404. Health insurance plan defined.

Subtitle B—Electronic Medical Data Standards

Sec. 411. Medical data standards for hospitals and other providers.

Sec. 412. Application of electronic data standards to certain hospitals.

Sec. 413. Electronic transmission to Federal agencies.

Sec. 414. Limitation on data requirements where standards in effect.

Sec. 415. Advisory commission.

Subtitle C—Development and Distribution of Comparative Value Information

Sec. 421. State comparative value information programs for health care purchasing.

Sec. 422. Federal implementation.

Sec. 423. Comparative value information concerning Federal programs.

Subtitle D—Preemption of State Quill Pen Laws

Sec. 431. Preemption of State quill pen laws.

TITLE V—ANTI-FRAUD

Subtitle A—Criminal Prosecution of Health Care Fraud

Sec. 501. Penalties for health care fraud.

Sec. 502. Rewards for information leading to prosecution and conviction.

Subtitle B—Coordination of Health Care Anti-Fraud and Abuse Activities

Sec. 511. Application of Federal health anti-fraud and abuse sanctions to all fraud and abuse against any health insurance plan.

TITLE VI—ANTITRUST PROVISIONS

Sec. 601. Exemption from antitrust laws for certain competitive and collaborative activities.

Sec. 602. Safe harbors.

Sec. 603. Designation of additional safe harbors.

Sec. 604. Certificates of review.

Sec. 605. Notifications providing reduction in certain penalties under antitrust law for health care cooperative ventures.

Sec. 606. Review and reports on safe harbors and certificates of review.

Sec. 607. Rules, regulations, and guidelines.

Sec. 608. Definitions.

TITLE VII—LONG-TERM CARE

Sec. 701. Exclusion from gross income for amounts withdrawn from individual retirement plans or 401(k) plans for long-term care insurance.

Sec. 702. Certain exchanges of life insurance contracts for long-term care insurance contracts not taxable.

Sec. 703. Tax treatment of accelerated death benefits under life insurance contracts.

Sec. 704. Effective date.

1 **SEC. 2. PURPOSES.**

2 The purposes of this Act are to—

3 (1) provide Americans with secure, portable
4 health insurance benefits and greater choice of
5 health insurance plans,

6 (2) make the American health care system re-
7 sponsive to consumer needs and encourage the provi-
8 sion of quality medical care at reasonable prices
9 through enhanced competition,

10 (3) provide more equitable tax treatment of
11 health insurance and medical care expenses, and

1 (4) assist low-income and uninsured Americans
2 in purchasing health insurance and receiving pri-
3 mary medical care.

4 **TITLE I—TAX AND INSURANCE**
5 **PROVISIONS**

6 **Subtitle A—Tax Treatment of**
7 **Health Care Expenses**

8 **SEC. 101. REFUNDABLE HEALTH CARE EXPENSES TAX**
9 **CREDIT.**

10 (a) IN GENERAL.—Subpart C of part IV of sub-
11 chapter A of chapter 1 of the Internal Revenue Code of
12 1986 (relating to refundable personal credits) is amended
13 by inserting after section 34 the following new section:

14 **“SEC. 34A. HEALTH CARE EXPENSES.**

15 “(a) ALLOWANCE OF CREDIT.—In the case of a
16 qualified individual, there shall be allowed as a credit
17 against the tax imposed by this subtitle for the taxable
18 year an amount equal to the applicable percentage of the
19 sum of—

20 “(1) 25 percent of the sum of the qualified
21 health insurance premiums and the unreimbursed
22 expenses for medical care paid by such individual
23 during the taxable year which does not exceed 10
24 percent of the adjusted gross income of such individ-
25 ual for such year, plus

1 “(2) 50 percent of the sum of such premiums
2 and such unreimbursed expenses so paid which ex-
3 ceeds 10 percent but does not exceed 20 percent of
4 such adjusted gross income, plus

5 “(3) 75 percent of the sum of such premiums
6 and such unreimbursed expenses so paid which ex-
7 ceeds 20 percent of such adjusted gross income.

8 “(b) QUALIFIED INDIVIDUALS.—For purposes of this
9 section—

10 “(1) IN GENERAL.—The term ‘qualified individ-
11 ual’ means the taxpayer, the spouse of the taxpayer,
12 and each dependent of the taxpayer (as defined in
13 section 152) who is enrolled in a federally qualified
14 health insurance plan.

15 “(2) FEDERALLY COVERED INDIVIDUALS.—The
16 term ‘qualified individual’ does not include any indi-
17 vidual whose medical care is covered under—

18 “(A) title XVIII or XIX of the Social Se-
19 curity Act,

20 “(B) chapter 55 of title 10, United States
21 Code,

22 “(C) chapter 17 of title 38, United States
23 Code, or

24 “(D) the Indian Health Care Improvement
25 Act.

1 “(3) SPECIAL RULE IN THE CASE OF CHILD OF
2 DIVORCED PARENTS, ETC.—Any child to whom sec-
3 tion 152(e) applies shall be treated as a dependent
4 of both parents.

5 “(4) MARRIAGE RULES.—The determination of
6 whether an individual is married at any time during
7 the taxable year shall be made in accordance with
8 the provisions of section 6013(d) (relating to deter-
9 mination of status as husband and wife).

10 “(c) APPLICABLE PERCENTAGE.—For purposes of
11 subsection (a), the applicable percentage for any taxable
12 year is determined by the number of whole months in such
13 year in which the taxpayer is a qualified individual.

14 “(d) QUALIFIED HEALTH INSURANCE PREMIUMS.—
15 For purposes of this section, the term ‘qualified health in-
16 surance premiums’ means premiums for—

17 “(1) a federally qualified health insurance plan,
18 and

19 “(2) any other benefits or plans supplementary
20 to such a federally qualified health insurance plan.

21 “(e) FEDERALLY QUALIFIED HEALTH INSURANCE
22 PLAN.—For purposes of this section, the term ‘federally
23 qualified health insurance plan’ means a health insurance
24 plan which is described in section 111 of the Consumer
25 Choice Health Security Act of 1994.

1 “(f) MEDICAL CARE.—For purposes of this section:

2 “(1) IN GENERAL.—The term ‘medical care’
3 means amounts paid—

4 “(A) for the diagnosis, cure, mitigation,
5 treatment, or prevention of disease, or for the
6 purpose of affecting any structure or function
7 of the body, and

8 “(B) for transportation primarily for and
9 essential to medical care referred to in subpara-
10 graph (A).

11 “(2) AMOUNTS PAID FOR CERTAIN LODGING
12 AWAY FROM HOME TREATED AS PAID FOR MEDICAL
13 CARE.—Amounts paid for lodging (not lavish or ex-
14 travagant under the circumstances) while away from
15 home primarily for and essential to medical care re-
16 ferred to in paragraph (1)(A) shall be treated as
17 amounts paid for medical care if—

18 “(A) the medical care referred to in para-
19 graph (1)(A) is provided by a physician in a li-
20 censed hospital (or in a medical care facility
21 which is related to, or the equivalent of, a li-
22 censed hospital), and

23 “(B) there is no significant element of per-
24 sonal pleasure, recreation, or vacation in the
25 travel away from home.

1 The amount taken into account under the preceding
2 sentence shall not exceed \$50 for each night for each
3 individual.

4 “(3) COSMETIC SURGERY.—

5 “(A) IN GENERAL.—The term ‘medical
6 care’ does not include cosmetic surgery or other
7 similar procedures, unless the surgery or proce-
8 dure is necessary to ameliorate a deformity
9 arising from, or directly related to, a congenital
10 abnormality, a personal injury resulting from
11 an accident or trauma, or disfiguring disease.

12 “(B) COSMETIC SURGERY DEFINED.—For
13 purposes of this paragraph, the term ‘cosmetic
14 surgery’ means any procedure which is directed
15 at improving the patient’s appearance and does
16 not meaningfully promote the proper function
17 of the body or prevent or treat illness or dis-
18 ease.

19 “(4) PHYSICIAN.—The term ‘physician’ has the
20 meaning given to such term by section 1861(r) of
21 the Social Security Act (42 U.S.C. 1395x(r)).

22 “(g) SPECIAL RULES.—For purposes of this sec-
23 tion—

24 “(1) LIMITATION WITH RESPECT TO MEDICINE
25 AND DRUGS.—

1 “(A) IN GENERAL.—An amount paid dur-
2 ing the taxable year for medicine or a drug
3 shall be taken into account under subsection (a)
4 only if such medicine or drug is a prescribed
5 drug or is insulin.

6 “(B) PRESCRIBED DRUG.—The term ‘pre-
7 scribed drug’ means a drug or biological which
8 requires a prescription of a physician for its use
9 by an individual.

10 “(2) SPECIAL RULE FOR DECEDENTS.—

11 “(A) TREATMENT OF EXPENSES PAID
12 AFTER DEATH.—Expenses for the medical care
13 of the taxpayer which are paid out of the tax-
14 payer’s estate during the 1-year period begin-
15 ning with the day after the date of the tax-
16 payer’s death shall be treated as paid by the
17 taxpayer at the time incurred.

18 “(B) LIMITATION.—Subparagraph (A)
19 shall not apply if the amount paid is allowable
20 under section 2053 as a deduction in computing
21 the taxable estate of the decedent, but this sub-
22 paragraph shall not apply if (within the time
23 and in the manner and form prescribed by the
24 Secretary) there is filed—

1 “(i) a statement that such amount
2 has not been allowed as a deduction under
3 section 2053, and

4 “(ii) a waiver of the right to have
5 such amount allowed at any time as a de-
6 duction under section 2053.

7 “(3) FORM OF INSURANCE CONTRACT.—In the
8 case of an insurance contract under which amounts
9 are payable for other than medical care—

10 “(A) no amount shall be treated as paid
11 for insurance to which subsection (a) applies
12 unless the charge for such insurance is either
13 separately stated in the contract, or furnished
14 to the policyholder by the insurance company in
15 a separate statement,

16 “(B) the amount taken into account as the
17 amount paid for such insurance shall not exceed
18 such charge, and

19 “(C) no amount shall be treated as paid
20 for such insurance if the amount specified in
21 the contract (or furnished to the policyholder by
22 the insurance company in a separate statement)
23 as the charge for such insurance is unreason-
24 ably large in relation to the total charges under
25 the contract.

1 “(4) EXCLUSION OF AMOUNTS ALLOWED FOR
2 CARE OF CERTAIN DEPENDENTS.—Any expense al-
3 lowed as a credit under section 21 shall not be
4 treated as an expense paid for medical care.

5 “(5) COORDINATION WITH ADVANCE PAYMENT
6 AND MINIMUM TAX.—Rules similar to the rules of
7 subsections (g) and (h) of section 32 shall apply to
8 any credit to which this section applies.

9 “(6) SUBSIDIZED EXPENSES.—No expense shall
10 be taken into account under subsection (a), if—

11 “(A) such expense is paid, reimbursed, or
12 subsidized (whether by being disregarded for
13 purposes of another program or otherwise) by
14 the Federal Government, a State or local gov-
15 ernment, or any agency or instrumentality
16 thereof, and

17 “(B) the payment, reimbursement, or sub-
18 sidy of such expense is not includable in the
19 gross income of the recipient.

20 “(7) COORDINATION WITH MEDICAL SAVINGS
21 ACCOUNTS.—The amount otherwise taken into ac-
22 count under subsection (a) shall be reduced by the
23 amount (if any) of the distributions from any medi-
24 cal savings account of the taxpayer during the tax-
25 able year which is not includible in gross income by

1 reason of being used for qualified medical expenses
2 (as defined in section 25A(c)(2)).

3 “(h) INDEXING OF PERCENTAGES.—For each year
4 after 1997, the Secretary, in consultation with the Sec-
5 retary of Health and Human Services, shall adjust the ref-
6 erences to 10 percent and 20 percent in subsection (a)
7 by the ratio of—

8 “(1) the percentage increase in medical care in-
9 flation between 1996 and the year before the year
10 involved, to

11 “(2) the national average percentage increase in
12 adjusted gross income of individuals between such
13 years.

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

17 (b) ADVANCE PAYMENT OF CREDIT.—Chapter 25 of
18 the Internal Revenue Code of 1986 (relating to general
19 provisions relating to employment taxes) is amended by
20 inserting after section 3507 the following new section:

21 **“SEC. 3507A. ADVANCE PAYMENT OF HEALTH EXPENSES**
22 **CREDIT.**

23 “(a) GENERAL RULE.—Except as otherwise provided
24 in this section, every employer making payment of wages
25 with respect to whom a health care expenses eligibility cer-

1 tificate is in effect shall, at the time of paying such wages,
2 make an additional payment equal to such employee's
3 health care expenses advance amount.

4 “(b) HEALTH CARE EXPENSES ELIGIBILITY CER-
5 TIFICATE.—For purposes of this title, a health care ex-
6 penses eligibility certificate is a statement furnished by an
7 employee to the employer which—

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

11 “(2) certifies that the employee does not have
12 a health care expenses eligibility certificate in effect
13 for the calendar year with respect to the payment of
14 wages by another employer,

15 “(3) states whether or not the employee's
16 spouse has a health care expenses eligibility certifi-
17 cate in effect, and

18 “(4) estimates the amount of premiums for a
19 federally qualified health insurance plan and unreim-
20 bursed expenses for medical care (as defined in sec-
21 tion 34A) for the calendar year.

22 For purposes of this section, a certificate shall be treated
23 as being in effect with respect to a spouse if such a certifi-
24 cate will be in effect on the first status determination date

1 following the date on which the employee furnishes the
2 statement in question.

3 “(c) HEALTH CARE EXPENSES ADVANCE
4 AMOUNT.—

5 “(1) IN GENERAL.—For purposes of this title,
6 the term ‘health expenses advance amount’ means,
7 with respect to any payroll period, the amount deter-
8 mined—

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

11 “(B) on the basis of the employee’s esti-
12 mated premiums for a federally qualified health
13 insurance plan and unreimbursed expenses for
14 medical care included in the health care ex-
15 penses eligibility certificate, and

16 “(C) in accordance with tables provided by
17 the Secretary.

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

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

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

7 (c) CLERICAL AMENDMENTS.—

8 (1) The table of sections for subpart A of part
9 IV of subchapter A of chapter 1 of the Internal Rev-
10 enue Code of 1986 is amended by inserting after the
11 item relating to section 34 the following new item:

“Sec. 34A. Health care expenses.”.

12 (2) The table of sections for chapter 25 of such
13 Code is amended by adding after the item relating
14 to section 3507 the following new item:

“Sec. 3507A. Advance payment of health care expenses credit.”.

15 (d) EFFECTIVE DATE.—The amendments made by
16 this section shall apply to taxable years beginning after
17 December 31, 1997.

18 **SEC. 102. MEDICAL SAVINGS ACCOUNTS.**

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

1 **“SEC. 25A. MEDICAL SAVINGS ACCOUNTS.**

2 “(a) ALLOWANCE OF CREDIT.—In the case of an in-
3 dividual, there shall be allowed as a credit against the tax
4 imposed by this subtitle for the taxable year an amount
5 equal to 25 percent of the amount paid in cash during
6 such year by or on behalf of such individual to a medical
7 savings account.

8 “(b) LIMITATIONS.—For purposes of this section:

9 “(1) ONLY 1 ACCOUNT PER FAMILY.—No credit
10 shall be allowed under subsection (a) for amounts
11 paid to any medical savings account for the benefit
12 of an individual, such individual’s spouse, or any de-
13 pendent (as defined in section 152) of such individ-
14 ual if such individual, spouse, or dependent is a ben-
15 efiary of any other medical savings account.

16 “(2) DOLLAR LIMITATION.—The aggregate
17 amount of contributions which may be taken into ac-
18 count under subsection (a) with respect to any indi-
19 vidual for any taxable year shall not exceed the sum
20 of—

21 “(A) \$3,000, plus

22 “(B) \$500 for each individual who is a de-
23 pendent (as so defined) of the individual for
24 whose benefit the account is established.

25 “(c) DEFINITIONS AND SPECIAL RULES.—For pur-
26 poses of this section—

1 “(1) MEDICAL SAVINGS ACCOUNT.—

2 “(A) IN GENERAL.—The term ‘medical
3 savings account’ means a trust created or orga-
4 nized in the United States exclusively for the
5 purpose of paying the qualified medical ex-
6 penses of the individual for whose benefit the
7 trust is established, but only if the written gov-
8 erning instrument creating the trust meets the
9 following requirements:

10 “(i) Except in the case of a rollover
11 contribution described in subsection (d)(4),
12 no contribution will be accepted unless it is
13 in cash and contributions will not be ac-
14 cepted for any taxable year in excess of the
15 amount determined under subsection
16 (b)(1).

17 “(ii) The trustee is a bank (as defined
18 in section 408(n)) or another person who
19 demonstrates to the satisfaction of the Sec-
20 retary that the manner in which such per-
21 son will administer the trust will be con-
22 sistent with the requirements of this sec-
23 tion.

24 “(iii) No part of the trust assets will
25 be invested in life insurance contracts.

1 “(iv) The assets of the trust will not
2 be commingled with other property except
3 in a common trust fund or common invest-
4 ment fund.

5 “(v) The interest of an individual in
6 the balance in such individual’s account is
7 nonforfeitable.

8 “(vi) Under regulations prescribed by
9 the Secretary, rules similar to the rules of
10 section 401(a)(9) shall apply to the dis-
11 tribution of the entire interest of bene-
12 ficiaries of such trust.

13 “(B) TREATMENT OF COMPARABLE AC-
14 COUNTS HELD BY INSURANCE COMPANIES.—An
15 account held by an insurance company in the
16 United States shall be treated as a medical
17 savings account (and such company shall be
18 treated as a bank) if—

19 “(i) such account is part of a federally
20 qualified health insurance plan (as defined
21 in section 34A(e)),

22 “(ii) such account is exclusively for
23 the purpose of paying the medical expenses
24 of the beneficiaries of such account who

1 are covered under such health insurance
2 plan, and

3 “(iii) the written instrument govern-
4 ing the account meets the requirements of
5 clauses (i), (v), and (vi) of subparagraph
6 (A).

7 “(2) QUALIFIED MEDICAL EXPENSES.—The
8 term ‘qualified medical expenses’ means amounts
9 paid by the individual for whose benefit the account
10 was established for premiums for a federally quali-
11 fied health insurance plan (as so defined) and the
12 unreimbursed expenses for medical care (as deter-
13 mined under section 34A) of such individual, the
14 spouse of such individual, and any dependent (as so
15 defined) of such individual.

16 “(3) TIME WHEN CONTRIBUTIONS DEEMED
17 MADE.—A contribution shall be deemed to be made
18 on the last day of the preceding taxable year if the
19 contribution is made on account of such taxable year
20 and is made not later than the time prescribed by
21 law for filing the return for such taxable year (not
22 including extensions thereof).

23 “(d) TAX TREATMENT OF DISTRIBUTIONS.—

24 “(1) IN GENERAL.—Except as otherwise pro-
25 vided in this subsection, any amount paid or distrib-

1 uted out of a medical savings account shall be in-
2 cluded in the gross income of the individual for
3 whose benefit such account was established unless
4 such amount is used exclusively to pay the qualified
5 medical expenses of such individual.

6 “(2) EXCESS CONTRIBUTIONS RETURNED BE-
7 FORE DUE DATE OF RETURN.—Paragraph (1) shall
8 not apply to the distribution of any contribution paid
9 during a taxable year to a medical savings account
10 to the extent that such contribution exceeds the
11 amount allowable under subsection (b) if—

12 “(A) such distribution is received on or be-
13 fore the day prescribed by law (including exten-
14 sions of time) for filing such individual’s return
15 for such taxable year,

16 “(B) no credit is allowed under subsection
17 (a) with respect to such excess contribution,
18 and

19 “(C) such distribution is accompanied by
20 the amount of net income attributable to such
21 excess contribution.

22 Any net income described in subparagraph (C) shall
23 be included in the gross income of the individual for
24 the taxable year in which it is received.

1 “(3) PENALTY FOR DISTRIBUTIONS NOT USED
2 FOR MEDICAL EXPENSES.—The tax imposed by this
3 chapter for any taxable year in which there is a pay-
4 ment or distribution from a medical savings account
5 which is not used to pay the medical expenses of the
6 individual for whose benefit the account was estab-
7 lished, shall be increased by 10 percent of the
8 amount of such payment or distribution which is in-
9 cludible in gross income under paragraph (1).

10 “(4) ROLLOVERS.—Paragraph (1) shall not
11 apply to any amount paid or distributed out of a
12 medical savings account to the individual for whose
13 benefit the account is maintained, if the entire
14 amount received (including money and any other
15 property) is paid into another medical savings ac-
16 count for the benefit of such individual not later
17 than the 60th day after the day on which the indi-
18 vidual received the payment or distribution.

19 “(e) TAX TREATMENT OF ACCOUNTS.—

20 “(1) EXEMPTION FROM TAX.—Any medical sav-
21 ings account is exempt from taxation under this sub-
22 title unless such account has ceased to be a medical
23 savings account by reason of paragraph (2) or (3).
24 Notwithstanding the preceding sentence, any such
25 account shall be subject to the taxes imposed by sec-

1 tion 511 (relating to imposition of tax on unrelated
2 business income of charitable, etc. organizations).

3 “(2) LOSS OF EXEMPTION OF ACCOUNT WHERE
4 INDIVIDUAL ENGAGES IN PROHIBITED TRANS-
5 ACTION.—

6 “(A) IN GENERAL.—If, during any taxable
7 year of the individual for whose benefit the
8 medical savings account was established, such
9 individual engages in any transaction prohibited
10 by section 4975 with respect to the account, the
11 account ceases to be a medical savings account
12 as of the first day of that taxable year.

13 “(B) ACCOUNT TREATED AS DISTRIBUTING
14 ALL ITS ASSETS.—In any case in which any ac-
15 count ceases to be a medical savings account by
16 reason of subparagraph (A) on the first day of
17 any taxable year, paragraph (1) of subsection
18 (d) applies as if there were a distribution on
19 such first day in an amount equal to the fair
20 market value (on such first day) of all assets in
21 the account (on such first day) and no portion
22 of such distribution were used to pay qualified
23 medical expenses.

24 “(3) EFFECT OF PLEDGING ACCOUNT AS SECUR-
25 RITY.—If, during any taxable year, the individual for

1 whose benefit a medical savings account was estab-
2 lished uses the account or any portion thereof as se-
3 curity for a loan, the portion so used is treated as
4 distributed to that individual and not used to pay
5 qualified medical expenses.

6 “(f) CUSTODIAL ACCOUNTS.—For purposes of this
7 section, a custodial account shall be treated as a trust if—

8 “(1) the assets of such account are held by a
9 bank (as defined in section 408(n)) or another per-
10 son who demonstrates to the satisfaction of the Sec-
11 retary that the manner in which he will administer
12 the account will be consistent with the requirements
13 of this section, and

14 “(2) the custodial account would, except for the
15 fact that it is not a trust, constitute a medical sav-
16 ings account described in subsection (c).

17 For purposes of this title, in the case of a custodial
18 account treated as a trust by reason of the preceding
19 sentence, the custodian of such account shall be
20 treated as the trustee thereof.

21 “(g) INFLATION ADJUSTMENT.—

22 “(1) IN GENERAL.—In the case of any taxable
23 year beginning in a calendar year after 1998, each
24 applicable dollar amount shall be increased by an
25 amount equal to—

1 “(A) such dollar amount, multiplied by

2 “(B) the cost-of-living adjustment for the
3 calendar year in which the taxable year begins.

4 “(2) COST-OF-LIVING ADJUSTMENT.—For pur-
5 poses of paragraph (1), the cost-of-living adjustment
6 for any calendar year is the percentage (if any) by
7 which—

8 “(A) the deemed average total wages (as
9 defined in section 209(k) of the Social Security
10 Act) for the preceding calendar year, exceeds

11 “(B) the deemed average total wages (as
12 so defined) for calendar year 1997.

13 “(3) APPLICABLE DOLLAR AMOUNT.—For pur-
14 poses of paragraph (1), the term ‘applicable dollar
15 amount’ means the \$3,000 and \$500 amounts in
16 subsection (b)(2).

17 “(4) ROUNDING.—If any amount as adjusted
18 under paragraph (1) is not a multiple of \$10, such
19 amount shall be rounded to the nearest multiple of
20 \$10 (or, if such amount is a multiple of \$5 and not
21 of \$10, such amount shall be rounded to the next
22 highest multiple of \$10).

23 “(h) REPORTS.—The trustee of a medical savings ac-
24 count shall make such reports regarding such account to
25 the Secretary and to the individual for whose benefit the

1 account is maintained with respect to contributions, dis-
2 tributions, and such other matters as the Secretary may
3 require under regulations. The reports required by this
4 subsection shall be filed at such time and in such manner
5 and furnished to such individuals at such time and in such
6 manner as may be required by those regulations.”.

7 (b) TAX ON EXCESS CONTRIBUTIONS.—Section 4973
8 of the Internal Revenue Code of 1986 (relating to tax on
9 excess contributions to individual retirement accounts, cer-
10 tain section 403(b) contracts, and certain individual re-
11 tirement annuities) is amended—

12 (1) by inserting “**MEDICAL SAVINGS AC-**
13 **COUNTS,**” after “**ACCOUNTS,**” in the heading of
14 such section,

15 (2) by redesignating paragraph (2) of sub-
16 section (a) as paragraph (3) and by inserting after
17 paragraph (1) the following:

18 “(2) a medical savings account (within the
19 meaning of section 25A(c)(1)),”,

20 (3) by striking “or” at the end of paragraph
21 (1) of subsection (a), and

22 (4) by adding at the end thereof the following
23 new subsection:

24 “(d) EXCESS CONTRIBUTIONS TO MEDICAL SAVINGS
25 ACCOUNTS.—For purposes of this section, in the case of

1 a medical savings account (within the meaning of section
2 25A(c)(1)), the term ‘excess contributions’ means the
3 amount by which the amount contributed for the taxable
4 year to the account exceeds the amount allowable under
5 section 25A(b)(2) for such taxable year. For purposes of
6 this subsection, any contribution which is distributed out
7 of the medical savings account and a distribution to which
8 section 25A(d)(2) applies shall be treated as an amount
9 not contributed.’’.

10 (c) TAX ON PROHIBITED TRANSACTIONS.—Section
11 4975 of the Internal Revenue Code of 1986 (relating to
12 prohibited transactions) is amended—

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

15 “(4) SPECIAL RULE FOR MEDICAL SAVINGS AC-
16 COUNTS.—An individual for whose benefit a medical
17 savings account (within the meaning of section
18 25A(c)(1)) is established shall be exempt from the
19 tax imposed by this section with respect to any
20 transaction concerning such account (which would
21 otherwise be taxable under this section) if, with re-
22 spect to such transaction, the account ceases to be
23 a medical savings account by reason of the applica-
24 tion of section 25A(e)(2)(A) to such account.’’, and

1 (2) by inserting “or a medical savings account
2 described in section 25A(c)(1)” in subsection (e)(1)
3 after “described in section 408(a)”.

4 (d) FAILURE TO PROVIDE REPORTS ON MEDICAL
5 SAVINGS ACCOUNTS.—Section 6693 of the Internal Reve-
6 nue Code of 1986 (relating to failure to provide reports
7 on individual retirement account or annuities) is amend-
8 ed—

9 (1) by inserting “**OR ON MEDICAL SAVINGS**
10 **ACCOUNTS**” after “**ANNUITIES**” in the heading of
11 such section, and

12 (2) by adding at the end of subsection (a) the
13 following: “The person required by section 25A(h) to
14 file a report regarding a medical savings account at
15 the time and in the manner required by such section
16 shall pay a penalty of \$50 for each failure unless it
17 is shown that such failure is due to reasonable
18 cause.”.

19 (e) CLERICAL AMENDMENTS.—

20 (1) The table of sections for subpart A of part
21 IV of subchapter A of chapter 1 of the Internal Rev-
22 enue Code of 1986 is amended by inserting after the
23 item relating to section 25 the following:

“Sec. 25A. Medical savings accounts.”.

1 (2) The table of sections for chapter 43 of such
2 Code is amended by striking the item relating to sec-
3 tion 4973 and inserting the following:

“Sec. 4973. Tax on excess contributions to individual retirement
accounts, medical savings accounts, certain 403(b)
contracts, and certain individual retirement annu-
ities.”.

4 (3) The table of sections for subchapter B of
5 chapter 68 of such Code is amended by inserting “or
6 on medical savings accounts” after “annuities” in
7 the item relating to section 6693.

8 (f) EFFECTIVE DATE.—The amendments made by
9 this section shall apply to taxable years beginning after
10 December 31, 1997.

11 **SEC. 103. OTHER TAX PROVISIONS.**

12 (a) TERMINATION OF MEDICAL EXPENSE DEDUC-
13 TION.—Section 213 of the Internal Revenue Code of 1986
14 (relating to medical, dental, etc., expenses) is amended by
15 adding at the end thereof the following new subsection:

16 “(g) TERMINATION.—No amount paid after Decem-
17 ber 31, 1997, shall be treated as an expense paid for medi-
18 cal care.”.

19 (b) TERMINATION OF EXCLUSION FOR EMPLOYER-
20 PROVIDED HEALTH INSURANCE.—Section 106 of the In-
21 ternal Revenue Code of 1986 (relating to contributions by
22 employer to accident and health plans) is amended by add-
23 ing at the end the following new sentence: “The preceding

1 sentence shall not apply to any amount paid after Decem-
2 ber 31, 1997.”.

3 **Subtitle B—Insurance Provisions**

4 **PART I—FEDERALLY QUALIFIED HEALTH** 5 **INSURANCE PLAN**

6 **SEC. 111. FEDERALLY QUALIFIED HEALTH INSURANCE** 7 **PLAN.**

8 (a) **IN GENERAL.**—A federally qualified health insur-
9 ance plan is a health insurance plan offered, issued, or
10 renewed on or after January 1, 1998, which is certified
11 by the applicable regulatory authority as meeting, at a
12 minimum, the requirements of sections 112, 113, 114, and
13 115, and the regulatory program described in section 117.

14 (b) **GENERAL DEFINITIONS.**—As used in this Act:

15 (1) **HEALTH INSURANCE PLAN.**—The term
16 “health insurance plan” means any hospital or medi-
17 cal service policy or certificate, hospital or medical
18 service plan contract, or health maintenance organi-
19 zation group contract and, in States which have dis-
20 tinct licensure requirements, a multiple employer
21 welfare arrangement, but does not include any of the
22 following offered by an insurer:

23 (A) Accident only, dental only, disability
24 only, or long-term care only insurance.

1 (B) Coverage issued as a supplement to li-
2 ability insurance.

3 (C) Workers' compensation or similar in-
4 surance.

5 (D) Automobile medical-payment insur-
6 ance.

7 (2) APPLICABLE REGULATORY AUTHORITY.—
8 The term 'applicable regulatory authority' means—

9 (A) in the case of a State with a program
10 described in section 117, the State commis-
11 sioner or superintendent of insurance or other
12 State authority responsible for regulation of
13 health insurance; or

14 (B) if the State has not established such a
15 program or such program has been decertified
16 under section 117(b), the Secretary.

17 (3) SECRETARY.—The term "Secretary" means
18 the Secretary of Health and Human Services.

19 (4) STATE.—The term "State" means each of
20 the several States of the United States, the District
21 of Columbia, the Commonwealth of Puerto Rico, the
22 United States Virgin Islands, Guam, America
23 Samoa, and the Commonwealth of the Northern
24 Mariana Islands.

1 **SEC. 112. FAMILY SECURITY BENEFITS PACKAGE.**

2 (a) IN GENERAL.—The requirements of this section
3 are met, if the health insurance plan—

4 (1) provides coverage for all medically necessary
5 acute medical care described in subsection (b),

6 (2) does not exclude coverage for selected ill-
7 nesses or selected treatments if consistent with
8 medically accepted practices, and

9 (3) meets the patient cost sharing requirements
10 of subsection (c).

11 (b) ACUTE MEDICAL CARE.—Coverage for all medi-
12 cally necessary acute medical care is described in this sub-
13 section if such coverage includes—

14 (1) physician services,

15 (2) inpatient, outpatient, and emergency hos-
16 pital services and appropriate alternatives to hos-
17 pitalization, and

18 (3) inpatient prescription drugs.

19 Nothing in this subsection may be construed to require
20 the inclusion of abortion services.

21 (c) LIMITATION ON COST SHARING.—

22 (1) IN GENERAL.—A health insurance plan may
23 not require the payment of any deductible,
24 copayment, or coinsurance for an item or service for
25 which coverage is required under this section after
26 an individual or a family covered under the plan has

1 incurred out-of-pocket expenses under the plan that
2 are equal to the out-of-pocket limit for a plan year.

3 (2) LIMIT ON OUT-OF-POCKET EXPENSES.—As
4 used in this paragraph:

5 (A) OUT-OF-POCKET EXPENSES DE-
6 FINED.—The term “out-of-pocket expenses”
7 means, with respect to an individual or a family
8 in a plan year, amounts payable under the plan
9 as deductibles, coinsurance, and copayments
10 with respect to items and services provided
11 under the plan and furnished in the plan year
12 on behalf of the individual or the family covered
13 under the plan.

14 (B) OUT-OF-POCKET LIMIT DEFINED.—

15 (i) IN GENERAL.—The term “out-of-
16 pocket limit” means—

17 (I) the amount specified under
18 clause (ii), or

19 (II) 10 percent of the adjusted
20 gross income of the family involved,
21 whichever is greater.

22 (ii) MINIMUM AMOUNT.—The amount
23 specified in this clause for a plan year be-
24 ginning in—

1 (I) a calendar year prior to 1998,
2 is \$5,000; or

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

13 If the amount computed under subclause
14 (II) is not a multiple of \$10, it shall be
15 rounded to the next highest multiple of
16 \$10.

17 **SEC. 113. RATING PRACTICES.**

18 (a) IN GENERAL.—The requirements of this section
19 are met, if, except as provided in subsection (b), the health
20 insurance plan provides for—

21 (1) a variation in premium rates only on the
22 basis of age, sex, and geography, and

23 (2) a charge of the same premium rates to new
24 applicants and existing policyholders with the same
25 age, sex, and geographic characteristics.

1 (b) INCENTIVE DISCOUNTS.—A plan may discount
2 an individual’s premium rate as an incentive for partici-
3 pating in a program, approved by the applicable regulatory
4 authority to be offered in conjunction with the coverage,
5 which has as its objective, 1 or more of the following:

6 (1) To promote healthy behavior.

7 (2) To prevent or delay the onset of illness.

8 (3) To provide for screening or early detection
9 of illness.

10 **SEC. 114. GUARANTEED ISSUE.**

11 (a) IN GENERAL.—Except as provided in paragraph
12 (2), in the case of applications made on and after January
13 1, 1999, the following rules apply:

14 (1) IN GENERAL.—The requirements of this
15 section are met, if, except as provided in paragraph
16 (2), the health insurance plan—

17 (A) provides guaranteed issue at standard
18 rates to all applicants, and

19 (B) does not exclude from coverage, or
20 limit coverage for, any preexisting medical con-
21 dition of any applicant who, on the date the ap-
22 plication is made, has been continuously insured
23 for a period of at least 1 year prior to the date
24 of the application under 1 or more of the fol-
25 lowing health insurance plans or programs:

1 (i) Another federally qualified health
2 insurance plan.

3 (ii) An employer-sponsored group
4 health insurance plan in effect before the
5 date of the enactment of this Act.

6 (iii) An individual health insurance
7 plan in effect before such date.

8 (iv) A program described in—

9 (I) title XVIII or XIX of the
10 Social Security Act,

11 (II) chapter 55 of title 10,
12 United States Code,

13 (III) chapter 17 of title 38,
14 United States Code,

15 (IV) chapter 89 of title 5, United
16 States Code, or

17 (V) the Indian Health Care
18 Improvement Act.

19 (2) BREAK IN COVERAGE.—In the case of an
20 applicant who has not been continuously insured for
21 a period of 1 year prior to the date the application
22 is made, the health insurance plan may exclude from
23 coverage, or limit coverage for, any preexisting medi-
24 cal condition for a period no greater than the lesser
25 of—

1 (A) the number of months immediately
2 prior to the date of the application during
3 which the individual was not insured since the
4 illness or condition in question was first diag-
5 nosed, or

6 (B) 1 year.

7 (b) TRANSITION RULE.—In the case of applications
8 made in 1998, the requirements of this section are met,
9 if the health insurance plan—

10 (1) provides guaranteed issue at standard rates
11 to all applicants, and

12 (2) does not exclude from coverage, or limit
13 coverage for, any preexisting medical condition of
14 any applicant.

15 **SEC. 115. GUARANTEED RENEWABILITY.**

16 The requirements of this section are met, if the
17 health insurance plan provides the policyholder with a con-
18 tractual right to renew the coverage which stipulates that
19 the insurer cannot cancel or refuse to renew the coverage
20 except for cases of—

21 (1) nonpayment of premiums by the policy-
22 holder, or

23 (2) fraud or misrepresentation by the policy-
24 holder.

1 **PART II—CERTIFICATION OF FEDERALLY**
2 **QUALIFIED HEALTH INSURANCE PLANS**
3 **SEC. 117. ESTABLISHMENT OF REGULATORY PROGRAM**
4 **FOR CERTIFICATION OF PLANS.**

5 (a) IN GENERAL.—Each State shall establish no later
6 than January 1, 1998, a regulatory program which meets
7 the standards referred to in section 118.

8 (b) PERIODIC SECRETARIAL REVIEW OF STATE REG-
9 ULATORY PROGRAM.—The Secretary periodically shall re-
10 view each State regulatory program to determine if such
11 program continues to meet and enforce the standards re-
12 ferred to in section 118. If the Secretary initially deter-
13 mines that a State regulatory program no longer meets
14 and enforces such standards, the Secretary shall provide
15 the State an opportunity to adopt a plan of correction that
16 would bring such program into compliance with such
17 standards. If the Secretary makes a final determination
18 that the State regulatory program fails to meet and en-
19 force such standards after such an opportunity, the Sec-
20 retary shall decertify such program and assume respon-
21 sibility with respect to health insurance plans in the State.

22 **SEC. 118. STANDARDS FOR REGULATORY PROGRAMS.**

23 (a) IN GENERAL.—The Secretary, in consultation
24 with the National Association of Insurance Commissioners
25 (hereafter in this section referred to as “NAIC”) shall de-
26 velop by not later than 1 year after the date of the enact-

1 ment of this Act, in the form of model Acts and model
2 regulations, State regulatory program standards which in-
3 clude—

4 (1) procedures for certifying that the require-
5 ments of part I of this subtitle have been met by a
6 health insurance plan applying for certification as a
7 federally qualified health insurance plan,

8 (2) the requirements described in subsections
9 (b), (c), and (d),

10 (3) requirements with respect to solvency stand-
11 ards and guaranty funds for carriers of federally
12 qualified health insurance plans, and

13 (4) reporting requirements under which carriers
14 report to the Internal Revenue Service regarding the
15 acquisition and termination by individuals of cov-
16 erage under federally qualified health insurance
17 plans.

18 (b) PASSBACK OF CLAIMS AND PREMIUMS.—The re-
19 quirements of this subsection are met, if, in the case of
20 an applicant who has been continuously insured, as de-
21 scribed in section 114(b)(1)(B), and is at the time of the
22 application receiving treatment for a preexisting medical
23 condition—

24 (1) the federally qualified health insurance plan
25 is allowed to pass back to the applicant's previous

1 plan any claims relating to such condition, together
2 with a portion of the premium, and

3 (2) such previous plan is required to pay such
4 claims and premium incurred during the lesser of—

5 (A) the duration of the course of the treat-
6 ment or spell of illness, or

7 (B) 2 years from the date at which cov-
8 erage commenced under the federally qualified
9 health insurance plan.

10 (c) **MARKETING PRACTICES.**—The requirements of
11 this subsection are met, if the carrier offering the federally
12 qualified health insurance plan retains the right to select
13 agents with whom such plan contracts and to determine
14 the amount and form of compensation to such agents, ex-
15 cept that—

16 (1) if the carrier chooses to contract with an
17 agent, the carrier may not terminate or refuse to
18 renew the agency contract for any reason related to
19 the age, sex, health status, claims experience, occu-
20 pation, or geographic location of the insureds placed
21 by the agent with such plan, and

22 (2) the carrier may not, directly or indirectly,
23 enter into any contract, agreement, or arrangement
24 with an agent that provides for, or results in, any
25 consideration provided to such agent for the issu-

1 (1) withhold from each employee's wages the
2 amount of the employee's health insurance premium
3 and remit, directly or indirectly, such premium to
4 the insurance plan of the employee's choice accord-
5 ing to an agreed upon schedule, and

6 (2) within the first 30 days of any calendar
7 year or the date of the hire of an employee, notify
8 each employee of the employee's right to claim an
9 advance refundable tax credit for such premium
10 under section 34A of the Internal Revenue Code of
11 1986.

12 (b) EFFECTIVE DATE.—The requirements under
13 subsection (a) shall apply with respect to calendar year
14 1998 and thereafter.

15 **SEC. 122. CONVERSION OF NON-SELF-INSURED PLANS.**

16 In the case of an employer-sponsored health insur-
17 ance plan in force on the date of the enactment of this
18 Act, and which is not a self-insured plan, the insurer from
19 whom the plan was purchased (or, in the event such in-
20 surer refuses, any new subsidiary, corporation, insurer,
21 union, cooperative, or association willing to become the
22 new sponsor of the plan) shall—

23 (1) notify, not later than October 1, 1997, all
24 of the primary insured beneficiaries of the employer-
25 sponsored plan of their rights to convert their insur-

1 ance coverage to a federally qualified health insur-
2 ance plan (as defined in section 111) offered by the
3 insurer with benefits identical to, or actuarially
4 equivalent to, those of the employer-sponsored plan
5 and the rates of that coverage, and provide such
6 beneficiaries 60 additional days to decline or accept
7 the new coverage, and

8 (2) offer such coverage beginning January 1,
9 1998, at premium rates which vary only by age, sex,
10 and geography, except that the combined total of the
11 new rates charged separately to the various bene-
12 ficiaries may not exceed the total group rate paid by
13 the employer or employees or both under the em-
14 ployer-sponsored plan on the last day it is, or was,
15 in force.

16 **SEC. 123. PROVISIONS RELATING TO EXISTING SELF-IN-**
17 **SURED PLANS.**

18 (a) IN GENERAL.—In the case of an employer-spon-
19 sored health insurance plan in force on the date of the
20 enactment of this Act, and which is a self-insured plan,
21 the employer sponsoring the plan may, at anytime follow-
22 ing such date sell, transfer, or assign the plan to any exist-
23 ing or new, subsidiary, corporation, insurer, union, cooper-
24 ative or association, willing to become the new sponsor of
25 the plan, except that—

1 (1) such sale, transfer, or assignment may not
2 take effect unless first approved by a two-thirds ma-
3 jority vote of all the primary-insured beneficiaries of
4 the plan, and

5 (2) the terms or conditions and benefits or cov-
6 erage of the plan, and the eligibility criteria for par-
7 ticipation in the plan, may not be altered before
8 such date.

9 (b) PROVISIONS GOVERNING PLAN.—As of the date
10 of the enactment of this Act, the sponsor of the plan de-
11 scribed in subsection (a) becomes subject to all laws gov-
12 erning the operation of a corporation selling health insur-
13 ance in the applicable State or States and to the provisions
14 of section 122.

15 **SEC. 124. CONTINUATION OF EMPLOYER-PROVIDED**
16 **HEALTH COVERAGE REQUIRED UNTIL EF-**
17 **FECTIVE DATE OF NEW COVERAGE UNDER**
18 **THIS ACT.**

19 (a) IN GENERAL.—Clause (i) of section
20 4980B(f)(2)(B) of the Internal Revenue Code of 1986 (re-
21 lating to period of coverage) is amended by inserting after
22 subclause (V) the following new subclause:

23 “(VI) QUALIFYING EVENT IN-
24 VOLVING END OF PLAN.—In the case

1 of an event described in paragraph
2 (3)(G), December 31, 1997.”.

3 (b) QUALIFYING EVENT INVOLVING END OF
4 PLAN.—Paragraph (3) of section 4980B(f) of the Internal
5 Revenue Code of 1986 (defining qualifying event) is
6 amended by inserting after subparagraph (F) the follow-
7 ing new subparagraph:

8 “(G) The termination by the employer of
9 the group health plan after the date of the en-
10 actment of the Consumer Choice Health Secu-
11 rity Act of 1994.”.

12 (c) CONFORMING AMENDMENT.—Clause (ii) of sec-
13 tion 4980B(f)(2)(B) of the Internal Revenue Code of 1986
14 is amended by striking “The date” and inserting “Except
15 in the case of a qualifying event described in paragraph
16 (3)(G), the date”.

17 (d) EFFECTIVE DATE.—The amendments made by
18 this section shall apply to qualifying events occurring after
19 the date of the enactment of this Act.

20 **SEC. 125. REQUIREMENTS WITH RESPECT TO CASHING OUT**
21 **EMPLOYER-SPONSORED PLANS.**

22 (a) NON-FEDERAL EMPLOYERS.—

23 (1) IN GENERAL.—Each employer contributing
24 in whole or in part to an employer-sponsored health

1 insurance plan on December 1, 1997, shall, within
2 30 days after such date—

3 (A) notify each employee participating in
4 the plan of the amount spent by the employer
5 on the employee's health insurance, as deter-
6 mined under paragraph (2),

7 (B) add such amount to the cash wages of
8 the employee commencing with pay periods be-
9 ginning on and after January 1, 1998, and

10 (C) hold each employee harmless for the
11 employer's share of any payroll taxes due under
12 chapter 31 of the Internal Revenue Code of
13 1986 on such amount.

14 (2) AMOUNT OF INCLUSION.—The amount de-
15 scribed in paragraph (1)(A) shall equal the actuarial
16 value of the employer's contribution for group health
17 insurance coverage apportioned to the plan's bene-
18 ficiaries according to the new premiums for individ-
19 ual and family coverage determined by the insurer.

20 (3) PRIOR TERMINATION.—Any beneficiary of
21 an employer-sponsored health insurance plan who
22 voluntarily terminates coverage under such a plan
23 before December 1, 1997, forfeits the right to re-
24 ceive the value of the beneficiary's coverage in cash.

1 (b) COMMISSION ON CASHING OUT FEHBP BENE-
2 FITS.—

3 (1) ESTABLISHMENT.—

4 (A) IN GENERAL.—There is established an
5 independent board to be known as the “Bene-
6 fits Cash Out Commission” (in this subtitle, re-
7 ferred to as the “Commission”).

8 (B) DUTIES.—The Commission shall study
9 and propose a procedure under which individ-
10 uals may cash out health benefits under chapter
11 89 of title 5, United States Code, and pay
12 scales and retirement benefits would be ad-
13 justed accordingly. The Commission shall report
14 to Congress regarding such study and proposal
15 not later than 1 year after the date of the en-
16 actment of this Act.

17 (C) MEMBERSHIP.—

18 (i) IN GENERAL.—The Commission
19 shall be composed of 13 members ap-
20 pointed by the President by and with the
21 advice and consent of the Senate.

22 (ii) CONSULTATION.—In selecting in-
23 dividuals for nominations for appointments
24 for the Commission, the President should
25 consult with—

1 (I) the Speaker of the House of
2 Representatives concerning the ap-
3 pointment of 3 members;

4 (II) the Majority Leader of the
5 Senate concerning the appointment of
6 3 members;

7 (III) the Minority Leader of the
8 House of Representatives concerning
9 the appointment of 3 members; and

10 (IV) the Minority Leader of the
11 Senate concerning the appointment of
12 3 members.

13 (iii) CHAIR.—The President shall des-
14 ignate 1 individual described in clause (ii)
15 who shall serve as Chair of the Commis-
16 sion.

17 (iv) COMPOSITION OF COMMISSION.—
18 The membership of the Commission shall
19 include individuals with national recogni-
20 tion for expertise in the valuation of health
21 insurance benefits and of Federal civilian
22 pay and retirement benefits.

23 (D) ADMINISTRATIVE PROVISIONS.—

24 (i) MEETINGS.—Each meeting of the
25 Commission shall be open to the public.

1 (ii) PAY AND TRAVEL EXPENSES.—

2 (I) IN GENERAL.—Each member,
3 other than the Chair, shall be paid at
4 a rate equal to the daily equivalent of
5 the minimum annual rate of basic pay
6 payable for level IV of the Executive
7 Schedule under section 5315 of title
8 5, United States Code, for each day
9 (including travel time) during which
10 the member is engaged in the actual
11 performance of duties vested in the
12 Commission.

13 (II) CHAIR.—The Chair shall be
14 paid for each day referred to in
15 subclause (I) at a rate equal to the
16 daily equivalent of the minimum an-
17 nual rate of basic pay payable for
18 level III of the Executive Schedule
19 under section 5314 of title 5, United
20 States Code.

21 (III) TRAVEL EXPENSES.—Mem-
22 bers shall receive travel expenses, in-
23 cluding per diem in lieu of subsist-
24 ence, in accordance with sections

1 5702 and 5703 of title 5, United
2 States Code.

3 (iii) STAFF.—

4 (I) IN GENERAL.—Subject to
5 subclauses (II) and (III), the Chair,
6 with the approval of the Commission,
7 may appoint and fix the pay of addi-
8 tional personnel.

9 (II) PAY.—The Chair may make
10 such appointments without regard to
11 the provisions of title 5, United States
12 Code, governing appointments in the
13 competitive service, and any personnel
14 so appointed may be paid without re-
15 gard to the provisions of chapter 51
16 and subchapter III of chapter 53 of
17 such title, relating to classification
18 and General Schedule pay rates, ex-
19 cept that an individual so appointed
20 may not receive pay in excess of 120
21 percent of the annual rate of basic
22 pay payable for GS-15 of the General
23 Schedule.

24 (III) DETAILED PERSONNEL.—
25 Upon request of the Chair, the head

1 of any Federal department or agency
2 may detail any of the personnel of
3 that department or agency to the
4 Commission to assist the Commission
5 in carrying out its duties under this
6 Act.

7 (iv) OTHER AUTHORITY.—

8 (I) CONTRACT SERVICES.—The
9 Commission may procure by contract,
10 to the extent funds are available, the
11 temporary or intermittent services of
12 experts or consultants pursuant to
13 section 3109 of title 5, United States
14 Code.

15 (II) LEASES, ETC.—The Com-
16 mission may lease space and acquire
17 personal property to the extent funds
18 are available.

19 (2) CONSIDERATION.—

20 (A) IN GENERAL.—The proposal described
21 in paragraph (1)(B) shall be considered by the
22 Congress under the procedures for consider-
23 ation of an “approval resolution” as described
24 in subparagraph (D).

1 (B) EFFECTIVE DATE OF IMPLEMENTA-
2 TION.—The provisions of the proposal shall be-
3 come effective on January 1, 1997.

4 (C) PERIOD FOR RESUBMISSION OF PRO-
5 POSAL IN CASE OF NONAPPROVAL.—If the pro-
6 posal of the Commission described in subpara-
7 graph (A) is not approved by Congress, the
8 Commission shall by not later than January 1,
9 1996, submit a new proposal to Congress.

10 (D) RULES GOVERNING CONGRESSIONAL
11 CONSIDERATION.—

12 (i) RULES OF HOUSE OF REPRESENT-
13 ATIVES AND SENATE.—This subparagraph
14 is enacted by the Congress—

15 (I) as an exercise of the rule-
16 making power of the House of Rep-
17 resentatives and the Senate, respec-
18 tively, and as such is deemed a part
19 of the rules of each House, respec-
20 tively, but applicable only with respect
21 to the procedure to be followed in that
22 House in the case of approval resolu-
23 tions described in clause (ii), and su-
24 persedes other rules only to the extent

1 that such rules are inconsistent there-
2 with; and

3 (II) with full recognition of the
4 constitutional right of either House to
5 change the rules (so far as relating to
6 the procedure of that House) at any
7 time, in the same manner and to the
8 same extent as in the case of any
9 other rule of that House.

10 (ii) TERMS OF THE RESOLUTION.—

11 For purposes of subparagraph (A), the
12 term “approval resolution” means only a
13 joint resolution of the 2 Houses of the
14 Congress, providing in—

15 (I) the matter after the resolving
16 clause of which is as follows: “That
17 the Congress approves the rec-
18 ommendations of the Benefits Cash
19 Out Commission as submitted by the
20 Commission on
21 _____”;

22 the blank space being filled in with
23 the appropriate date; and

24 (II) the title of which is as fol-
25 lows: “Joint Resolution approving the

1 recommendation of the Benefits Cash
2 Out Commission”.

3 (iii) INTRODUCTION AND REFER-
4 RAL.—On the day on which the rec-
5 ommendation of the Commission is trans-
6 mitted to the House of Representatives
7 and the Senate, an approval resolution
8 with respect to such recommendation shall
9 be introduced (by request) in the House of
10 Representatives by the Majority Leader of
11 the House, for himself or herself and the
12 Minority Leader of the House, or by Mem-
13 bers of the House designated by the Ma-
14 jority Leader and Minority Leader of the
15 House; and shall be introduced (by re-
16 quest) in the Senate by the Majority Lead-
17 er of the Senate, for himself or herself and
18 the Minority Leader of the Senate, or by
19 Members of the Senate designated by the
20 Majority Leader and Minority Leader of
21 the Senate. If either House is not in ses-
22 sion on the day on which such rec-
23 ommendation is transmitted, the approval
24 resolution with respect to such rec-
25 ommendation shall be introduced in the

1 House, as provided in the preceding sen-
2 tence, on the first day thereafter on which
3 the House is in session. The approval reso-
4 lution introduced in the House of Rep-
5 resentatives and the Senate shall be re-
6 ferred to the appropriate committees of
7 each House.

8 (iv) AMENDMENTS PROHIBITED.—No
9 amendment to an approval resolution shall
10 be in order in either the House of Rep-
11 resentatives or the Senate; and no motion
12 to suspend the application of this clause
13 shall be in order in either House, nor shall
14 it be in order in either House for the Pre-
15 siding Officer to entertain a request to sus-
16 pend the application of this clause by
17 unanimous consent.

18 (v) PERIOD FOR COMMITTEE AND
19 FLOOR CONSIDERATION.—

20 (I) IN GENERAL.—Except as pro-
21 vided in subclause (II), if the commit-
22 tee or committees of either House to
23 which an approval resolution has been
24 referred have not reported it at the
25 close of the 30th day after its intro-

1 duction, such committee or commit-
2 tees shall be automatically discharged
3 from further consideration of the ap-
4 proval resolution and it shall be
5 placed on the appropriation calendar.
6 A vote on final passage of the ap-
7 proval resolution shall be taken in
8 each House on or before the close of
9 the 30th day after the approval reso-
10 lution is reported by the committees
11 or committee of that House to which
12 it was referred, or after such commit-
13 tee or committees have been dis-
14 charged from further consideration of
15 the approval resolution. If prior to the
16 passage by 1 House of an approval
17 resolution of that House, that House
18 receives the same approval resolution
19 from the other House then the proce-
20 dure in that House shall be the same
21 as if no approval resolution had been
22 received from the other House, but
23 the vote on final passage shall be on
24 the approval resolution of the other
25 House.

1 (II) COMPUTATION OF DAYS.—

2 For purposes of subclause (I), in com-
3 puting a number of days in either
4 House, there shall be excluded any
5 day on which the House is not in
6 session.

7 (vi) FLOOR CONSIDERATION IN THE
8 HOUSE OF REPRESENTATIVES.—

9 (I) MOTION TO PROCEED.—A
10 motion in the House of Representa-
11 tives to proceed to the consideration
12 of an approval resolution shall be
13 highly privileged and not debatable.
14 An amendment to the motion shall
15 not be in order, nor shall it be in
16 order to move to reconsider the vote
17 by which the motion is agreed to or
18 disagreed to.

19 (II) DEBATE.—Debate in the
20 House of Representatives on an ap-
21 proval resolution shall be limited to
22 not more than 20 hours, which shall
23 be divided equally between those fa-
24 voring and those opposing the bill or
25 resolution. A motion further to limit

1 debate shall not be debatable. It shall
2 not be in order to move to recommit
3 an approval resolution or to move to
4 reconsider the vote by which an ap-
5 proval resolution is agreed to or dis-
6 agreed to.

7 (III) MOTION TO POSTPONE.—

8 Motions to postpone, made in the
9 House of Representatives with respect
10 to the consideration of an approval
11 resolution, and motions to proceed to
12 the consideration of other business,
13 shall be decided without debate.

14 (IV) APPEALS.—All appeals from

15 the decisions of the Chair relating to
16 the application of the Rules of the
17 House of Representatives to the pro-
18 cedure relating to an approval resolu-
19 tion shall be decided without debate.

20 (V) GENERAL RULES APPLY.—

21 Except to the extent specifically pro-
22 vided in the preceding provisions of
23 this clause, consideration of an ap-
24 proval resolution shall be governed by
25 the Rules of the House of Representa-

1 tives applicable to other bills and reso-
2 lutions in similar circumstances.

3 (vii) FLOOR CONSIDERATION IN THE
4 SENATE.—

5 (I) MOTION TO PROCEED.—A
6 motion in the Senate to proceed to the
7 consideration of an approval resolu-
8 tion shall be privileged and not debat-
9 able. An amendment to the motion
10 shall not be in order, nor shall it be
11 in order to move to reconsider the
12 vote by which the motion is agreed to
13 or disagreed to.

14 (II) GENERAL DEBATE.—Debate
15 in the Senate on an approval resolu-
16 tion, and all debatable motions and
17 appeals in connection therewith, shall
18 be limited to not more than 20 hours.
19 The time shall be equally divided be-
20 tween, and controlled by, the Majority
21 Leader and the Minority Leader or
22 their designees.

23 (III) DEBATE OF MOTIONS AND
24 APPEALS.—Debate in the Senate on
25 any debatable motion or appeal in

1 connection with an approval resolution
2 shall be limited to not more than 1
3 hour, to be equally divided between,
4 and controlled by, the mover and the
5 manager of the approval resolution,
6 except that in the event the manager
7 of the approval resolution is in favor
8 of any such motion or appeal, the
9 time in opposition thereto, shall be
10 controlled by the Minority Leader or
11 his designee. Such leaders, or either of
12 them, may, from time under their
13 control on the passage of an approval
14 resolution, allot additional time to any
15 Senator during the consideration of
16 any debatable motion or appeal.

17 (IV) OTHER MOTIONS.—A mo-
18 tion in the Senate to further limit de-
19 bate is not debatable. A motion to re-
20 commit an approval resolution is not
21 in order.

22 **SEC. 126. ENFORCEMENT.**

23 (a) IN GENERAL.—Chapter 47 of the Internal Reve-
24 nue Code of 1986 (relating to excise taxes on qualified

1 pension, etc. plans) is amended by inserting after section
2 5000 the following new sections:

3 **“SEC. 5000A. FAILURE OF EMPLOYERS WITH RESPECT TO**
4 **HEALTH INSURANCE.**

5 “(a) GENERAL RULE.—There is hereby imposed a
6 tax on the failure of any person to comply with the re-
7 quirements of sections 121 and 125(a) of the Consumer
8 Choice Health Security Act of 1994 with respect to any
9 employee of the person.

10 “(b) AMOUNT OF TAX.—

11 “(1) IN GENERAL.—The amount of the tax im-
12 posed by subsection (a) on any failure with respect
13 to an employee shall be \$50 for each day in the non-
14 compliance period with respect to such failure.

15 “(2) NONCOMPLIANCE PERIOD.—For purposes
16 of this section, the term ‘noncompliance period’
17 means, with respect to any failure, the period—

18 “(A) beginning on the date such failure
19 first occurs, and

20 “(B) ending on the date such failure is
21 corrected.

22 “(3) CORRECTION.—A failure of a person to
23 comply with the requirements of section 121 or
24 125(a) of the Consumer Choice Health Security Act

1 of 1994 with respect to any employee of the person
2 shall be treated as corrected if—

3 “(A) such failure is retroactively undone to
4 the extent possible, and

5 “(B) the employee is placed in a financial
6 position which is as good as such employee
7 would have been in had such failure not
8 occurred.

9 “(c) LIMITATIONS ON AMOUNT OF TAX.—

10 “(1) TAX NOT TO APPLY WHERE FAILURE NOT
11 DISCOVERED EXERCISING REASONABLE DILI-
12 GENCE.—No tax shall be imposed by subsection (a)
13 on any failure during any period for which it is es-
14 tablished to the satisfaction of the Secretary that
15 none of the persons referred to in subsection (d)
16 knew, or exercising reasonable diligence would have
17 known, that such failure existed.

18 “(2) TAX NOT TO APPLY TO FAILURES COR-
19 RECTED WITHIN 30 DAYS.—No tax shall be imposed
20 by subsection (a) on any failure if—

21 “(A) such failure was due to reasonable
22 cause and not to willful neglect, and

23 “(B) such failure is corrected during the
24 30-day period beginning on the first date any of
25 the persons referred to in subsection (d) knew,

1 or exercising reasonable diligence would have
2 known, that such failure existed.

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

9 “(d) LIABILITY FOR TAX.—

10 “(1) IN GENERAL.—Except as otherwise provided
11 in this subsection, the following shall be liable
12 for the tax imposed by subsection (a) on a failure:

13 “(A) In the case of a health insurance plan
14 other than a multiemployer plan, the employer.

15 “(B) In the case of a multiemployer plan,
16 the plan.

17 “(C) Each person who is responsible (other
18 than in a capacity as an employee) for administering
19 or providing benefits under the health insurance plan
20 and whose act or failure to act caused (in whole or in part)
21 the failure.

22 “(2) SPECIAL RULES FOR PERSONS DESCRIBED
23 IN PARAGRAPH (1)(C).—A person described in subparagraph
24 (C) (and not in subparagraphs (A) and
25 (B)) of paragraph (1) shall be liable for the tax im-

1 posed by subsection (a) on any failure only if such
2 person assumed (under a legally enforceable written
3 agreement) responsibility for the performance of the
4 act to which the failure relates.

5 **“SEC. 5000B. FAILURE OF CARRIERS WITH RESPECT TO**
6 **HEALTH INSURANCE.**

7 “(a) GENERAL RULE.—There is hereby imposed a
8 tax on the failure of any carrier offering any health insur-
9 ance plan to comply with the requirements of sections 122
10 and 123 of the Consumer Choice Health Security Act of
11 1994.

12 “(b) AMOUNT OF TAX.—

13 “(1) IN GENERAL.—The amount of tax imposed
14 by subsection (a) by reason of 1 or more failures
15 during a taxable year shall be equal to 50 percent
16 of the gross premiums received during such taxable
17 year with respect to all health insurance plans issued
18 by the carrier on whom such tax is imposed.

19 “(2) GROSS PREMIUMS.—For purposes of para-
20 graph (1), gross premiums shall include any consid-
21 eration received with respect to any health insurance
22 contract.

23 “(3) CONTROLLED GROUPS.—For purposes of
24 paragraph (1)—

1 “(A) CONTROLLED GROUP OF CORPORATIONS.—All corporations which are members of
2 the same controlled group of corporations shall
3 be treated as 1 carrier. For purposes of the pre-
4 ceding sentence, the term ‘controlled group of
5 corporations’ has the meaning given to such
6 term by section 1563(a), except that—
7

8 “(i) ‘more than 50 percent’ shall be
9 substituted for ‘at least 80 percent’ each
10 place it appears in section 1563(a)(1), and

11 “(ii) the determination shall be made
12 without regard to subsections (a)(4) and
13 (e)(3)(C) of section 1563.

14 “(B) PARTNERSHIPS, PROPRIETORSHIPS,
15 ETC., WHICH ARE UNDER COMMON CONTROL.—
16 Under regulations prescribed by the Secretary,
17 all trades or business (whether or not incor-
18 porated) which are under common control shall
19 be treated as 1 carrier. The regulations pre-
20 scribed under this subparagraph shall be based
21 on principles similar to the principles which
22 apply in the case of subparagraph (A).

23 “(c) LIMITATION ON TAX.—

24 “(1) TAX NOT TO APPLY WHERE FAILURE NOT
25 DISCOVERED EXERCISING REASONABLE DILI-

1 GENCE.—No tax shall be imposed by subsection (a)
2 with respect to any failure for which it is established
3 to the satisfaction of the Secretary that the carrier
4 on whom the tax is imposed did not know, and exer-
5 cising reasonable diligence would not have known,
6 that such failure existed.

7 “(2) TAX NOT TO APPLY WHERE FAILURES
8 CORRECTED WITHIN 30 DAYS.—No tax shall be im-
9 posed by subsection (a) with respect to any failure
10 if—

11 “(A) such failure was due to reasonable
12 cause and not to willful neglect, and

13 “(B) such failure is corrected during the
14 30-day period beginning on the 1st date any of
15 the carriers on whom the tax is imposed knew,
16 or exercising reasonable diligence would have
17 known, that such failure existed.

18 “(3) WAIVER BY SECRETARY.—In the case of a
19 failure which is due to reasonable cause and not to
20 willful neglect, the Secretary may waive part or all
21 of the tax imposed by subsection (a) to the extent
22 that the payment of such tax would be excessive rel-
23 ative to the failure involved.”.

1 (b) CLERICAL AMENDMENTS.—The table of sections
 2 for such chapter 47 is amended by adding at the end
 3 thereof the following new items:

“Sec. 5000A. Failure of employers with respect to health insur-
 ance.

“Sec. 5000B. Failure of carriers with respect to health insur-
 ance.”.

4 (c) EFFECTIVE DATE.—The amendments made by
 5 this section shall take effect on January 1, 1998.

6 **Subtitle D—Federal Preemption**

7 **SEC. 131. FEDERAL PREEMPTION OF CERTAIN STATE LAWS.**

8 All State laws in existence on January 1, 1998, in
 9 the following areas are preempted:

10 (1) MANDATED INSURANCE BENEFIT LAWS.—
 11 Laws requiring health insurance policies to cover
 12 specific diseases, services, or providers.

13 (2) ANTI-MANAGED CARE LAWS.—Laws re-
 14 stricting the ability of managed care plans to selec-
 15 tively contract with providers of their choice.

16 (3) MANDATED COST-SHARING LAWS.—Laws
 17 restricting the extent to which insurers may require
 18 enrollee cost sharing as part of their plans, or re-
 19 stricting the extent to which managed care plans
 20 may impose different levels of cost sharing on en-
 21 rollee claims for treatment by providers not partici-
 22 pating in the plan.

Subtitle E—Report

2 SEC. 141. REPORT ON HEALTH INSURANCE COVERAGE.

3 The Secretary shall submit to the Congress, not later
4 than 5 years after the date of the enactment of this Act,
5 a report on the following:

6 (1) The number and demographic profile of
7 Americans who have purchased health insurance
8 pursuant to the provisions of this Act, including in-
9 formation concerning the type of coverage purchased
10 and its cost.

11 (2) The number and demographic profile of
12 Americans who have chosen to forgo health insur-
13 ance coverage.

14 (3) The estimated health care costs incurred by
15 the insured and the extent to which such costs have
16 been—

17 (A) paid for directly by the uninsured, or

18 (B) shifted to individuals with health in-
19 surance coverage and to Federal, State, and
20 local governmental entities.

1 **TITLE II—MEDICARE AND**
2 **MEDICAID REFORMS**
3 **Subtitle A—Medicare**

4 **SEC. 201. STUDY OF MEDICARE PRIVATE HEALTH INSUR-**
5 **ANCE PROGRAM.**

6 (a) STUDY.—The Secretary shall conduct a study of
7 the feasibility of permitting future medicare beneficiaries
8 to elect, upon attaining medicare eligibility, to retain pri-
9 vate health insurance coverage and receive, in lieu of the
10 medicare benefits such beneficiaries would otherwise be
11 entitled to, certificates for use in purchasing private health
12 insurance coverage. The study shall recommend—

13 (1) certificate amounts which—

14 (A) provide the maximum assistance pos-
15 sible to eligible individuals,

16 (B) are adjusted for different classes of
17 beneficiaries on the basis of age, sex, and geog-
18 raphy to reflect actuarial differences in the cost
19 of insurance, and

20 (C) will not further jeopardize the future
21 solvency of the medicare program, as projected
22 by the trustees of the medicare trust funds as
23 of the date of the report of the study,

24 (2) a mechanism for annually adjusting such
25 amounts, and

1 (3) legislative, regulatory, and administrative
2 reforms necessary or desirable for establishing such
3 a program.

4 (b) REPORT.—The Secretary shall submit a report
5 regarding the study described in subsection (a) to the Con-
6 gress no later than January 1, 1997.

7 **SEC. 202. ELIMINATION OF MEDICARE HOSPITAL DIS-**
8 **PROPORTIONATE SHARE ADJUSTMENT PAY-**
9 **MENTS.**

10 Section 1886(d)(5)(F)(i) of the Social Security Act
11 (42 U.S.C. 1395ww(d)(5)(F)(i)) is amended by inserting
12 “and before September 30, 1994,” after “1986,”.

13 **SEC. 203. REDUCTION IN ADJUSTMENT FOR INDIRECT MED-**
14 **ICAL EDUCATION.**

15 Section 1886(d)(5)(B)(ii) of the Social Security Act
16 (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended to read as
17 follows:

18 “(ii) For purposes of clause (i)(II), the indirect
19 teaching adjustment factor is equal to $c * (((1+r)$
20 $to\ the\ nth\ power) - 1)$, where ‘r’ is the ratio of the
21 hospital’s full-time equivalent interns and residents
22 to beds and ‘n’ equals .405. For discharges occur-
23 ring on or after—

24 “(I) May 1, 1986, and before October 1,
25 1994, ‘c’ is equal to 1.89,

1 “(II) October 1, 1994, and before October
2 1, 1995, ‘c’ is equal to 1.395, and

3 “(III) October 1, 1995, ‘c’ is equal to
4 0.74.”.

5 **SEC. 204. IMPOSITION OF COPAYMENT ON LABORATORY**
6 **SERVICES.**

7 (a) IN GENERAL.—Paragraphs (1)(D) and (2)(D) of
8 section 1833(a) of the Social Security Act (42 U.S.C.
9 1395l(a)) are each amended—

10 (1) by striking “(or 100 percent” and all that
11 follows through “the first opinion)”; and

12 (2) by striking “100 percent of such negotiated
13 rate” and inserting “80 percent of such negotiated
14 rate”.

15 (b) EFFECTIVE DATE.—The amendments made by
16 subsection (a) shall apply to tests furnished on or after
17 October 1, 1994.

18 **SEC. 205. IMPOSITION OF COPAYMENT FOR CERTAIN HOME**
19 **HEALTH VISITS.**

20 (a) IN GENERAL.—

21 (1) PART A.—Section 1813(a) of the Social Se-
22 curity Act (42 U.S.C. 1395e(a)) is amended by add-
23 ing at the end the following new paragraph:

24 “(5) The amount payable for home health services
25 furnished to an individual under this part shall be reduced

1 by a copayment amount equal to 20 percent of the average
2 of all per visit costs for home health services furnished
3 under this title determined under section 1861(v)(1)(L)
4 (as determined by the Secretary on a prospective basis for
5 services furnished during a calendar year), unless such
6 services were furnished to the individual during the 30-
7 day period that begins on the date the individual is dis-
8 charged as an inpatient from a hospital.”.

9 (2) PART B.—Section 1833(a)(2) of such Act
10 (42 U.S.C. 1395l(a)(2)) is amended—

11 (A) in subparagraph (A), by striking “to
12 home health services,” and by striking the
13 comma after “opinion)”;

14 (B) in subparagraph (D), by striking
15 “and” at the end;

16 (C) in subparagraph (E), by striking the
17 semicolon at the end and inserting “; and”;

18 (D) by adding at the end the following new
19 subparagraph:

20 “(F) with respect to home health serv-
21 ices—

22 “(i) the lesser of —

23 “(I) the reasonable cost of such
24 services, as determined under section
25 1861(v), or

1 “(II) the customary charges with
2 respect to such services,
3 less the amount a provider may charge as
4 described in clause (ii) of section
5 1866(a)(2)(A),

6 “(ii) if such services are furnished by
7 a public provider of services, or by another
8 provider which demonstrates to the satis-
9 faction of the Secretary that a significant
10 portion of its patients are low-income (and
11 requests that payment be made under this
12 clause), free of charge or at nominal
13 charges to the public, the amount deter-
14 mined in accordance with section
15 1814(b)(2), or

16 “(iii) if (and for so long as) the condi-
17 tions described in section 1814(b)(3) are
18 met, the amounts determined under the re-
19 imbursement system described in such sec-
20 tion,

21 less a copayment amount equal to 20 percent of
22 the average of all per visit costs for home
23 health services furnished under this title deter-
24 mined under section 1861(v)(1)(L) (as deter-
25 mined by the Secretary on a prospective basis

1 for services furnished during a calendar year),
2 unless such services were furnished to the indi-
3 vidual during the 30-day period that begins on
4 the date the individual is discharged as an inpa-
5 tient from a hospital;”.

6 (3) PROVIDER CHARGES.—Section
7 1866(a)(2)(A)(i) of such Act (42 U.S.C.
8 1395cc(a)(2)(A)(i)) is amended—

9 (A) by striking “deduction or coinsurance”
10 and inserting “deduction, coinsurance, or
11 copayment”; and

12 (B) by striking “or (a)(4)” and inserting
13 “(a)(4), or (a)(5)”.

14 (b) EFFECTIVE DATE.—The amendments made by
15 subsection (a) shall apply to home health services fur-
16 nished on or after October 1, 1994.

17 **SEC. 206. IMPOSITION OF COPAYMENT FOR SKILLED NURS-**
18 **ING FACILITY SERVICES.**

19 (a) IN GENERAL.—Paragraph (3) of section 1813(b)
20 of the Social Security Act (42 U.S.C. 1395e(b)) is amend-
21 ed to read as follows:

22 “(3) The amount payable for post-hospital extended
23 care services furnished an individual during any spell of
24 illness shall be reduced by a copayment amount equal to
25 20 percent of the average of all per day costs for such

1 services furnished under this title (as determined by the
2 Secretary on a prospective basis for services furnished
3 during a calendar year).”.

4 (b) EFFECTIVE DATE.—The amendment made by
5 subsection (a) shall apply to post-hospital extended care
6 services furnished on or after October 1, 1994.

7 **SEC. 207. SHIFT PAYMENT UPDATES TO JANUARY FOR ALL**
8 **PAYMENT RATES UNDER HOSPITAL INSUR-**
9 **ANCE PROGRAM.**

10 (a) PPS HOSPITALS.—

11 (1) IN GENERAL.—Section 1886(b)(3)(B)(i) of
12 the Social Security Act (42 U.S.C.
13 1395ww(b)(3)(B)(i)) is amended—

14 (A) in the matter preceding subclause (I),
15 by striking “fiscal year” and inserting “particu-
16 lar time period”,

17 (B) in subclause (IX), by striking “fiscal
18 year 1994”, and inserting “the 15-month pe-
19 riod beginning on October 1, 1993”,

20 (C) in subclauses (X), (XI), and (XII), by
21 striking “fiscal year”, and

22 (D) in subclause (XIII), by striking “fiscal
23 year 1998 and each subsequent fiscal year” and
24 inserting “1998 and each subsequent calendar
25 year”.

1 (2) OTHER HOSPITALS.—

2 (A) IN GENERAL.—Section
3 1886(b)(3)(B)(ii) of such Act (42 U.S.C.
4 1395ww(b)(3)(B)(ii)) is amended—

5 (A) in subclause (V)—

6 (i) by striking “fiscal years 1994
7 through 1997” and inserting “the 15-
8 month period beginning on October 1,
9 1993,” and

10 (ii) by striking “and” at the end, and

11 (B) by striking subclause (VI) and insert
12 the following:

13 “(VI) 1995 through 1997, is the market basket
14 percentage increase minus the applicable reduction
15 (as defined in clause (vi)(II)), or in the case of a
16 hospital for a calendar year for which the hospital’s
17 update adjustment percentage (as defined in clause
18 (vi)(I)) is at least 10 percent, the market basket per-
19 centage increase, and

20 “(VII) subsequent calendar years is the market
21 basket percentage increase.”.

22 (B) CONFORMING AMENDMENT.—Section
23 1886(b)(3)(B) of such Act (42 U.S.C.
24 1395ww(b)(3)(B)) is amended by adding at the
25 end the following new clause:

1 “(vi) For purposes of clause (ii)(VI)—

2 “(I) a hospital’s ‘update adjustment percentage’
3 for a calendar year is the percentage by which the
4 hospital’s allowable operating cost of inpatient hos-
5 pital services recognized under this title for the cost
6 reporting period beginning in fiscal year 1990 ex-
7 ceeds the hospital’s target amount (as determined
8 under subparagraph (A)) for such cost reporting pe-
9 riod, increased for each calendar year (beginning
10 with 1995) by the sum of any of the hospital’s appli-
11 cable reductions under subclause (VI) for previous
12 years; and

13 “(II) the ‘applicable reduction’ with respect to
14 a hospital for a calendar year is the lesser of 1 per-
15 centage point or the percentage point difference be-
16 tween 10 percent and the hospital’s update adjust-
17 ment percentage for the calendar year.”.

18 (3) SOLE COMMUNITY AND MEDICARE-DEPEND-
19 ENT, SMALL RURAL HOSPITALS.—

20 (A) IN GENERAL.—Section
21 1886(b)(3)(B)(iv) of such Act (42 U.S.C.
22 1395ww(b)(3)(B)(iv)) is amended—

23 (i) in subclause (II), by striking “fis-
24 cal year 1994” and inserting “the 15-

1 month period beginning on October 1,
2 1993”,

3 (ii) in subclause (III), by striking “fis-
4 cal year”, and

5 (iii) in subclause (IV), by striking
6 “fiscal year 1996 and each subsequent fis-
7 cal year” and inserting “1996 and each
8 subsequent calendar year”.

9 (B) TARGET AMOUNT ADJUSTMENT.—Sec-
10 tion 1886(b)(3)(C) of such Act (42 U.S.C.
11 1395ww(b)(3)(C)) is amended—

12 (i) in clause (iii), by inserting “or por-
13 tion of a cost reporting period occurring
14 before December 31, 1994,” before “the
15 target amount”, and

16 (ii) in clause (iv), by striking “fiscal
17 year 1995 and each subsequent fiscal
18 year” and inserting “1995 and each subse-
19 quent year”.

20 (C) EXTENSION OF REGIONAL FLOOR.—
21 Section 1886(d)(1)(A)(iii)(II) of such Act (42
22 U.S.C. 1395ww(d)(1)(A)(iii)(II)) is amended—

23 (i) by striking “for discharges occur-
24 ring during a fiscal year ending on or be-
25 fore September 30, 1996” and inserting

1 “for discharges occurring during the 15-
2 month period beginning on October 1,
3 1993, and during any calendar year ending
4 on or before December 31, 1996”, and

5 (ii) by striking “such fiscal year” and
6 inserting “such 15-month period or such
7 calendar year, as the case may be”.

8 (4) CONFORMING AMENDMENTS.—

9 (A) Section 1886(b)(3)(B)(iii) of such Act
10 (42 U.S.C. 1395ww(b)(3)(B)(iii)) is amended—

11 (i) by inserting “beginning in” after
12 “cost reporting periods”,

13 (ii) by striking “fiscal year” the first
14 place it appears and inserting “particular
15 time period”,

16 (iii) by striking “or fiscal year” the
17 first and second place it appears, and

18 (iv) by striking “cost reporting period
19 or fiscal year” and inserting “period”.

20 (B) Section 1886(d)(1)(A) of such Act (42
21 U.S.C. 1395ww(d)(1)(A)) is amended in the
22 matter preceding clause (i) by inserting “or cal-
23 endar” after “fiscal”.

24 (C) Section 1886(d)(2)(D) of such Act (42
25 U.S.C. 1395ww(d)(2)(D)) is amended by insert-

1 ing “or calendar” after “fiscal” each place it
2 appears.

3 (D) Section 1886(d)(3) of such Act (42
4 U.S.C. 1395ww(d)(3)) is amended in the first
5 sentence by inserting “or calendar” after “fis-
6 cal” the first place it appears and by inserting
7 “for each fiscal year through 1994” after “in
8 the United States, and”.

9 (E) Section 1886(d)(3)(A)(ii) of such Act
10 (42 U.S.C. 1395ww(d)(3)(A)(ii)) is amended—

11 (i) by striking “1994,” and inserting
12 “1993, and occurring in the 15-month pe-
13 riod beginning on October 1, 1993,” and

14 (ii) by striking “fiscal year” the sec-
15 ond and last place it appears and inserting
16 “time period”.

17 (F) Section 1886(d)(3)(A)(iii) of such Act
18 (42 U.S.C. 1395ww(d)(3)(A)(iii)) is amended
19 by striking “the fiscal year beginning on Octo-
20 ber 1, 1994” and inserting “1995”.

21 (G) Section 1886(d)(3)(A)(iv) of such Act
22 (42 U.S.C. 1395ww(d)(3)(A)(iv)) is amended—

23 (i) by striking “fiscal year beginning
24 on or after October 1, 1995” and inserting

1 “year beginning on or after January 1,
2 1996”,

3 (ii) by striking “and within each re-
4 gion”, and

5 (iii) by striking “fiscal” each place it
6 appears.

7 (H) Section 1886(d)(3)(D) of such Act (42
8 U.S.C. 1395ww(d)(3)(D)) is amended—

9 (i) by inserting “or calendar” after
10 “fiscal” each place it appears, and

11 (ii) by inserting “for each fiscal year
12 through 1994” after “and shall establish”.

13 (I) Section 1886(d)(3)(E) of such Act (42
14 U.S.C. 1395ww(d)(3)(E)) is amended—

15 (i) in the second sentence, by striking
16 “at least every 12 months thereafter” and
17 inserting “beginning January 1, 1995, at
18 least every 12 months thereafter”, and

19 (ii) in the last sentence, by inserting
20 “or calendar” after “fiscal” the first and
21 last place it appears.

22 (J)(i) Section 1886(d)(4)(C)(iii) of such
23 Act (42 U.S.C. 1395ww(d)(4)(C)(iii)) is amend-
24 ed—

1 (I) by inserting “or calendar” after
2 “fiscal” the first place it appears, and

3 (II) by deleting “fiscal” the last place
4 it appears.

5 (ii) The requirements of paragraphs (3)(E)
6 and (4)(C)(iii) of section 1886(d) of the Social
7 Security Act (42 U.S.C. 1395ww(d)(4)(C)(iii))
8 shall be applied on a 15-month basis for the pe-
9 riod beginning on October 1, 1993, and ending
10 on December 31, 1994.

11 (K)(i) Section 1886(d)(5)(A) of such Act
12 (42 U.S.C. 1395ww(d)(5)(A)) is amended—

13 (I) in clause (i), by striking “fiscal
14 years ending on or before September 30,
15 1997” and inserting “calendar years end-
16 ing on or before December 31, 1997”,

17 (II) in clause (ii), by striking “fiscal
18 years beginning on or after October 1,
19 1994” and inserting “calendar years begin-
20 ning on or after January 1, 1995”,

21 (III) in clause (iv), by inserting “or
22 calendar” after “fiscal”,

23 (IV) in clause (v), by striking “fiscal
24 year” each place it appears, and

1 (V) in clause (vi), by striking “fiscal”
2 and inserting “calendar”.

3 (ii) The requirement of section
4 1886(d)(5)(A)(iv) of the Social Security Act
5 (42 U.S.C. 1395ww(d)(5)(A)(iv)) shall be ap-
6 plied on a 15-month basis for the period begin-
7 ning on October 1, 1993, and ending on De-
8 cember 31, 1994.

9 (L) Section 1886(d)(5)(E)(ii) of such Act
10 (42 U.S.C. 1395ww(d)(5)(E)(ii)) is amended by
11 inserting “or calendar” after “fiscal”.

12 (M) Section 1886(d)(6) of such Act (42
13 U.S.C. 1395ww(d)(6)) is amended by inserting
14 “or December 1 of each calendar year (begin-
15 ning with calendar year 1995)” after “1984”.

16 (N) Section 1886(d)(9)(A) of such Act (42
17 U.S.C. 1395ww(d)(9)(A)) is amended in the
18 matter preceding clause (i) by striking “fiscal
19 year” and inserting “particular time period”.

20 (O) Section 1886(d)(9)(C)(i) of such Act
21 (42 U.S.C. 1395ww(d)(9)(C)(i)) is amended—

22 (i) by striking “fiscal year” the first
23 place it appears and inserting “time pe-
24 riod”,

1 (ii) by striking “for fiscal year 1989”,
2 and

3 (iii) by striking “fiscal years” and in-
4 serting “time periods”.

5 (P) Section 1886(d)(10)(C) of such Act
6 (42 U.S.C. 1395ww(d)(10)(C)) is amended—

7 (i) in clause (i), by striking “fiscal
8 year” and inserting “particular time pe-
9 riod”, and

10 (ii) in clause (ii), by inserting “or cal-
11 endar” after “fiscal” the first place it ap-
12 pears and striking “fiscal” the last place it
13 appears.

14 (Q) Section 1886(e)(2) of such Act (42
15 U.S.C. 1395ww(e)(2)) is amended—

16 (i) in subparagraph (A), by striking
17 “fiscal years” and inserting “particular
18 time periods”, and

19 (ii) in subparagraph (B), by striking
20 “fiscal year” each place it appears and in-
21 serting “particular time period”.

22 (R) Section 1886(e)(3) of such Act (42
23 U.S.C. 1395ww(e)(3)) is amended—

24 (i) in subparagraph (A)—

1 (I) by striking “before the begin-
2 ning of each fiscal year (beginning
3 with fiscal year 1986)”, and

4 (II) by striking “that fiscal year”
5 and inserting “the succeeding year”,
6 and

7 (ii) in subparagraph (B)—

8 (I) by striking “before the begin-
9 ning of each fiscal year (beginning
10 with fiscal year 1989)”, and

11 (II) by striking “that fiscal year”
12 and inserting “the succeeding year”.

13 (S) Section 1886(e)(4)(A) of such Act (42
14 U.S.C. 1395ww(e)(4)(A)) is amended in the
15 first sentence by striking “fiscal” the first and
16 last place it appears and by striking “(begin-
17 ning with fiscal year 1988)”.

18 (T) Section 1886(e)(4)(B) of such Act (42
19 U.S.C. 1395ww(e)(4)(B)) is amended by strik-
20 ing “fiscal” the first place it appears and by
21 striking “(beginning with fiscal year 1992)”.

22 (U) Section 1886(e)(5) of such Act (42
23 U.S.C. 1395ww(e)(5)) is amended—

24 (i) in subparagraph (A), by striking
25 “the May 1 before each fiscal year (begin-

1 ning with fiscal year 1986) and inserting
2 “May 1” and by striking “that fiscal year”
3 and inserting “the succeeding year”, and

4 (ii) in subparagraph (B), by striking
5 “fiscal”.

6 (V) The second and third sentences of sec-
7 tion 1886(e)(5) of such Act (42 U.S.C.
8 1395ww(e)(5)) are each amended by striking
9 “fiscal” each place it appears.

10 (W) Section 1886(g)(1)(A) of such Act (42
11 U.S.C. 1395ww(g)(1)(A)) is amended—

12 (i) by striking “fiscal years 1992,
13 through 1995” and inserting “fiscal years
14 1992 and 1993, the 15-month period be-
15 ginning on October 1, 1993, and calendar
16 year 1995”, and

17 (ii) by striking “such fiscal year” and
18 inserting “such period”.

19 (5) CLERICAL AMENDMENTS CONCERNING
20 TRANSITIONAL PAYMENTS FOR A RECLASSIFIED
21 HOSPITAL.—

22 (A) Section 1886(d)(8)(A) of such Act (42
23 U.S.C. 1395ww(d)(8)(A)) is amended in the
24 matter preceding clause (i), by striking “cost
25 reporting periods” and inserting “years”.

1 (B) Section 1886(d)(8)(A)(i) of such Act
2 (42 U.S.C. 1395ww(d)(8)(A)(i)) is amended—

3 (i) in the matter preceding subclause
4 (I), by striking “cost reporting period” and
5 inserting “year” and by striking “reporting
6 period” and inserting “year”,

7 (ii) in subclause (I), by striking “re-
8 porting period” and inserting “year”, and

9 (iii) in subclause (II), by striking “re-
10 porting period” and inserting “year”.

11 (C) Section 1886(d)(8)(A)(ii) of such Act
12 (42 U.S.C. 1395ww(d)(8)(A)(ii)) is amended—

13 (i) in the matter preceding subclause
14 (I), by striking “cost reporting period” and
15 inserting “year” and by striking “reporting
16 period” and inserting “year”,

17 (ii) in subclause (I), by striking “re-
18 porting period” and inserting “year”, and

19 (iii) in subclause (II), by striking “re-
20 porting period” and inserting “year”.

21 (b) HOME HEALTH AGENCIES.—Clause (iii) of sec-
22 tion 1861(v)(1)(L) of such Act (42 U.S.C.
23 1395x(v)(1)(L)) is amended by striking “July 1, 1991,
24 and annually thereafter (but not for cost reporting periods
25 beginning on and after July 1, 1994, and before July 1,

1 1996)” and inserting “July 1 of 1991, 1992, and 1993
2 (but not for cost reporting periods beginning on and after
3 July 1, 1994, and before January 1, 1997), and annually
4 thereafter ”.

5 (c) HOSPICE CARE.—

6 (1) IN GENERAL.—Clause (ii) of section
7 1814(i)(1)(C) of such Act (42 U.S.C.
8 1395f(i)(1)(C)) is amended—

9 (A) in subclause (II), by striking “fiscal
10 year 1994” and inserting “the 15-month period
11 beginning on October 1, 1993”, and

12 (B) in subclauses (III), (IV), (V), and
13 (VI), by striking “fiscal year” each place it ap-
14 pears and inserting “calendar year”.

15 (2) CONFORMING AMENDMENT.—Section
16 1814(i)(2) of such Act (42 U.S.C. 1395f(i)(2)) is
17 amended by adding at the end the following new
18 subparagraph:

19 “(D) For purposes of subparagraph (A), the term
20 ‘accounting year’ means—

21 “(i) fiscal years 1985 through 1993,

22 “(ii) the 15-month period beginning on October
23 1, 1993, and

24 “(iii) calendar years beginning on or after Jan-
25 uary 1, 1995.”.

1 (d) SKILLED NURSING FACILITY SERVICES.—

2 (1) IN GENERAL.—The last sentence of section
3 1888(a) of such Act (42 U.S.C. 1395yy(b)) is
4 amended by striking “October 1, 1995” and insert-
5 ing “January 1, 1996”.

6 (2) CONFORMING AMENDMENTS.—

7 (A) Section 1888(d)(4) of such Act (42
8 U.S.C. 1395yy(d)(4)) is amended by striking
9 “fiscal” each place it appears.

10 (B) Subsections (a)(1) and (b) of section
11 13503 of the Omnibus Budget Reconciliation
12 Act of 1993 are amended by striking “fiscal
13 years 1994 and 1995” each place it appears
14 and inserting “the 15-month period beginning
15 on October 1, 1993, and calendar year 1995”.

16 **SEC. 208. ACCELERATION OF TRANSITION TO PROSPEC-**
17 **TIVE RATES FOR FACILITY COSTS IN HOS-**
18 **PITAL OUTPATIENT DEPARTMENTS.**

19 (a) OUTPATIENT SURGERY.—Section
20 1833(i)(3)(B)(ii) of the Social Security Act (42 U.S.C.
21 1395l(i)(3)(B)(ii)) is amended—

22 (1) in subclause (I)—

23 (A) by striking “and 42 percent” and in-
24 serting “42 percent”, and

1 (B) by striking “1991” and inserting
2 “1991, and beginning on or before September
3 30, 1994, 25 percent for portions of cost re-
4 porting periods beginning in fiscal year 1995,
5 and 0 percent for portions of cost reporting pe-
6 riods beginning on or after October 1, 1995”,
7 and

8 (2) in subclause (II)—

9 (A) by striking “and 58 percent” and in-
10 sserting “58 percent”, and

11 (B) by striking “1991” and inserting
12 “1991, and beginning on or before September
13 30, 1994, 75 percent for portions of cost re-
14 porting periods beginning in fiscal year 1995,
15 and 100 percent for portions of cost reporting
16 periods beginning on or after October 1, 1995”.

17 (b) OUTPATIENT RADIOLOGY AND DIAGNOSTIC
18 SERVICES.—Section 1833(n)(1)(B)(ii)(I) of the Social Se-
19 curity Act (42 U.S.C. 1395l(n)(1)(B)(ii)(I)) is amended
20 by striking “January 1, 1991.” and inserting “January
21 1, 1991, and beginning on or before September 30, 1994.
22 The term means 25 percent for portions of cost reporting
23 periods beginning in fiscal year 1995 and 0 percent for
24 portions of cost reporting periods beginning on or after
25 October 1, 1995.”.

Subtitle B—Medicaid

1 **SEC. 211. CAP ON FEDERAL PAYMENTS MADE FOR ACUTE**
 2 **MEDICAL SERVICES UNDER THE MEDICAID**
 3 **PROGRAM.**
 4

5 (a) IN GENERAL.—Title XIX of the Social Security
 6 Act (42 U.S.C. 1396 et seq.) is amended by redesignating
 7 section 1931 as section 1932 and by inserting after section
 8 1930 the following new section:

9 “CAP ON FEDERAL PAYMENT MADE FOR ACUTE MEDICAL
 10 SERVICES FURNISHED UNDER THE MEDICAID PROGRAM

11 “SEC. 1931. (a) ANNUAL FEDERAL CAP.—For pur-
 12 poses of furnishing acute medical services to eligible indi-
 13 viduals, the Secretary shall pay to a State for a fiscal year
 14 under section 1903 an amount that does not exceed the
 15 State’s total funding amount for such fiscal year deter-
 16 mined under subsection (b).

17 “(b) STATE TOTAL FUNDING AMOUNT.—

18 “(1) IN GENERAL.—A State’s total funding
 19 amount for a fiscal year is an amount equal to the
 20 lesser of—

21 “(A) the sum of—

22 “(i) the product of—

23 “(I) the per-adult funding
 24 amount for the State for such fiscal
 25 year, and

1 “(II) the total number of eligible
2 individuals who are at least 21 years
3 of age who will receive acute medical
4 services in the State during the fiscal
5 year; and

6 “(ii) the product of—

7 “(I) the per-child funding
8 amount for the State for such fiscal
9 year, and

10 “(II) the total number of eligible
11 individuals who are under 21 years of
12 age who will receive acute medical
13 services in the State during the fiscal
14 year; or

15 “(B) the maximum Federal amount for
16 such State (as determined under paragraph
17 (3)).

18 “(2) PER-ADULT AND PER-CHILD FUNDING
19 AMOUNTS.—The Secretary shall calculate for each
20 State a per-adult funding amount and a per-child
21 funding amount for each fiscal year as follows:

22 “(A) IN GENERAL.—

23 “(i) FISCAL YEAR 1995.—For fiscal
24 year 1995—

1 “(I) the per-adult funding
2 amount for a State shall be an
3 amount equal to the base per-adult
4 funding amount determined under
5 subparagraph (B) increased by 20
6 percent of such amount; and

7 “(II) the per-child funding
8 amount for the State shall be an
9 amount equal to the base per-child
10 funding amount for the State deter-
11 mined under subparagraph (C) in-
12 creased by 20 percent of such amount.

13 “(ii) SUBSEQUENT FISCAL YEARS.—
14 For fiscal year 1996 and subsequent fiscal
15 years, the per-adult funding amount for a
16 State and the per-child funding amount for
17 a State, respectively, shall be an amount
18 equal to the amount determined under this
19 subparagraph for the previous fiscal year
20 updated, through the midpoint of the pe-
21 riod, by the estimated percentage change
22 in the Consumer Price Index during the
23 12-month period ending at that midpoint,
24 with appropriate adjustments to reflect
25 previous underestimations or overesti-

1 mations under this clause in the projected
2 percentage change in the Consumer Price
3 Index, plus 1 percentage point.

4 “(B) BASE PER-ADULT FUNDING
5 AMOUNT.—The base per-adult funding amount
6 for a State is an amount equal to—

7 “(i) the total amount of Federal funds
8 paid to such State under section 1903(a)
9 for fiscal year 1993 for providing acute
10 medical services to eligible individuals who
11 were at least 21 years of age; divided by

12 “(ii) the total number of eligible indi-
13 viduals who were at least 21 years of age
14 who received acute medical services in such
15 State during fiscal year 1993.

16 “(C) BASE PER-CHILD FUNDING
17 AMOUNT.—The base per-child funding amount
18 for a State is an amount equal to—

19 “(i) the total amount of Federal funds
20 paid to such State under section 1903(a)
21 for fiscal year 1993 for providing acute
22 medical services to eligible individuals who
23 were under 21 years of age; divided by

24 “(ii) the total number of eligible indi-
25 viduals who were under 21 years of age

1 who received acute medical services in such
2 State during fiscal year 1993.

3 “(3) MAXIMUM FEDERAL AMOUNT.—The Sec-
4 retary shall calculate for each State a maximum
5 Federal amount for each fiscal year as follows:

6 “(A) IN GENERAL.—

7 “(i) FISCAL YEAR 1995.—For fiscal
8 year 1995, the maximum Federal amount
9 for a State shall be an amount equal to the
10 base maximum Federal amount determined
11 under subparagraph (C) increased by 20
12 percent of such amount.

13 “(ii) SUBSEQUENT FISCAL YEARS.—
14 For fiscal year 1996 and subsequent fiscal
15 years, the maximum Federal amount for a
16 State shall be an amount equal to the
17 amount determined under this subpara-
18 graph for the previous fiscal year updated,
19 through the midpoint of the period, by the
20 estimated percentage change in the
21 Consumer Price Index during the 12-
22 month period ending at that midpoint,
23 with appropriate adjustments to reflect
24 previous underestimations or overesti-
25 mations under this clause in the projected

1 percentage change in the Consumer Price
2 Index, plus 2.5 percentage points.

3 “(B) BASE MAXIMUM FEDERAL
4 AMOUNT.—

5 “(i) IN GENERAL.—The base maxi-
6 mum Federal amount for a State is an
7 amount equal to the State’s applicable per-
8 centage (as determined under clause (ii))
9 of the State’s total maximum amount (as
10 determined under clause (iii)).

11 “(ii) STATE’S APPLICABLE PERCENT-
12 AGE.—A State’s applicable percentage de-
13 termined under this clause is a percentage
14 equal to the quotient of—

15 “(I) the amount of Federal funds
16 paid to the State for the furnishing of
17 acute medical services to eligible indi-
18 viduals and the provision of adminis-
19 trative services to such individuals in
20 fiscal year 1993, divided by

21 “(II) the amount of Federal
22 funds paid to all States for the fur-
23 nishing of acute medical services to el-
24 igible individuals and the provision of

1 administrative services to such indi-
2 viduals in fiscal year 1993.

3 “(iii) STATE’S TOTAL MAXIMUM
4 AMOUNT.—A State’s total maximum
5 amount determined under this clause is an
6 amount equal to the applicable percentage
7 of the total amount of Federal funds paid
8 to all States for the furnishing of acute
9 medical services to eligible individuals and
10 the provision of administrative services to
11 such individuals in fiscal year 1993.

12 “(c) MINIMUM EXPENDITURE BY STATES.—

13 “(1) IN GENERAL.—For the purpose of furnish-
14 ing acute medical services to eligible individuals and
15 providing administrative services to such individuals
16 in a fiscal year, a State shall incur expenditures
17 which are at least equal to the product of—

18 “(A) the State’s updated per capita
19 amount, and

20 “(B) the total number of eligible individ-
21 ual’s receiving acute medical services in the
22 State during such fiscal year.

23 “(2) UPDATED PER CAPITA AMOUNT.—For pur-
24 poses of paragraph (1)(A)—

1 “(A) IN GENERAL.—The updated per cap-
2 ita amount for a State shall be—

3 “(i) for fiscal year 1995, an amount
4 equal to the State’s base per capita
5 amount, and

6 “(ii) for fiscal year 1996 and each
7 succeeding fiscal year, an amount equal to
8 the amount determined under this sub-
9 paragraph for the first preceding fiscal
10 year updated by the percentage change in
11 the consumer price index between such
12 first preceding fiscal year and the second
13 preceding fiscal year (as determined by the
14 Secretary of Commerce).

15 “(B) BASE PER CAPITA AMOUNT.—The
16 base per capita amount for a State shall be an
17 amount equal to the quotient of—

18 “(i) the total amount of State expend-
19 itures in fiscal year 1993 for the furnish-
20 ing of acute medical services to eligible in-
21 dividuals and the provision of administra-
22 tive services to such individuals, divided by

23 “(ii) the total number of eligible indi-
24 viduals receiving acute medical services
25 during fiscal year 1993.

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

2 “(1) ACUTE MEDICAL SERVICES.—The term
3 ‘acute medical services’ means all of the care and
4 services furnished to individuals eligible under a
5 State plan under this title except the following:

6 “(A) Nursing facility services (as defined
7 in section 1905(f)).

8 “(B) Intermediate care facility for the
9 mentally retarded services (as defined in section
10 1905(d)).

11 “(C) Personal care services (as described
12 in section 1905(a)(24)).

13 “(D) Private duty nursing services (as re-
14 ferred to in section 1905(a)(8)).

15 “(E) Home or community-based services
16 furnished under a waiver granted under sub-
17 section (c), (d), or (e) of section 1915.

18 “(F) Home and community care furnished
19 to functionally disabled elderly individuals
20 under section 1929.

21 “(G) Community supported living arrange-
22 ments services under section 1930.

23 “(H) Case-management services (as de-
24 scribed in section 1915(g)(2)).

1 “(I) Home health care services (as referred
2 to in section 1905(a)(7)).

3 “(J) Hospice care (as defined in section
4 1905(o)).

5 “(2) ELIGIBLE INDIVIDUAL.—The term ‘eligible
6 individual’ means an individual who is eligible to re-
7 ceive medical assistance under the State plan under
8 this title.

9 “(3) FEDERAL FUNDS.—The term ‘Federal
10 funds’ means funds paid to a State under section
11 1903, excluding funds paid under such section with
12 respect to expenditures by such State in the form of
13 payment adjustments made by such State in order
14 to comply with the requirement under section
15 1902(a)(13)(A) (as in effect on the date of the en-
16 actment of this section) that payments to hospitals
17 to take into account the situation of hospitals which
18 serve a disproportionate number of low income pa-
19 tients with special needs.

20 “(4) STATE EXPENDITURES.—The term ‘State
21 expenditures’ means expenditures by a State under
22 its plan under this title, excluding expenditures in
23 the form of payment adjustments made by such
24 State in order to comply with the requirement under
25 section 1902(a)(13)(A) (as in effect on the date of

1 the enactment of this section) that payments made
 2 by the State to hospitals take into account the situa-
 3 tion of hospitals which serve a disproportionate
 4 number of low income patients with special needs.”.

5 (b) EFFECTIVE DATE.—The amendment made by
 6 subsection (a) shall be effective with respect to fiscal years
 7 beginning after September 30, 1994.

8 **SEC. 212. WAIVERS FOR THE FURNISHING OF ACUTE MEDI-**
 9 **CAL SERVICES UNDER THE MEDICAID PRO-**
 10 **GRAM.**

11 (a) IN GENERAL.—Title XIX of the Social Security
 12 Act (42 U.S.C. 1396 et seq.) is amended by redesignating
 13 section 1932 as section 1933 and by inserting after section
 14 1931 the following new section:

15 “WAIVERS FOR THE FURNISHING OF ACUTE MEDICAL
 16 SERVICES UNDER THE MEDICAID PROGRAM

17 “SEC. 1932. (a) IN GENERAL.—The Secretary shall
 18 establish a process under which a State with a State plan
 19 approved under this title may apply for waivers of any
 20 of the requirements under this title in order to establish
 21 innovative and cost effective programs for furnishing acute
 22 medical services (as defined in section 1931(d)(1)) to eligi-
 23 ble individuals (as defined in section 1931(d)(2)).

24 “(b) APPLICATION FOR WAIVERS.—

25 “(1) IN GENERAL.—In order to receive a waiver
 26 under subsection (a), a State shall submit an appli-

1 cation to the Secretary at such time and containing
2 such information as the Secretary determines appro-
3 priate.

4 “(2) APPROVAL OF APPLICATION.—

5 “(A) INITIAL REVIEW.—Within 60 days
6 after an application is submitted by the State
7 under this subsection, the Secretary shall review
8 and approve such application or provide the
9 State with a list of the modifications that are
10 necessary for such application to be approved.

11 “(B) ADDITIONAL REVIEW.—Within 60
12 days after a State resubmits any application
13 under this subsection, the Secretary shall review
14 and approve such application or provide the
15 State with a summary of which items included
16 on the list provided to the State under subpara-
17 graph (A) remain unsatisfied. A State may re-
18 submit an application under this subparagraph
19 as many times as necessary to gain approval.

20 “(c) DURATION OF WAIVERS.—Except as provided in
21 subsection (d), any waiver under this section shall be
22 granted for a period of 5 years, and renewed for subse-
23 quent 5-year periods, unless the Secretary determines that
24 the State has failed to furnish acute medical services in
25 accordance with the terms of the waiver and any provi-

1 sions of this title with respect to which the Secretary has
2 not granted a waiver.

3 “(d) TERMINATION OF WAIVERS.—The Secretary
4 may terminate a waiver granted under this section at any
5 time if the Secretary determines that the State has failed
6 to furnish acute medical services in accordance with the
7 terms of the waiver and any provisions of this title with
8 respect to which the Secretary has not granted a waiver.

9 “(e) REPORTS.—

10 “(1) IN GENERAL.—The State shall, through
11 an independent entity, evaluate the programs oper-
12 ated under a waiver granted under this section and
13 submit interim and final reports to the Secretary at
14 such times and containing such information as the
15 Secretary shall require.

16 “(2) REPORT TO CONGRESS.—Not later than
17 60 days after the receipt of a final report by the
18 State regarding a waiver granted under this section,
19 the Secretary shall submit a report to Congress.”.

20 (b) EFFECTIVE DATE.—The amendment made by
21 subsection (a) shall be effective with respect to fiscal years
22 beginning after September 30, 1994.

23 **SEC. 213. TERMINATION OF DISPROPORTIONATE SHARE**
24 **PAYMENTS.**

25 (a) IN GENERAL.—

1 (1) ELIMINATION OF STATE PLAN REQUIRE-
2 MENT.—Section 1902(a)(13) of the Social Security
3 Act (42 U.S.C. 1396a(a)(13)) is amended by strik-
4 ing “which, in the case of hospitals, take into ac-
5 count the situation of hospitals which serve a dis-
6 proportionate number of low income patients with
7 special needs and”.

8 (2) CONFORMING AMENDMENTS.—(A) Section
9 1923 of such Act (42 U.S.C. 1396r-4) is repealed.

10 (B) Section 1902(a)(55) of such Act (42 U.S.C.
11 1396a(a)(55)) is amended by striking “facilities de-
12 fined as disproportionate share hospitals under sec-
13 tion 1923(a)(1)(A) and”.

14 (C) Section 1902(s) of such Act (42 U.S.C.
15 1396a(s)) is amended by striking “, and to children
16 who have not attained the age of 6 years and who
17 receive such services in a disproportionate share hos-
18 pital described in section 1923(b)(1),”.

19 (D) Section 1903(a)(1) of such Act (42 U.S.C.
20 1396b(a)(1)) is amended by striking “and sub-
21 section 1923(f)”.

22 (E) Section 1903(d)(6) of such Act (42 U.S.C.
23 1396b(d)(6)) is amended—

24 (i) by striking “(6)(A)” and inserting
25 “(6)”.

1 (ii) by striking “(i)” and “(ii)” and insert-
2 ing “(A)” and “(B)”, respectively, and

3 (iii) by striking subparagraph (B).

4 (b) EFFECTIVE DATE.—The amendments made by
5 this section shall be effective on and after October 1,
6 1996.

7 **SEC. 214. GRANTS FOR HEALTH INSURANCE COVERAGE,**
8 **ACUTE MEDICAL SERVICES, PREVENTIVE**
9 **CARE, AND DISEASE PREVENTION.**

10 (a) IN GENERAL.—Title XIX of the Social Security
11 Act (42 U.S.C. 1396 et seq.) is amended by redesignating
12 section 1933 as section 1934 and by inserting after section
13 1932 the following new section:

14 “GRANTS FOR HEALTH INSURANCE COVERAGE, ACUTE
15 MEDICAL SERVICES, PREVENTIVE CARE, AND DIS-
16 EASE PREVENTION

17 “SEC. 1933. (a) IN GENERAL.—The Secretary shall
18 provide grants to States for the purpose of conducting
19 State programs under which individuals with incomes
20 below 150 percent of the income official poverty line are
21 provided health insurance coverage, acute medical serv-
22 ices, preventive care, and disease prevention services. A
23 State receiving a grant under this section shall conduct
24 a program described in this section in consultation with
25 the Secretary and in any manner determined appropriate
26 by the State which is in accordance with subsection (b).

1 “(b) REQUIREMENTS ON PROGRAMS.—

2 “(1) PRIORITY OF BENEFITS.—A State pro-
3 gram conducted under this section shall give priority
4 to individuals who—

5 “(A) are ineligible for benefits under a
6 State plan under this title,

7 “(B) are eligible for the tax credit estab-
8 lished under section 34A of the Internal Reve-
9 nue Code of 1986, and

10 “(C) have unreimbursed expenses for
11 health insurance coverage and medical care—

12 “(i) exceeding 5 percent of the indi-
13 vidual’s adjusted gross income, and

14 “(ii) not otherwise taken into account
15 in determining the credit under section
16 34A of the Internal Revenue Code of 1986
17 for such individual.

18 “(2) SERVICES.—

19 “(A) MANDATORY.—A State program con-
20 ducted under this section shall provide financial
21 assistance as determined by the State for pur-
22 chasing health insurance coverage and paying
23 medical bills to individuals described in para-
24 graph (1).

1 “(B) OPTIONAL.— A State program con-
2 ducted under this section may provide—

3 “(i) medical services directly to eligi-
4 ble individuals,

5 “(ii) primary and preventive care serv-
6 ices to underserved populations,

7 “(iii) funding for community and mi-
8 grant health centers,

9 “(iv) delivery of outpatient primary
10 and preventive health services,

11 “(v) improvements to the availability
12 and quality of emergency medical services
13 and trauma care,

14 “(vi) transportation of victims of med-
15 ical emergencies, including air transpor-
16 tation for victims of medical emergencies
17 in rural areas, and

18 “(vii) telecommunications systems be-
19 tween rural medical facilities and other
20 medical facilities which have expertise in
21 certain areas or equipment that can be uti-
22 lized by rural facilities through such sys-
23 tems.

24 “(c) FEDERAL FUNDS AVAILABLE FOR GRANTS.—

1 “(1) IN GENERAL.—The total amount of Fed-
2 eral funds available under this title for grants to
3 States under this section shall be—

4 “(A) \$8,500,000,000 for fiscal year 1998,
5 and

6 “(B) for each fiscal year thereafter, the
7 amount for the preceding fiscal year increased
8 by 10 percent of such amount.

9 “(2) FORMULA FOR DISTRIBUTION OF
10 GRANTS.—

11 “(A) IN GENERAL.—The Secretary shall
12 pay to each State conducting a program under
13 this section for a fiscal year an amount equal
14 to the State’s percentage (as determined under
15 subparagraph (B)) of the total amount available
16 for grants under this section as provided in
17 paragraph (1).

18 “(B) STATE PERCENTAGE.—

19 “(i) IN GENERAL.—A State’s percent-
20 age determined under this subparagraph
21 for a fiscal year is a percentage equal to
22 the quotient of—

23 “(I) the number of individuals in
24 the State’s needy population (as de-

1 fined in clause (ii)) for such fiscal
2 year, divided by

3 “(II) the total number of individ-
4 uals in the needy populations of all
5 States for the fiscal year.

6 “(ii) STATE NEEDY POPULATION.—
7 The term (State’s needy population)
8 means, with respect to a fiscal year, the
9 number of individuals equal to the product
10 of—

11 “(I) the average number of indi-
12 viduals in the State with incomes
13 below the income official poverty line
14 during the 3 preceding fiscal years (as
15 determined by the Secretary), and

16 (II) the State’s Federal percent-
17 age (as determined under clause (iii)).

18 “(iii) STATE FEDERAL PERCENT-
19 AGE.—

20 “(I) IN GENERAL.—A State’s
21 Federal percentage for a fiscal year is
22 the greater of—

23 “(aa) 1 minus the percent-
24 age determined under subclause
25 (II), or

1 “(bb) 25 percent.

2 “(II) PERCENTAGE DETER-
3 MINED.—The percentage determined
4 under this subclause is the product
5 of—

6 “(aa) .5157, and

7 “(bb) the amount deter-
8 mined under subclause (III).

9 “(III) AMOUNT DETERMINED.—
10 The amount determined under this
11 subclause is the quotient of—

12 “(aa) the State’s share of
13 total taxable resources, divided
14 by

15 “(bb) the State’s share of
16 need.

17 “(d) STATE EXPENDITURES.—

18 “(1) IN GENERAL.—For a fiscal year, a State
19 shall expend for purposes of conducting the State
20 program described in subsection (a) an amount at
21 least equal to the State share percentage for the
22 State (determined under paragraph (2)) of the
23 amount the State is eligible to receive under sub-
24 section (c)(2) for the fiscal year.

1 “(2) STATE SHARE PERCENTAGE.—The State
2 share percentage for a State determined under this
3 paragraph for a fiscal year is a percentage equal to
4 the quotient of—

5 “(A) the percentage determined under sub-
6 section (c)(2)(B)(iii)(II) for the fiscal year, di-
7 vided by

8 “(B) the State’s Federal percentage deter-
9 mined under subsection (c)(2)(B)(iii) for the
10 fiscal year.

11 “(e) OTHER DEFINITIONS.—

12 “(1) INCOME OFFICIAL POVERTY LINE.—For
13 purposes of this section, the term ‘income official
14 poverty line’ means the income official poverty line
15 (as defined by the Office of Management and Budg-
16 et, and revised annually in accordance with section
17 673(2) of the Omnibus Budget Reconciliation Act of
18 1981).

19 “(2) STATE’S SHARE OF TOTAL TAXABLE RE-
20 SOURCES.—

21 “(A) IN GENERAL.—Except as provided in
22 subparagraph (B), the term ‘State share of
23 total taxable resources’ for a fiscal year means
24 an amount equal to the quotient of—

1 “(i) the average of total taxable re-
2 sources for the State (as determined by the
3 Secretary of the Treasury based on data
4 available for the 3 most recent calendar
5 years), divided by

6 “(ii) the average of the total taxable
7 resources for all States (as determined by
8 the Secretary of the Treasury based on
9 data available for the 3 most recent cal-
10 endar years).

11 “(B) SPECIAL RULE FOR THE DISTRICT OF
12 COLUMBIA.—Notwithstanding subparagraph
13 (A), with respect to the District of Columbia,
14 the term ‘State share of total taxable resources’
15 for a fiscal year means an amount equal to the
16 quotient of—

17 “(i) the average of the total personal
18 income in such District for the 3 preceding
19 calendar years (as determined by the Sec-
20 retary of Commerce), divided by

21 “(ii) the average of the total personal
22 income for all States for the 3 preceding
23 calendar years (as determined by the Sec-
24 retary of Commerce).

1 “(3) STATE’S SHARE OF NEED.—The term
2 ‘State’s share of need’ for a fiscal year means the
3 quotient of—

4 “(A) the average number of individuals in
5 the State with incomes below the income official
6 poverty line for the 3 preceding fiscal years (as
7 determined by the Secretary), divided by

8 “(B) the average number of individuals in
9 all States with incomes below the income offi-
10 cial poverty line for the 3 preceding fiscal years
11 (as determined by the Secretary).”.

12 (b) EFFECTIVE DATE.—The amendment made by
13 subsection (a) shall be effective with respect to fiscal years
14 beginning after September 30, 1997.

15 **TITLE III—HEALTH CARE** 16 **LIABILITY REFORM**

17 **SEC. 301. SHORT TITLE.**

18 This title may be cited as the “Health Care Liability
19 Reform Act of 1994”.

20 **SEC. 302. DEFINITIONS.**

21 For purposes of this title the term—

22 (1) “approved by the Food and Drug Adminis-
23 tration” means, with respect to a health care prod-
24 uct, that the health care product—

1 (A) was subject to premarket approval by
2 the Food and Drug Administration with respect
3 to the safety of the formulation or performance
4 of the aspect of such drug or device which
5 caused the claimant's harm or the adequacy of
6 the packaging or labeling of such drug or de-
7 vice, and such drug or device was approved by
8 the Food and Drug Administration; or

9 (B) is generally recognized as safe and ef-
10 fective under conditions established by the Food
11 and Drug Administration and applicable regula-
12 tions, including packaging and labeling regula-
13 tions;

14 (2) "arbitration" means a dispute resolution
15 process in which the parties submit the dispute out-
16 side of a Federal or State civil justice system for
17 resolution by a person or panel of persons;

18 (3) "economic losses" means losses for hospital
19 and medical expenses, lost wages, lost employment,
20 and other pecuniary losses;

21 (4) "health care malpractice action" means a
22 civil action alleging a health care malpractice claim
23 against a health care provider or health care profes-
24 sional;

1 (5) “health care malpractice claim” means any
2 claim relating to the provision of (or the failure to
3 provide) health care services based on negligence or
4 gross negligence, breach of express or implied war-
5 ranty or contract, or failure to discharge a duty to
6 warn or instruct to obtain consent;

7 (6) “health care product” means a drug, as de-
8 fined under section 201(g)(1) of the Federal Food,
9 Drug, and Cosmetic Act (21 U.S.C. 321(g)(1)) or a
10 medical device, as defined under section 201(h) of
11 the Federal Food, Drug, and Cosmetic Act (21
12 U.S.C. 321(h)), or any combination thereof;

13 (7) “health care product liability action” means
14 a civil action alleging a health care product liability
15 claim against a manufacturer or seller of a health
16 care product or against a health care provider or
17 health care professional;

18 (8) “health care product liability claim” means
19 any claim relating to harm alleged to have been
20 caused by a health care product;

21 (9) “health care professional” means any indi-
22 vidual who provides health care services in a State
23 and who is required by State law or regulation to be
24 licensed or certified by the State to provide such
25 services in the State, including a physician, nurse,

1 chiropractor, nurse midwife, physical therapist, so-
2 cial worker, or physician assistant;

3 (10) “health care provider” means any organi-
4 zation or institution that is engaged in the delivery
5 of health care services in a State and that is re-
6 quired by State law or regulation to be licensed or
7 certified by the State to engage in the delivery of
8 such services in the State;

9 (11) “injury” means any injury, illness, disease,
10 or other harm that is the subject of a health care
11 malpractice claim; and

12 (12) “noneconomic losses” means losses for
13 physical and emotional pain, suffering, inconven-
14 ience, physical impairment, mental anguish, dis-
15 figurement, loss of enjoyment of life, and other
16 nonpecuniary losses.

17 **SEC. 303. HEALTH CARE MALPRACTICE.**

18 (a) APPLICATION.—The provisions of this section
19 shall apply to any health care malpractice action filed in
20 any Federal or State court and any health care mal-
21 practice claim resolved through arbitration.

22 (b) PAYMENTS.—No person may be required to pay
23 more than \$100,000 in a single payment in damages for
24 expenses to be incurred in the future, but such person
25 shall be permitted to make such payments on a periodic

1 basis. The periods for such payments shall be determined
2 by the court, based on projections of when expenses are
3 likely to be incurred.

4 (c) DAMAGES.—(1) The total amount of damages re-
5 ceived by an individual shall be reduced, in accordance
6 with paragraph (2), by any other payment which has been
7 made or which will be made to such individual to com-
8 pensate such individual for an injury, including payments
9 under—

10 (A) Federal or State disability or sickness pro-
11 grams;

12 (B) Federal, State, or private health insurance
13 programs;

14 (C) private disability insurance programs;

15 (D) employer wage continuation programs; and

16 (E) any other source of payment intended to
17 compensate such individual for such injury.

18 (2) The amount by which an award of damages to
19 an individual for an injury shall be reduced under para-
20 graph (1) shall be—

21 (A) the total amount of any payments (other
22 than such award) which have been made or which
23 will be made to such individual to compensate such
24 individual for such injury; minus

1 (B) the amount paid by such individual (or by
2 the spouse, parent, or legal guardian of such individ-
3 ual) to secure the payments described under sub-
4 paragraph (A).

5 (d) STATUTE OF LIMITATIONS.—(1) Except as pro-
6 vided under paragraph (2), no health care malpractice
7 claim may be initiated after the expiration of the 2-year
8 period that begins on the date the alleged injury should
9 reasonably have been discovered, or the expiration of the
10 4-year period that begins on the date the alleged injury
11 occurred, whichever is later.

12 (2) In the case of an alleged injury suffered by a
13 minor who has not attained 6 years of age, no health care
14 malpractice claim may be initiated after the expiration of
15 the 2-year period that begins on the date the alleged injury
16 should reasonably have been discovered, or the date on
17 which the minor attains 10 years of age, whichever is
18 later.

19 (e) ATTORNEYS' FEES.—With respect to any health
20 care malpractice action or any health care malpractice
21 claim, attorneys' fees may not exceed—

22 (1) 25 percent of the first \$150,000 of any
23 award or settlement under such action or claim; and

24 (2) 15 percent of any additional amounts in ex-
25 cess of \$150,000.

1 **SEC. 304. HEALTH CARE PRODUCT LIABILITY OF MANUFAC-**
2 **TURER OR SELLER.**

3 (a) NONAPPLICATION OF STRICT LIABILITY.—A
4 manufacturer or seller of a health care product approved
5 by the Food and Drug Administration shall not be strictly
6 liable for any injury alleged to have resulted from—

7 (1) a defect in the design of the health care
8 product; or

9 (2) a failure to warn or instruct regarding a
10 risk posed by the health care product that was nei-
11 ther known nor reasonably knowable at the time the
12 health care product left the control of the manufac-
13 turer or seller.

14 (b) DUTY TO WARN.—(1) A manufacturer or seller
15 of a health care product that is to be prescribed by, or
16 used at the direction of, a health care professional shall
17 not be liable for harm allegedly caused by a failure to warn
18 or instruct the ultimate user or recipient of the product
19 about a risk if the manufacturer or seller provided ade-
20 quate warning or instruction to the user's or recipient's
21 health care professional.

22 (2) This subsection shall not apply to any health care
23 product to which the Food and Drug Administration spe-
24 cifically provides that a warning or instruction regarding
25 such product shall be given by the manufacturer or seller
26 directly to the ultimate user or recipient.

1 **SEC. 305. GENERAL PROVISIONS RELATING TO HEALTH**
2 **CARE LIABILITY.**

3 (a) LIMITATION ON NONECONOMIC DAMAGES.—(1)
4 Except as provided under paragraph (2), the total amount
5 of damages which may be awarded to an individual and
6 the family members of such individual for noneconomic
7 losses resulting from an injury which is the subject of a
8 health care malpractice claim or a health care product li-
9 ability claim may not exceed \$250,000, regardless of the
10 number of defendants against whom the claim is brought,
11 the number of claims brought with respect to the injury,
12 or the number of actions brought with respect to the in-
13 jury.

14 (2)(A) In any jury trial, the jury shall not be in-
15 formed of the limitation established under paragraph (1).
16 If the jury awards an amount for noneconomic damages
17 that exceeds \$250,000, the court shall reduce the award
18 to \$250,000 unless the court finds that special cir-
19 cumstances (such as egregious injury) would make such
20 reduction unjust.

21 (B) In any case in which the court finds a reduction
22 under subparagraph (A) would be unjust, the court may—

23 (i) decline to reduce such award; or

24 (ii) reduce such award by a lesser amount than
25 provided for under subparagraph (A).

1 (b) SEVERAL LIABILITY FOR NONECONOMIC LOSS.—

2 (1) In any health care malpractice action or health care
3 product liability action the liability of each defendant for
4 noneconomic loss and for punitive damages shall be sev-
5 eral only and shall not be joint. Each defendant shall be
6 liable only for the amount of noneconomic loss and puni-
7 tive damages allocated to such defendant in direct propor-
8 tion to such defendant's percentage of responsibility as de-
9 termined under paragraph (2). A separate judgment shall
10 be rendered against such defendant for that amount.

11 (2) For purposes of this subsection, the trier of fact
12 shall determine the proportion of responsibility of each
13 party for the claimant's harm.

14 **SEC. 306. PUNITIVE DAMAGES.**

15 (a) IN GENERAL.—Punitive damages may, if other-
16 wise permitted by applicable law, be awarded against a
17 defendant in a health care malpractice action or a health
18 care product liability action only if the claimant estab-
19 lishes by clear and convincing evidence that the harm suf-
20 fered by the claimant was the result of conduct manifest-
21 ing conscious, flagrant indifference to the health of the
22 claimant or to the health of those persons who might be
23 harmed by the health care product.

24 (b) DETERMINATION OF AMOUNT.—The amount of
25 any punitive damages award shall be determined (subject

1 to appellate review as permitted by applicable law) by the
2 trial judge.

3 (c) LIMITATION CONCERNING CERTAIN HEALTH
4 CARE PRODUCTS.—Punitive damages shall not be award-
5 ed against a manufacturer or seller of a health care prod-
6 uct approved by the Food and Drug Administration where
7 that health care product caused the claimant’s harm.

8 **SEC. 307. EXCEPTIONS.**

9 The provisions of sections 304(a) and 306(c) shall
10 not apply in any case in which—

11 (1) the defendant, before or after premarket ap-
12 proval of a drug or device, withheld from or mis-
13 represented to the Food and Drug Administration or
14 any other agency or official of the Federal Govern-
15 ment required information that is material and rel-
16 evant to the performance of such drug or device and
17 is causally related to the harm which the claimant
18 allegedly suffered; or

19 (2) the defendant made an illegal payment to
20 an official of the Food and Drug Administration for
21 the purpose of either securing or maintaining ap-
22 proval of such drug or device.

23 **SEC. 308. RULES OF CONSTRUCTION.**

24 Nothing in this title shall be construed to—

1 (1) waive or affect any defense of sovereign im-
2 munity asserted by any State under any provision of
3 law;

4 (2) waive or affect any defense of sovereign im-
5 munity asserted by the United States;

6 (3) affect the applicability of any provision of
7 the Foreign Sovereign Immunities Act of 1976;

8 (4) preempt State choice-of-law rules with re-
9 spect to claims brought by a foreign nation or a citi-
10 zen of a foreign nation;

11 (5) affect the right of any court to transfer
12 venue or to apply the law of a foreign nation or to
13 dismiss a claim of a foreign nation or of a citizen
14 of a foreign nation on the grounds of inconvenient
15 forum;

16 (6) restrict or limit the preemptive effect of any
17 other Federal law; or

18 (7) create any cause of action under Federal
19 law.

1 **TITLE IV—ADMINISTRATIVE**
2 **COST SAVINGS**
3 **Subtitle A—Standardization of**
4 **Claims Processing**

5 **SEC. 401. ADOPTION OF DATA ELEMENTS, UNIFORM**
6 **CLAIMS, AND UNIFORM ELECTRONIC TRANS-**
7 **MISSION STANDARDS.**

8 (a) IN GENERAL.—The Secretary shall adopt stand-
9 ards relating to each of the following:

10 (1) Data elements for use in paper and elec-
11 tronic claims processing under health insurance
12 plans, as well as for use in utilization review and
13 management of care (including data fields, formats,
14 and medical nomenclature, and including plan bene-
15 fit and insurance information).

16 (2) Uniform claims forms (including uniform
17 procedure and billing codes for uses with such forms
18 and including information on other health insurance
19 plans that may be liable for benefits).

20 (3) Uniform electronic transmission of the data
21 elements (for purposes of billing and utilization re-
22 view).

23 Standards under paragraph (3) relating to electronic
24 transmission of data elements for claims for services shall
25 supersede (to the extent specified in such standards) the

1 standards adopted under paragraph (2) relating to the
2 submission of paper claims for such services. Standards
3 under paragraph (3) shall include protections to assure
4 the confidentiality of patient-specific information and to
5 protect against the unauthorized use and disclosure of in-
6 formation.

7 (b) USE OF TASK FORCES.—In adopting standards
8 under this section—

9 (1) the Secretary shall take into account the
10 recommendations of current task forces, including at
11 least the Workgroup on Electronic Data Inter-
12 change, National Uniform Billing Committee, the
13 Uniform Claim Task Force, and the Computer-based
14 Patient Record Institute;

15 (2) the Secretary shall consult with the Na-
16 tional Association of Insurance Commissioners (and,
17 with respect to standards under subsection (a)(3),
18 the American National Standards Institute); and

19 (3) the Secretary shall, to the maximum extent
20 practicable, seek to make the standards consistent
21 with any uniform clinical data sets which have been
22 adopted and are widely recognized.

23 (c) DEADLINES FOR PROMULGATION.—The Sec-
24 retary shall promulgate the standards under—

1 (1) subsection (a)(1) relating to claims process-
2 ing data, by not later than 12 months after the date
3 of the enactment of this Act;

4 (2) subsection (a)(2) (relating to uniform
5 claims forms) by not later than 12 months after the
6 date of the enactment of this Act; and

7 (3)(A) subsection (a)(3) relating to trans-
8 mission of information concerning hospital and phy-
9 sicians services, by not later than 24 months after
10 the date of the enactment of this Act, and

11 (B) subsection (a)(3) relating to transmission
12 of information on other services, by such later date
13 as the Secretary may determine it to be feasible.

14 (d) REPORT TO CONGRESS.—Not later than 3 years
15 after the date of the enactment of this Act, the Secretary
16 shall report to Congress recommendations regarding re-
17 structuring the medicare peer review quality assurance
18 program given the availability of hospital data in elec-
19 tronic form.

20 **SEC. 402. APPLICATION OF STANDARDS.**

21 (a) IN GENERAL.—If the Secretary determines, at
22 the end of the 2-year period beginning on the date that
23 standards are adopted under section 401 with respect to
24 classes of services, that a significant number of claims for
25 benefits for such services under health insurance plans are

1 not being submitted in accordance with such standards,
2 the Secretary may require, after notice in the Federal
3 Register of not less than 6 months, that all providers of
4 such services must submit claims to health insurance plans
5 in accordance with such standards. The Secretary may
6 waive the application of such a requirement in such cases
7 as the Secretary finds that the imposition of the require-
8 ment would not be economically practicable.

9 (b) SIGNIFICANT NUMBER.—The Secretary shall
10 make an affirmative determination described in subsection
11 (a) for a class of services only if the Secretary finds that
12 there would be a significant, measurable additional gain
13 in efficiencies in the health care system that would be ob-
14 tained by imposing the requirement described in such
15 paragraph with respect to such services.

16 (c) APPLICATION OF REQUIREMENT.—

17 (1) IN GENERAL.—If the Secretary imposes the
18 requirement under subsection (a)—

19 (A) in the case of a requirement that im-
20 poses the standards relating to electronic trans-
21 mission of claims for a class of services, each
22 health care provider that furnishes such services
23 for which benefits are payable under a health
24 insurance plan shall transmit electronically and
25 directly to the plan on behalf of the beneficiary

1 involved a claim for such services in accordance
2 with such standards;

3 (B) any health insurance plan may reject
4 any claim subject to the standards adopted
5 under section 401 but which is not submitted in
6 accordance with such standards;

7 (C) it is unlawful for a health insurance
8 plan (i) to reject any such claim on the basis
9 of the form in which it is submitted if it is sub-
10 mitted in accordance with such standards or (ii)
11 to require, for the purpose of utilization review
12 or as a condition of providing benefits under
13 the plan, a provider to transmit medical data
14 elements that are inconsistent with the stand-
15 ards established under section 401(a)(1); and

16 (D) the Secretary may impose a civil
17 money penalty on any provider that knowingly
18 and repeatedly submits claims in violation of
19 such standards or on any health insurance plan
20 (other than a health insurance plan described in
21 paragraph (2)) that knowingly and repeatedly
22 rejects claims in violation of subparagraph (B),
23 in an amount not to exceed \$100 for each such
24 claim.

1 The provisions of section 1128A of the Social Secu-
2 rity Act (other than the first sentence of subsection
3 (a) and other than subsection (b)) shall apply to a
4 civil money penalty under subparagraph (D) in the
5 same manner as such provisions apply to a penalty
6 or proceeding under section 1128A(a) of such Act.

7 (2) PLANS SUBJECT TO EFFECTIVE STATE REG-
8 ULATION.—A plan described in this paragraph is a
9 health insurance plan—

10 (A) that is subject to regulation by a
11 State, and

12 (B) with respect to which the Secretary
13 finds that—

14 (i) the State provides for application
15 of the standards established under section
16 401, and

17 (ii) the State regulatory program pro-
18 vides for the appropriate and effective en-
19 forcement of such standards.

20 (d) TREATMENT OF REJECTIONS.—If a plan rejects
21 a claim pursuant to subsection (c)(1), the plan shall per-
22 mit the person submitting the claim a reasonable oppor-
23 tunity to resubmit the claim on a form or in an electronic
24 manner that meets the requirements for acceptance of the
25 claim under such subsection.

1 **SEC. 403. PERIODIC REVIEW AND REVISION OF STAND-**
2 **ARDS.**

3 (a) IN GENERAL.—The Secretary shall—

4 (1) provide for the ongoing receipt and review
5 of comments and suggestions for changes in the
6 standards adopted and promulgated under section
7 401;

8 (2) establish a schedule for the periodic review
9 of such standards; and

10 (3) based upon such comments, suggestions,
11 and review, revise such standards and promulgate
12 such revisions.

13 (b) APPLICATION OF REVISED STANDARDS.—If the
14 Secretary under subsection (a) revises the standards de-
15 scribed in 401, then, in the case of any claim for benefits
16 submitted under a health insurance plan more than the
17 minimum period (of not less than 6 months specified by
18 the Secretary) after the date the revision is promulgated
19 under subsection (a)(3), such standards shall apply under
20 section 402 instead of the standards previously promul-
21 gated.

22 **SEC. 404. HEALTH INSURANCE PLAN DEFINED.**

23 In this title, the term “health insurance plan” has
24 the meaning given such term in section 111(b) and in-
25 cludes—

1 (1) the medicare program (under title XVIII of
2 the Social Security Act) and medicare supplemental
3 health insurance, and

4 (2) a State medicaid plan (approved under title
5 XIX of such Act).

6 **Subtitle B—Electronic Medical**
7 **Data Standards**

8 **SEC. 411. MEDICAL DATA STANDARDS FOR HOSPITALS AND**
9 **OTHER PROVIDERS.**

10 (a) PROMULGATION OF HOSPITAL DATA STAND-
11 ARDS.—

12 (1) IN GENERAL.—Between July 1, 1995, and
13 January 1, 1996, the Secretary shall promulgate
14 standards described in subsection (b) for hospitals
15 concerning electronic medical data.

16 (2) REVISION.—The Secretary may from time
17 to time revise the standards promulgated under this
18 subsection.

19 (b) CONTENTS OF DATA STANDARDS.—The stand-
20 ards promulgated under subsection (a) shall include at
21 least the following:

22 (1) A definition of a standard set of data ele-
23 ments for use by utilization and quality control peer
24 review organizations.

1 (2) A definition of the set of comprehensive
2 data elements, which set shall include for hospitals
3 the standard set of data elements defined under
4 paragraph (1).

5 (3) Standards for an electronic patient care in-
6 formation system with data obtained at the point of
7 care, including standards to protect against the un-
8 authorized use and disclosure of information.

9 (4) A specification of, and manner of presen-
10 tation of, the individual data elements of the sets
11 and system under this subsection.

12 (5) Standards concerning the transmission of
13 electronic medical data.

14 (6) Standards relating to confidentiality of pa-
15 tient-specific information.

16 The standards under this section shall be consistent with
17 standards for data elements established under section 401.

18 (c) OPTIONAL DATA STANDARDS FOR OTHER PRO-
19 VIDERS.—

20 (1) IN GENERAL.—The Secretary may promul-
21 gate standards described in paragraph (2) concern-
22 ing electronic medical data for providers that are not
23 hospitals. The Secretary may from time to time re-
24 vise the standards promulgated under this sub-
25 section.

1 (2) CONTENTS OF DATA STANDARDS.—The
2 standards promulgated under paragraph (1) for non-
3 hospital providers may include standards comparable
4 to the standards described in paragraphs (2), (4),
5 and (5) of subsection (b) for hospitals.

6 (d) CONSULTATION.—In promulgating and revising
7 standards under this section, the Secretary shall—

8 (1) consult with the American National Stand-
9 ards Institute, hospitals, with the advisory commis-
10 sion established under section 415, and with other
11 affected providers, health insurance plans, and other
12 interested parties, and

13 (2) take into consideration, in developing stand-
14 ards under subsection (b)(1), the data set used by
15 the utilization and quality control peer review pro-
16 gram under part B of title XI of the Social Security
17 Act.

18 **SEC. 412. APPLICATION OF ELECTRONIC DATA STANDARDS**

19 **TO CERTAIN HOSPITALS.**

20 (a) MEDICARE REQUIREMENT FOR SHARING OF
21 HOSPITAL INFORMATION.—As of January 1, 1996, sub-
22 ject to paragraph (2), each hospital, as a requirement of
23 each participation agreement under section 1866 of the
24 Social Security Act, shall—

1 (1) maintain clinical data included in the set of
2 comprehensive data elements under section
3 411(b)(2) in electronic form on all inpatients,

4 (2) upon request of the Secretary or of a utili-
5 zation and quality control peer review organization
6 (with which the Secretary has entered into a con-
7 tract under part B of title XI of such Act), transmit
8 electronically the data set, and

9 (3) upon request of the Secretary, or of a fiscal
10 intermediary or carrier, transmit electronically any
11 data (with respect to a claim) from such data set,
12 in accordance with the standards promulgated under sec-
13 tion 411(a).

14 (b) WAIVER AUTHORITY.—Until January 1, 2000:

15 (1) The Secretary may waive the application of
16 the requirements of subsection (a) for a hospital
17 that is a small rural hospital, for such period as the
18 hospital demonstrates compliance with such require-
19 ments would constitute an undue financial hardship.

20 (2) The Secretary may waive the application of
21 the requirements of subsection (a) for a hospital
22 that is in the process of developing a system to pro-
23 vide the required data set and executes agreements
24 with its fiscal intermediary and its utilization and
25 quality control peer review organization that the hos-

1 pital will meet the requirements of subsection (a) by
2 a specified date (not later than January 1, 2000).

3 (3) The Secretary may waive the application of
4 the requirement of subsection (a)(1) for a hospital
5 that agrees to obtain from its records the data ele-
6 ments that are needed to meet the requirements of
7 paragraphs (2) and (3) of subsection (a) and agrees
8 to subject its data transfer process to a quality as-
9 surance program specified by the Secretary.

10 (c) APPLICATION TO HOSPITALS OF THE DEPART-
11 MENT OF VETERANS AFFAIRS.—

12 (1) IN GENERAL.—The Secretary of Veterans
13 Affairs shall provide that each hospital of the De-
14 partment of Veterans Affairs shall comply with the
15 requirements of subsection (a) in the same manner
16 as such requirements would apply to the hospital if
17 it were participating in the Medicare program.

18 (2) WAIVER.—The Secretary of Veterans Af-
19 fairs may waive the application of such requirements
20 to a hospital in the same manner as the Secretary
21 of Health and Human Services may waive under
22 subsection (b) the application of the requirements of
23 subsection (a).

1 **SEC. 413. ELECTRONIC TRANSMISSION TO FEDERAL AGEN-**
2 **CIES.**

3 (a) IN GENERAL.—Effective January 1, 2000, if a
4 provider is required under a Federal program to transmit
5 a data element that is subject to a presentation or trans-
6 mission standard (as defined in subsection (b)), the head
7 of the Federal agency responsible for such program (if not
8 otherwise authorized) is authorized to require the provider
9 to present and transmit the data element electronically in
10 accordance with such a standard.

11 (b) PRESENTATION OR TRANSMISSION STANDARD
12 DEFINED.—In subsection (a), the term “presentation or
13 transmission standard” means a standard, promulgated
14 under subsection (b) or (c) of section 411, described in
15 paragraph (4) or (5) of section 411(b).

16 **SEC. 414. LIMITATION ON DATA REQUIREMENTS WHERE**
17 **STANDARDS IN EFFECT.**

18 (a) IN GENERAL.—If standards with respect to data
19 elements are promulgated under section 411 with respect
20 to a class of provider, a health insurance plan may not
21 require, for the purpose of utilization review or as a condi-
22 tion of providing benefits under the plan, that a provider
23 in the class—

24 (1) provide any data element not in the set of
25 comprehensive data elements specified under such
26 standards, or

1 (2) transmit or present any such data element
2 in a manner inconsistent with the applicable stand-
3 ards for such transmission or presentation.

4 (b) COMPLIANCE.—

5 (1) IN GENERAL.—The Secretary may impose a
6 civil money penalty on any health insurance plan
7 (other than a health insurance plan described in
8 paragraph (2)) that fails to comply with subsection
9 (a) in an amount not to exceed \$100 for each such
10 failure. The provisions of section 1128A of the So-
11 cial Security Act (other than the first sentence of
12 subsection (a) and other than subsection (b)) shall
13 apply to a civil money penalty under this paragraph
14 in the same manner as such provisions apply to a
15 penalty or proceeding under section 1128A(a) of
16 such Act.

17 (2) PLANS SUBJECT TO EFFECTIVE STATE REG-
18 ULATION.—A plan described in this paragraph is a
19 health insurance plan that is subject to regulation by
20 a State, if the Secretary finds that—

21 (A) the State provides for application of
22 the requirement of subsection (a), and

23 (B) the State regulatory program provides
24 for the appropriate and effective enforcement of
25 such requirement with respect to such plans.

1 **SEC. 415. ADVISORY COMMISSION.**

2 (a) IN GENERAL.—The Secretary shall establish an
3 advisory commission including hospital executives, hospital
4 data base managers, physicians, health services research-
5 ers, and technical experts in collection and use of data
6 and operation of data systems. Such commission shall in-
7 clude, as ex officio members, a representative of the Direc-
8 tor of the National Institutes of Health, the Administrator
9 for Health Care Policy and Research, the Secretary of
10 Veterans Affairs, and the Director of the Centers for
11 Disease Control.

12 (b) FUNCTIONS.—The advisory commission shall
13 monitor and advise the Secretary concerning—

14 (1) the standards established under this sub-
15 title, and

16 (2) operational concerns about the implementa-
17 tion of such standards under this subtitle.

18 (c) STAFF.—From the amounts appropriated under
19 subsection (d), the Secretary shall provide sufficient staff
20 to assist the advisory commission in its activities under
21 this section.

22 (d) AUTHORIZATION OF APPROPRIATIONS.—There
23 are authorized to be appropriated \$2,000,000 for each of
24 fiscal years 1995 through 2000 to carry out this section.

1 **Subtitle C—Development and Dis-**
2 **tribution of Comparative Value**
3 **Information**

4 **SEC. 421. STATE COMPARATIVE VALUE INFORMATION PRO-**
5 **GRAMS FOR HEALTH CARE PURCHASING.**

6 (a) PURPOSE.—In order to assure the availability of
7 comparative value information to purchasers of health
8 care in each State, the Secretary shall determine whether
9 each State is developing and implementing a health care
10 value information program that meets the criteria and
11 schedule set forth in subsection (b).

12 (b) CRITERIA AND SCHEDULE FOR STATE PRO-
13 GRAMS.—The criteria and schedule for a State health care
14 value information program in this subsection shall be spec-
15 ified by the Secretary as follows:

16 (1) The State begins promptly after enactment
17 of this Act to develop (directly or through contrac-
18 tual or other arrangements with 1 or more States,
19 coalitions of health insurance purchasers, other enti-
20 ties, or any combination of such arrangements)
21 information systems regarding comparative health
22 values.

23 (2) The information contained in such systems
24 covers at least the average prices of common health
25 care services (as defined in subsection (d)) and

1 health insurance plans, and, where available, meas-
2 ures of the variability of these prices within a State
3 or other market areas.

4 (3) The information described in paragraph (2)
5 is made available within the State beginning not
6 later than 1 year after the date of the enactment of
7 this Act, and is revised as frequently as reasonably
8 necessary, but at intervals of no greater than 1 year.

9 (4) Not later than 6 years after the date of the
10 enactment of this Act the State has developed infor-
11 mation systems that provide comparative costs, qual-
12 ity, and outcomes data with respect to health insur-
13 ance plans and hospitals and made the information
14 broadly available within the relevant market areas.

15 Nothing in this section shall preclude a State from provid-
16 ing additional information, such as information on prices
17 and benefits of different health insurance plans, available.

18 (c) GRANTS TO STATES FOR THE DEVELOPMENT OF
19 STATE PROGRAMS.—

20 (1) GRANT AUTHORITY.—The Secretary may
21 make grants to each State to enable such State to
22 plan the development of its health care value infor-
23 mation program and, if necessary, to initiate the im-
24 plementation of such program. Each State seeking
25 such a grant shall submit an application therefor,

1 containing such information as the Secretary finds
2 necessary to assure that the State is likely to de-
3 velop and implement a program in accordance with
4 the criteria and schedule in subsection (b).

5 (2) OFFSET AUTHORITY.—If, at any time with-
6 in the 3-year period following the receipt by a State
7 of a grant under this subsection, the Secretary is re-
8 quired by section 422 to implement a health care in-
9 formation program in the State, the Secretary may
10 recover the amount of the grant under this sub-
11 section by offset against any other amount payable
12 to the State under the Social Security Act. The
13 amount of the offset shall be made available (from
14 the appropriation account with respect to which the
15 offset was taken) to the Secretary to carry out such
16 section.

17 (3) AUTHORIZATION OF APPROPRIATIONS.—
18 There are authorized to be appropriated such sums
19 as are necessary to make grants under this sub-
20 section, to remain available until expended.

21 (d) COMMON HEALTH CARE SERVICES DEFINED.—
22 In this section, the term “common health care services”
23 includes such procedures as the Secretary may specify and
24 any additional health care services which a State may wish
25 to include in its comparative value information program.

1 (e) STATE DEFINED.—In this title, the term “State”
2 includes the District of Columbia, Puerto Rico, the Virgin
3 Islands, Guam, and American Samoa.

4 **SEC. 422. FEDERAL IMPLEMENTATION.**

5 (a) IN GENERAL.—If the Secretary finds, at any
6 time, that a State has failed to develop or to continue to
7 implement a health care value information program in ac-
8 cordance with the criteria and schedule in section 421(b),
9 the Secretary shall take the actions necessary, directly or
10 through grants or contract, to implement a comparable
11 program in the State.

12 (b) FEES.—Fees may be charged by the Secretary
13 for the information materials provided pursuant to a pro-
14 gram under this section. Any amounts so collected shall
15 be deposited in the appropriation account from which the
16 Secretary’s costs of providing such materials were met,
17 and shall remain available for such purposes until
18 expended.

19 **SEC. 423. COMPARATIVE VALUE INFORMATION CONCERN-**
20 **ING FEDERAL PROGRAMS.**

21 (a) DEVELOPMENT.—The head of each Federal agen-
22 cy with responsibility for the provision of health insurance
23 or of health care services to individuals shall promptly de-
24 velop health care value information relating to each pro-
25 gram that such head administers and covering the same

1 types of data that a State program meeting the criteria
2 of section 421(b) would provide.

3 (b) DISSEMINATION OF INFORMATION.—Such infor-
4 mation shall be made generally available to States and to
5 providers and consumers of health care services.

6 **Subtitle D—Preemption of State**
7 **Quill Pen Laws**

8 **SEC. 431. PREEMPTION OF STATE QUILL PEN LAWS.**

9 (a) IN GENERAL.—Effective January 1, 1996, no ef-
10 fect shall be given to any provision of State law that re-
11 quires medical or health insurance records (including bill-
12 ing information) to be maintained in written, rather than
13 electronic form.

14 (b) SECRETARIAL AUTHORITY.—The Secretary may
15 issue regulations to carry out subsection (a). Such regula-
16 tions may provide for such exceptions to subsection (a)
17 as the Secretary determines to be necessary to prevent
18 fraud and abuse, with respect to controlled substances,
19 and in such other cases as the Secretary deems appro-
20 priate.

1 **TITLE V—ANTI-FRAUD**
2 **Subtitle A—Criminal Prosecution**
3 **of Health Care Fraud**

4 **SEC. 501. PENALTIES FOR HEALTH CARE FRAUD.**

5 (a) IN GENERAL.—Chapter 63 of title 18, United
6 States Code, is amended by adding at the end the follow-
7 ing:

8 **“§ 1347. Health care fraud**

9 “(a) OFFENSE.—Whoever, being a health care pro-
10 vider, knowingly engages in any scheme or artifice to de-
11 fraud any person in connection with the provision of
12 health care shall be fined under this title or imprisoned
13 not more than 5 years, or both.

14 “(b) DEFINITION.—In this section, the term ‘health
15 care provider’ means—

16 “(1) a physician, nurse, dentist, therapist, phar-
17 macist, or other professional provider of health care;
18 and

19 “(2) a hospital, health maintenance organiza-
20 tion, pharmacy, laboratory, clinic, or other health
21 care facility or a provider of medical services, medi-
22 cal devices, medical equipment, or other medical sup-
23 plies.”.

24 (b) CLERICAL AMENDMENT.—The table of sections
25 at the beginning of chapter 63 of title 18, United States

1 Code, is amended by adding at the end the following new
2 item:

“1347. Health care fraud.”.

3 **SEC. 502. REWARDS FOR INFORMATION LEADING TO PROS-**
4 **ECUTION AND CONVICTION.**

5 Section 3059 of title 18, United States Code, is
6 amended by adding at the end the following new sub-
7 section:

8 “(c)(1) In special circumstances and in the Attorney
9 General’s sole discretion, the Attorney General may make
10 a payment of up to \$10,000 to a person who furnishes
11 information unknown to the Government relating to a pos-
12 sible prosecution under section 1101.

13 “(2) A person is not eligible for a payment under
14 paragraph (1) if—

15 “(A) the person is a current or former officer
16 or employee of a Federal or State government agen-
17 cy or instrumentality who furnishes information dis-
18 covered or gathered in the course of government em-
19 ployment;

20 “(B) the person knowingly participated in the
21 offense;

22 “(C) the information furnished by the person
23 consists of allegations or transactions that have been
24 disclosed to the public—

1 “(i) in a criminal, civil, or administrative
2 proceeding;

3 “(ii) in a congressional, administrative or
4 General Accounting Office report, hearing,
5 audit, or investigation; or

6 “(iii) by the news media, unless the person
7 is the original source of the information; or

8 “(D) when, in the judgment of the Attorney
9 General, it appears that a person whose illegal ac-
10 tivities are being prosecuted or investigated could
11 benefit from the award.

12 “(3) For the purposes of paragraph (2)(C)(iii), the
13 term ‘original source’ means a person who has direct and
14 independent knowledge of the information that is fur-
15 nished and has voluntarily provided the information to the
16 Government prior to disclosure by the news media.

17 “(4) Neither the failure of the Attorney General to
18 authorize a payment under paragraph (1) nor the amount
19 authorized shall be subject to judicial review.”.

1 **Subtitle B—Coordination of Health**
2 **Care Anti-Fraud and Abuse Ac-**
3 **tivities**

4 **SEC. 511. APPLICATION OF FEDERAL HEALTH ANTI-FRAUD**
5 **AND ABUSE SANCTIONS TO ALL FRAUD AND**
6 **ABUSE AGAINST ANY HEALTH INSURANCE**
7 **PLAN.**

8 (a) CIVIL MONETARY PENALTIES.—Section 1128A
9 of the Social Security Act (42 U.S.C. 1320a–7a) is
10 amended as follows:

11 (1) In subsection (a)(1), in the matter before
12 subparagraph (A), by inserting “or of any health in-
13 surance plan,” after “subsection (i)(1),”.

14 (2) In subsection (b)(1)(A), by inserting “or
15 under a health insurance plan” after “title XIX”.

16 (3) In subsection (f)—

17 (A) by redesignating paragraph (3) as
18 paragraph (4); and

19 (B) by inserting after paragraph (2) the
20 following new paragraph:

21 “(3) With respect to amounts recovered arising
22 out of a claim under a health insurance plan, the
23 portion of such amounts as is determined to have
24 been paid by the plan shall be repaid to the plan.”.

25 (4) In subsection (i)—

1 (A) in paragraph (2), by inserting “or
2 under a health insurance plan” before the pe-
3 riod at the end, and

4 (B) in paragraph (5), by inserting “or
5 under a health insurance plan” after “or XX”.

6 (b) CRIMES.—

7 (1) SOCIAL SECURITY ACT.—Section 1128B of
8 such Act (42 U.S.C. 1320a-7b) is amended as fol-
9 lows:

10 (A) In the heading, by adding at the end
11 the following: “OR HEALTH INSURANCE PLANS”.

12 (B) In subsection (a)(1)—

13 (i) by striking “title XVIII or” and
14 inserting “title XVIII,” and

15 (ii) by adding at the end the follow-
16 ing: “or a health insurance plan (as de-
17 fined in section 1128(i))”.

18 (C) In subsection (a)(5), by striking “title
19 XVIII or a State health care program” and in-
20 serting “title XVIII, a State health care pro-
21 gram, or a health insurance plan”.

22 (D) In the second sentence of subsection
23 (a)—

1 (i) by inserting after “title XIX” the
2 following: “or a health insurance plan”,
3 and

4 (ii) by inserting after “the State” the
5 following: “or the plan”.

6 (E) In subsection (b)(1), by striking “title
7 XVIII or a State health care program” each
8 place it appears and inserting “title XVIII, a
9 State health care program, or a health insur-
10 ance plan”.

11 (F) In subsection (b)(2), by striking “title
12 XVIII or a State health care program” each
13 place it appears and inserting “title XVIII, a
14 State health care program, or a health insur-
15 ance plan”.

16 (G) In subsection (b)(3), by striking “title
17 XVIII or a State health care program” each
18 place it appears in subparagraphs (A) and (C)
19 and inserting “title XVIII, a State health care
20 program, or a health insurance plan”.

21 (H) In subsection (d)(2)—

22 (i) by striking “title XIX,” and insert-
23 ing “title XIX or under a health insurance
24 plan,” and

1 (ii) by striking “State plan,” and in-
2 sserting “State plan or the health insurance
3 plan,”.

4 (2) TREBLE DAMAGES FOR CRIMINAL SANC-
5 TIONS.—Section 1128B of such Act (42 U.S.C.
6 1320a–7b) is amended by adding at the end the fol-
7 lowing new subsection:

8 “(f) In addition to the fines that may be imposed
9 under subsection (a), (b), or (c), any individual found to
10 have violated the provisions of any of such subsections
11 may be subject to treble damages.”.

12 (3) IDENTIFICATION OF COMMUNITY SERVICE
13 OPPORTUNITIES.—Section 1128B of such Act (42
14 U.S.C. 1320a–7b) is further amended by adding at
15 the end the following new subsection:

16 “(g) The Secretary shall—

17 “(1) in consultation with State and local health
18 care officials, identify opportunities for the satisfac-
19 tion of community service obligations that a court
20 may impose upon the conviction of an offense under
21 this section, and

22 “(2) make information concerning such oppor-
23 tunities available to Federal and State law enforce-
24 ment officers and State and local health care offi-
25 cials.”.

1 (c) HEALTH INSURANCE PLAN DEFINED.—Section
 2 1128 of such Act (42 U.S.C. 1320a-7) is amended by re-
 3 designating subsection (i) as subsection (j) and by insert-
 4 ing after subsection (h) the following new subsection:

5 “(i) HEALTH INSURANCE PLAN DEFINED.—For pur-
 6 poses of sections 1128A and 1128B, the term ‘health in-
 7 surance plan’ means a health insurance program other
 8 than the medicare program, the medicaid program, or a
 9 State health care program.”.

10 (d) CONFORMING AMENDMENT.—Section
 11 1128(b)(8)(B)(ii) of such Act (42 U.S.C. 1320a-
 12 7(b)(8)(B)(ii)) is amended by striking “1128A” and in-
 13 serting “1128A (other than a penalty arising from a
 14 health insurance plan, as defined in subsection (i))”.

15 (e) EFFECTIVE DATE.—The amendments made by
 16 this section shall take effect January 1, 1995.

17 **TITLE VI—ANTITRUST**

18 **PROVISIONS**

19 **SEC. 601. EXEMPTION FROM ANTITRUST LAWS FOR CER-**
 20 **TAIN COMPETITIVE AND COLLABORATIVE**
 21 **ACTIVITIES.**

22 (a) EXEMPTION DESCRIBED.—An activity relating to
 23 the provision of health care services shall be exempt from
 24 the antitrust laws if—

1 (1) the activity is within one of the categories
2 of safe harbors described in section 602;

3 (2) the activity is within an additional safe har-
4 bor designated by the Attorney General under sec-
5 tion 603; or

6 (3) the activity is specified in and in compliance
7 with the terms of a certificate of review issued by
8 the Attorney General under section 604 and the ac-
9 tivity occurs—

10 (A) while the certificate is in effect, or

11 (B) in the case of a certificate issued dur-
12 ing the 2-year period beginning on the date of
13 the enactment of this Act, at any time on or
14 after the first day of the 2-year period that
15 ends on the date the certificate takes effect.

16 (b) AWARD OF ATTORNEY'S FEES AND COSTS OF
17 SUIT.—

18 (1) IN GENERAL.—If any person brings an ac-
19 tion alleging a claim under the antitrust laws and
20 the activity on which the claim is based is found by
21 the court to be exempt from such laws under sub-
22 section (a), the court shall, at the conclusion of the
23 action—

1 (A) award to a substantially prevailing
2 claimant the cost of suit attributable to such
3 claim, including a reasonable attorney's fee, or

4 (B) award to a substantially prevailing
5 party defending against such claim the cost of
6 such suit attributable to such claim, including
7 reasonable attorney's fee, if the claim, or the
8 claimant's conduct during litigation of the
9 claim, was frivolous, unreasonable, without
10 foundation, or in bad faith.

11 (2) OFFSET IN CASES OF BAD FAITH.—The
12 court may reduce an award made pursuant to para-
13 graph (1) in whole or in part by an award in favor
14 of another party for any part of the cost of suit (in-
15 cluding a reasonable attorney's fee) attributable to
16 conduct during the litigation by any prevailing party
17 that the court finds to be frivolous, unreasonable,
18 without foundation, or in bad faith.

19 **SEC. 602. SAFE HARBORS.**

20 The following activities are safe harbors for purposes
21 of section 601(a)(1):

22 (1) COMBINATIONS WITH MARKET SHARE
23 BELOW THRESHOLD.—Activities relating to health
24 care services of any combination of health care pro-
25 viders if the number of each type or specialty of pro-

1 vider in question does not exceed 20 percent of the
2 total number of such type or specialty of provider in
3 the relevant market area.

4 (2) ACTIVITIES OF MEDICAL SELF-REGULATORY
5 ENTITIES.—

6 (A) IN GENERAL.—Subject to subpara-
7 graph (B), any activity of a medical self-regu-
8 latory entity relating to standard setting or
9 standard enforcement activities that are de-
10 signed to promote the quality of health care
11 provided to patients.

12 (B) EXCEPTION.—No activity of a medical
13 self-regulatory entity may be deemed to fall
14 under the safe harbor established under this
15 paragraph if the activity is conducted for pur-
16 poses of financial gain.

17 (3) PARTICIPATION IN SURVEYS.—The partici-
18 pation of a provider of health care services in a writ-
19 ten survey of the prices of services, reimbursement
20 levels, or the compensation and benefits of employ-
21 ees and personnel, but only if—

22 (A) the survey is conducted by a third
23 party, such as a purchaser of health care serv-
24 ices, governmental entity, institution of higher
25 education, or trade association;

1 (B) the information provided by partici-
2 pants in the survey is based on prices charged,
3 reimbursements received, or compensation and
4 benefits paid prior to the third month preceding
5 the month in which the information is provided;
6 and

7 (C) if the results of the survey are dissemi-
8 nated, the results are aggregated in a manner
9 that ensures that no recipient of the results
10 may identify the prices charged, reimbursement
11 received, or compensation and benefits paid by
12 any particular provider.

13 (4) JOINT VENTURES FOR HIGH TECHNOLOGY
14 AND COSTLY EQUIPMENT AND SERVICES.—Any ac-
15 tivity of a health care cooperative venture relating to
16 the purchase, operation, or marketing of high tech-
17 nology or other expensive medical equipment, or the
18 provision of high cost or complex services, but only
19 if the number of participants in the venture does not
20 exceed the lowest number needed to support the ven-
21 ture. Other providers may be included in the ven-
22 ture, but only if such other providers could not pur-
23 chase, operate, or market such equipment or provide
24 a competing service either alone or through the for-
25 mation of a competing venture.

1 (5) HOSPITAL MERGERS.—Activities relating to
2 a merger of 2 hospitals if, during the 3-year period
3 preceding the merger, one of the hospitals had an
4 average of 150 or fewer operational beds and an av-
5 erage daily inpatient census of less than 50 percent
6 of such beds.

7 (6) JOINT PURCHASING ARRANGEMENTS.—Any
8 joint purchasing arrangement among health care
9 providers if—

10 (A) the purchases under the arrangement
11 represent less than 35 percent of the total sales
12 of the product or service purchased in the rel-
13 evant market; and

14 (B) the cost of the products and services
15 purchased jointly accounts for less than 20 per-
16 cent of the total revenues from all products or
17 services sold by each participant in the joint
18 purchasing arrangement.

19 (7) NEGOTIATIONS.—Activities consisting of
20 good faith negotiations to carry out any activity—

21 (A) described in this section,

22 (B) within an additional safe harbor des-
23 ignated by the Attorney General under section
24 603,

1 (C) that is the subject of an application for
2 a certificate of review under section 604, or

3 (D) that is deemed a submission of a noti-
4 fication under section 605(a)(2)(B),
5 without regard to whether such an activity is carried
6 out.

7 **SEC. 603. DESIGNATION OF ADDITIONAL SAFE HARBORS.**

8 (a) IN GENERAL.—

9 (1) SOLICITATION OF PROPOSALS.—Not later
10 than 30 days after the date of the enactment of this
11 Act, the Attorney General shall publish a notice in
12 the Federal Register soliciting proposals for addi-
13 tional safe harbors.

14 (2) REVIEW AND REPORT ON PROPOSED SAFE
15 HARBORS.—Not later than 180 days after the date
16 of the enactment of this Act, the Attorney General
17 (in consultation with the Secretary and the Chair)
18 shall—

19 (A) review the proposed safe harbors sub-
20 mitted under paragraph (1); and

21 (B) submit a report to Congress describing
22 the proposals to be included in the publication
23 of additional safe harbors described in para-
24 graph (3) and the proposals that are not to be

1 so included, together with explanations there-
2 fore.

3 (3) PUBLICATION OF ADDITIONAL SAFE HAR-
4 BORS.—Not later than 180 days after the date of
5 the enactment of this Act, the Attorney General (in
6 consultation with the Secretary and the Chair) shall
7 publish in the Federal Register proposed additional
8 safe harbors for purposes of section 601(a)(2) for
9 providers of health care services. Not later than 180
10 days after publishing such proposed safe harbors in
11 the Federal Register, the Attorney General shall
12 issue final rules establishing such safe harbors.

13 (b) CRITERIA FOR SAFE HARBORS.—In establishing
14 safe harbors under subsection (a), the Attorney General
15 shall take into account the following:

16 (1) The extent to which a competitive or col-
17 laborative activity will accomplish any of the follow-
18 ing:

19 (A) An increase in access to health care
20 services.

21 (B) The enhancement of the quality of
22 health care services.

23 (C) The establishment of cost efficiencies
24 that will be passed on to consumers, including

1 economies of scale and reduced transaction and
2 administrative costs.

3 (D) An increase in the ability of health
4 care facilities to provide services in medically
5 underserved areas or to medically underserved
6 populations.

7 (E) An improvement in the utilization of
8 health care resources or the reduction in the in-
9 efficient duplication of the use of such re-
10 sources.

11 (2) Whether the designation of an activity as a
12 safe harbor under subsection (a) will result in the
13 following outcomes:

14 (A) Health plans and other health care in-
15 surers, consumers of health care services, and
16 health care providers will be better able to ne-
17 gotiate payment and service arrangements
18 which will reduce costs to consumers.

19 (B) Taking into consideration the charac-
20 teristics of the particular purchasers and pro-
21 viders involved, competition will not be unduly
22 restricted.

23 (C) Equally efficient and less restrictive al-
24 ternatives do not exist to meet the criteria de-
25 scribed in paragraph (1).

1 (D) The activity will not unreasonably
2 foreclose competition by denying competitors a
3 necessary element of competition.

4 **SEC. 604. CERTIFICATES OF REVIEW.**

5 (a) ESTABLISHMENT OF PROGRAM.—In consultation
6 with the Secretary and the Chair, the Attorney General
7 shall (not later than 180 days after the date of the enact-
8 ment of this Act) issue certificates of review in accordance
9 with this section for providers of health care services and
10 advise and assist any person with respect to applying for
11 such a certificate of review.

12 (b) PROCEDURES FOR APPLICATION FOR CERTIFI-
13 CATE.—

14 (1) FORM; CONTENT.—To apply for a certifi-
15 cate of review, a person shall submit to the Attorney
16 General a written application which—

17 (A) specifies the activities relating to the
18 provision of health care services which satisfy
19 the criteria described in section 603(b) and
20 which will be included in the certificate; and

21 (B) is in a form and contains any informa-
22 tion, including information pertaining to the
23 overall market in which the applicant operates,
24 required by rule or regulation promulgated
25 under section 607.

1 (2) PUBLICATION OF NOTICE IN FEDERAL REG-
2 ISTER.—Within 10 days after an application submit-
3 ted under paragraph (1) is received by the Attorney
4 General, the Attorney General shall publish in the
5 Federal Register a notice that announces that an
6 application for a certificate of review has been sub-
7 mitted, identifies each person submitting the appli-
8 cation, and describes the conduct for which the ap-
9 plication is submitted.

10 (3) ESTABLISHMENT OF PROCEDURES FOR IS-
11 SUANCE OF CERTIFICATE.—In consultation with the
12 Chair and the Secretary, the Attorney General shall
13 establish procedures to be used in applying for and
14 in determining whether to approve an application for
15 a certificate of review under this title. Under such
16 procedures the Attorney General shall approve an
17 application if the Attorney General determines that
18 the activities to be covered under the certificate will
19 satisfy the criteria described in section 603(b) for
20 additional safe harbors designated under such sec-
21 tion and that the benefits of the issuance of the cer-
22 tificate will outweigh any disadvantages that may re-
23 sult from reduced competition.

24 (4) TIMING FOR DECISION ON APPLICATION.—

1 (A) IN GENERAL.—Within 90 days after
2 the Attorney General receives an application for
3 a certificate of review, the Attorney General
4 shall determine whether the applicant’s health
5 care market activities are in accordance with
6 the procedures described in paragraph (3). If
7 the Attorney General, with the concurrence of
8 the Secretary, determines that such procedures
9 are met, the Attorney General shall issue to the
10 applicant a certificate of review. The certificate
11 of review shall specify—

12 (i) the health care market activities to
13 which the certificate applies,

14 (ii) the person to whom the certificate
15 of review is issued, and

16 (iii) any terms and conditions the At-
17 torney General or the Secretary deems nec-
18 essary to assure compliance with the appli-
19 cable procedures described in paragraph
20 (3).

21 (B) APPLICATIONS DEEMED APPROVED.—
22 If the Attorney General does not reject an ap-
23 plication before the expiration of the 90-period
24 beginning on the date the Attorney General re-
25 ceives the application, the Attorney General

1 shall be deemed to have approved the applica-
2 tion and to have issued a certificate of review
3 relating to the applicant's health care market
4 activities covered under the application.

5 (5) EXPEDITED ACTION.—If the applicant indi-
6 cates a special need for prompt disposition, the At-
7 torney General and the Secretary may expedite ac-
8 tion on the application, except that no certificate of
9 review may be issued within 30 days of publication
10 of notice in the Federal Register under subsection
11 (b)(2).

12 (6) ACTIONS UPON DENIAL.—

13 (A) NOTIFICATION.—If the Attorney Gen-
14 eral denies in whole or in part an application
15 for a certificate, the Attorney General shall no-
16 tify the applicant of the Attorney General's de-
17 termination and the reasons for it.

18 (B) REQUEST FOR RECONSIDERATION.—
19 An applicant may, within 30 days of receipt of
20 notification that the application has been denied
21 in whole or in part, request the Attorney Gen-
22 eral to reconsider the determination. The Attor-
23 ney General, with the concurrence of the Sec-
24 retary, shall notify the applicant of the deter-

1 mination upon reconsideration within 30 days
2 of receipt of the request.

3 (C) RETURN OF DOCUMENTS.—If the At-
4 torney General denies an application for the is-
5 suaunce of a certificate of review and thereafter
6 receives from the applicant a request for the re-
7 turn of documents submitted by the applicant
8 in connection with the application for the cer-
9 tificate, the Attorney General and the Secretary
10 shall return to the applicant, not later than 30
11 days after receipt of the request, the documents
12 and all copies of the documents available to the
13 Attorney General and the Secretary, except to
14 the extent that the information has been made
15 public under an exception to the rule against
16 public disclosure described in subsection
17 (g)(2)(B).

18 (7) FRAUDULENT PROCUREMENT.—A certifi-
19 cate of review shall be void ab initio with respect to
20 any health care market activities for which the cer-
21 tificate was procured by fraud.

22 (c) AMENDMENT AND REVOCATION OF CERTIFI-
23 CATES.—

24 (1) NOTIFICATION OF CHANGES.—Any appli-
25 cant who receives a certificate of review—

1 (A) shall promptly report to the Attorney
2 General any change relevant to the matters
3 specified in the certificate; and

4 (B) may submit to the Attorney General
5 an application to amend the certificate to re-
6 flect the effect of the change on the conduct
7 specified in the certificate.

8 (2) AMENDMENT TO CERTIFICATE.—An appli-
9 cation for an amendment to a certificate of review
10 shall be treated as an application for the issuance of
11 a certificate. The effective date of an amendment
12 shall be the date on which the application for the
13 amendment is submitted to the Attorney General.

14 (3) REVOCATION.—

15 (A) GROUNDS FOR REVOCATION.—In ac-
16 cordance with this paragraph, the Attorney
17 General may revoke in whole or in part a cer-
18 tificate of review issued under this section. The
19 following shall be considered grounds for the
20 revocation of a certificate:

21 (i) After the expiration of the 2-year
22 period beginning on the date a person's
23 certificate is issued, the activities of the
24 person have not substantially accomplished

1 the purposes for the issuance of the certifi-
2 cate.

3 (ii) The person has failed to comply
4 with any of the terms or conditions im-
5 posed under the certificate by the Attorney
6 General or the Secretary under subsection
7 (b)(4).

8 (iii) The activities covered under the
9 certificate no longer satisfy the criteria set
10 forth in section 603(b).

11 (B) REQUEST FOR COMPLIANCE INFORMA-
12 TION.—If the Attorney General or Secretary
13 has reason to believe that any of the grounds
14 for revocation of a certificate of review de-
15 scribed in subparagraph (A) may apply to a
16 person holding the certificate, the Attorney
17 General shall request such information from
18 such person as the Attorney General or the Sec-
19 retary deems necessary to resolve the matter of
20 compliance. Failure to comply with such request
21 shall be grounds for revocation of the certificate
22 under this paragraph.

23 (C) PROCEDURES FOR REVOCATION.—If
24 the Attorney General or the Secretary deter-
25 mines that any of the grounds for revocation of

1 a certificate of review described in subpara-
2 graph (A) apply to a person holding the certifi-
3 cate, or that such person has failed to comply
4 with a request made under subparagraph (B),
5 the Attorney General shall give written notice of
6 the determination to such person. The notice
7 shall include a statement of the circumstances
8 underlying, and the reasons in support of, the
9 determination. In the 60-day period beginning
10 30 days after the notice is given, the Attorney
11 General shall revoke the certificate or modify it
12 as the Attorney General or the Secretary deems
13 necessary to cause the certificate to apply only
14 to activities that meet the procedures for the is-
15 suance of certificates described in subsection
16 (b)(2).

17 (D) INVESTIGATION AUTHORITY.—For
18 purposes of carrying out this paragraph, the
19 Attorney General may conduct investigations in
20 the same manner as the Attorney General con-
21 ducts investigations under section 3 of the Anti-
22 trust Civil Process Act, except that no civil in-
23 vestigative demand may be issued to a person
24 to whom a certificate of review is issued if such
25 person is the target of such investigation.

1 (d) REVIEW OF DETERMINATIONS.—

2 (1) AVAILABILITY OF REVIEW FOR CERTAIN AC-
3 TIONS.—If the Attorney General denies, in whole or
4 in part, an application for a certificate of review or
5 for an amendment to a certificate, or revokes or
6 modifies a certificate pursuant to paragraph (3), the
7 applicant or certificate holder (as the case may be)
8 may, within 30 days of the denial or revocation,
9 bring an action in any appropriate district court of
10 the United States to set aside the determination on
11 the ground that such determination is erroneous
12 based on the preponderance of the evidence.

13 (2) NO OTHER REVIEW PERMITTED.—Except
14 as provided in paragraph (1), no action by the At-
15 torney General or the Secretary pursuant to this
16 title shall be subject to judicial review.

17 (3) EFFECT OF REJECTED APPLICATION.—If
18 the Attorney General denies, in whole or in part, an
19 application for a certificate of review or for an
20 amendment to a certificate, or revokes or amends a
21 certificate, neither the negative determination nor
22 the statement of reasons therefore shall be admissi-
23 ble in evidence, in any administrative or judicial pro-
24 ceeding, concerning any claim under the antitrust
25 laws.

1 (e) PUBLICATION OF DECISIONS.—The Attorney
2 General shall publish a notice in the Federal Register on
3 a timely basis of each decision made with respect to an
4 application for a certificate of review under this section
5 or the amendment or revocation of such a certificate, in
6 a manner that protects the confidentiality of any propri-
7 etary information relating to the application.

8 (f) ANNUAL REPORTS.—Every person to whom a cer-
9 tificate of review is issued shall submit to the Attorney
10 General an annual report, in such form and at such time
11 as the Attorney General may require, that contains any
12 necessary updates to the information required under sub-
13 section (b) and a description of the activities of the holder
14 under the certificate during the preceding year.

15 (g) RESTRICTIONS ON DISCLOSURE OF INFORMA-
16 TION.—

17 (1) WAIVER OF DISCLOSURE REQUIREMENTS
18 UNDER ADMINISTRATIVE PROCEDURE ACT.—Infor-
19 mation submitted by any person in connection with
20 the issuance, amendment, or revocation of a certifi-
21 cate of review shall be exempt from disclosure under
22 section 552 of title 5, United States Code.

23 (2) RESTRICTIONS ON DISCLOSURE OF COM-
24 MERCIAL OR FINANCIAL INFORMATION.—

1 (A) IN GENERAL.—Except as provided in
2 subparagraph (B), no officer or employee of the
3 United States shall disclose commercial or fi-
4 nancial information submitted in connection
5 with the issuance, amendment, or revocation of
6 a certificate of review if the information is priv-
7 ileged or confidential and if disclosure of the in-
8 formation would cause harm to the person who
9 submitted the information.

10 (B) EXCEPTIONS.—Subparagraph (A)
11 shall not apply with respect to information dis-
12 closed—

13 (i) upon a request made by the Con-
14 gress or any committee of the Congress,

15 (ii) in a judicial or administrative pro-
16 ceeding, subject to appropriate protective
17 orders,

18 (iii) with the consent of the person
19 who submitted the information,

20 (iv) in the course of making a deter-
21 mination with respect to the issuance,
22 amendment, or revocation of a certificate
23 of review, if the Attorney General deems
24 disclosure of the information to be nec-

1 essary in connection with making the de-
2 termination,

3 (v) in accordance with any require-
4 ment imposed by a statute of the United
5 States, or

6 (vi) in accordance with any rule or
7 regulation promulgated under subsection
8 (i) permitting the disclosure of the infor-
9 mation to an agency of the United States
10 or of a State on the condition that the
11 agency will disclose the information only
12 under the circumstances specified in
13 clauses (i) through (v).

14 (3) PROHIBITION AGAINST USE OF INFORMA-
15 TION TO SUPPORT OR ANSWER CLAIMS UNDER ANTI-
16 TRUST LAWS.—Any information disclosed in an ap-
17 plication for a certificate of review under this section
18 shall only be admissible into evidence in a judicial or
19 administrative proceeding for the sole purpose of es-
20 tablishing that a person is entitled to the protections
21 provided by such a certificate.

1 **SEC. 605. NOTIFICATIONS PROVIDING REDUCTION IN CER-**
2 **TAIN PENALTIES UNDER ANTITRUST LAW**
3 **FOR HEALTH CARE COOPERATIVE VEN-**
4 **TURES.**

5 (a) NOTIFICATIONS DESCRIBED.—

6 (1) SUBMISSION OF NOTIFICATION BY VEN-
7 TURE.—Any party to a health care cooperative ven-
8 ture, acting on such venture's behalf, may, not later
9 than 90 days after entering into a written agreement
10 to form such venture or not later than 90 days after
11 the date of the enactment of this Act, whichever is
12 later, file with the Attorney General a written notifi-
13 cation disclosing—

14 (A) the identities of the parties to such
15 venture,

16 (B) the nature and objectives of such ven-
17 ture, and

18 (C) such additional information as the At-
19 torney General may require by regulation.

20 (2) ACTIVITIES DEEMED SUBMISSION OF NOTI-
21 FICATION.—The following health care cooperative
22 ventures shall be deemed to have filed a written noti-
23 fication with respect to the venture under paragraph
24 (1):

25 (A) SUBMISSION OF APPLICATION FOR
26 CERTIFICATE OF REVIEW.—Any health care co-

1 operative venture for which an application for a
2 certificate of review is filed with the Attorney
3 General under section 603.

4 (B) CERTAIN VENTURES.—Any health care
5 cooperative venture meeting the following re-
6 quirements:

7 (i) The venture consists of a network
8 of non-institutional providers not greater
9 than—

10 (I) in the case of a nonexclusive
11 network in which the participating
12 members are permitted to create or
13 join other competing networks, 50
14 percent of the providers of health care
15 services in the relevant geographic
16 area and 50 percent of the members
17 of the provider specialty group in the
18 relevant market; or

19 (II) in the case of an exclusive
20 network in which the participating
21 members are not permitted to create
22 or join other competing networks, 35
23 percent of the providers of health care
24 services in the relevant geographic
25 area and 35 percent of the members

1 of the provider specialty group in the
2 relevant market.

3 (ii) Each member of the venture as-
4 sumes substantial financial risk for the op-
5 eration of the venture through risk-sharing
6 arrangements, including (but not limited
7 to)—

8 (I) the acceptance of capitation
9 contracts;

10 (II) the acceptance of contracts
11 with fee withholding mechanisms re-
12 lating to the ability to meet estab-
13 lished goals for utilization review and
14 management; and

15 (III) the holding by members of
16 significant ownership or equity inter-
17 ests in the venture, where the capital
18 contributed by the members is used to
19 fund the operational costs of the ven-
20 ture such as administration, market-
21 ing, and computer-operated medical
22 information, if the venture develops
23 and operates comprehensive programs
24 for utilization management and qual-
25 ity assurance that include controls

1 over the use of institutional, special-
2 ized, and ancillary medical services.

3 (3) SUBMISSION OF ADDITIONAL INFORMA-
4 TION.—

5 (A) REQUEST OF ATTORNEY GENERAL.—

6 At any time after receiving a notification filed
7 under paragraph (1), the Attorney General may
8 require the submission of additional information
9 or documentary material relevant to the pro-
10 posed health care cooperative venture.

11 (B) PARTIES TO VENTURE.—Any party to
12 a health care cooperative venture may submit
13 such additional information on the venture's be-
14 half as may be appropriate to ensure that the
15 venture will receive the protections provided
16 under subsection (b).

17 (C) REQUIRED SUBMISSION OF INFORMA-
18 TION ON CHANGES TO VENTURE.—A health
19 care cooperative venture for which a notification
20 is in effect under this section shall submit infor-
21 mation on any change in the membership of the
22 venture not later than 90 days after such
23 change occurs.

24 (4) PUBLICATION OF NOTIFICATION.—

1 (A) INFORMATION MADE PUBLICLY AVAIL-
2 ABLE.—Not later than 30 days after receiving
3 a notification with respect to a venture under
4 paragraph (1), the Attorney General shall pub-
5 lish in the Federal Register a notice with re-
6 spect to the venture that identifies the parties
7 to the venture and generally describes the pur-
8 pose and planned activity of the venture. Prior
9 to its publication, the contents of the notice
10 shall be made available to the parties to the
11 venture.

12 (B) RESTRICTION ON DISCLOSURE OF
13 OTHER INFORMATION.—All information and
14 documentary material submitted pursuant to
15 this section and all information obtained by the
16 Attorney General in the course of any investiga-
17 tion or case with respect to a potential violation
18 of the antitrust laws by the health care coopera-
19 tive venture (other than information and mate-
20 rial described in subparagraph (A)) shall be ex-
21 empt from disclosure under section 552 of title
22 5, United States Code, and shall not be made
23 publicly available by any agency of the United
24 States to which such section applies except in

1 a judicial proceeding in which such information
2 and material is subject to any protective order.

3 (5) WITHDRAWAL OF NOTIFICATION.—Any per-
4 son who files a notification pursuant to this section
5 may withdraw such notification before a publication
6 by the Attorney General pursuant to paragraph (4).
7 Any person who is deemed to have filed a notifica-
8 tion under paragraph (2)(A) shall be deemed to have
9 withdrawn the notification if the certificate of review
10 in question is revoked or withdrawn under section
11 604.

12 (6) NO JUDICIAL REVIEW PERMITTED.—Any
13 action taken or not taken by the Attorney General
14 with respect to notifications filed pursuant to this
15 subsection shall not be subject to judicial review.

16 (b) PROTECTIONS FOR VENTURES SUBJECT TO NO-
17 TIFICATION.—

18 (1) IN GENERAL.—

19 (A) PROTECTIONS DESCRIBED.—The pro-
20 visions of paragraphs (2), (3), (4), and (5) shall
21 apply with respect to any action under the anti-
22 trust laws challenging conduct within the scope
23 of a notification which is in effect pursuant to
24 subsection (a)(1).

1 (B) TIMING OF PROTECTIONS.—The pro-
2 tections described in this subsection shall apply
3 to the venture that is the subject of a notifica-
4 tion under subsection (a)(1) as of the earlier
5 of—

6 (i) the date of the publication in the
7 Federal Register of the notice published
8 with respect to the notification; or

9 (ii) if such notice is not published dur-
10 ing the period required under subsection
11 (a)(4), the expiration of the 30-day period
12 that begins on the date the Attorney Gen-
13 eral receives any necessary information re-
14 quired to be submitted under subsection
15 (a)(1) or any additional information re-
16 quired by the Attorney General under sub-
17 section (a)(3)(A).

18 (2) APPLICABILITY OF RULE OF REASON
19 STANDARD.—In any action under the antitrust laws,
20 the conduct of any person which is within the scope
21 of a notification filed under subsection (a) shall not
22 be deemed illegal per se, but shall be judged on the
23 basis of its reasonableness, taking into account all
24 relevant factors affecting competition, including, but

1 not limited to, effects on competition in relevant
2 markets.

3 (3) LIMITATION ON RECOVERY TO ACTUAL
4 DAMAGES AND INTEREST.—Notwithstanding section
5 4 of the Clayton Act, any person who is entitled to
6 recovery under the antitrust laws for conduct that is
7 within the scope of a notification filed under sub-
8 section (a) shall recover the actual damages sus-
9 tained by such person and interest calculated at the
10 rate specified in section 1961 of title 28, United
11 States Code, for the period beginning on the earliest
12 date for which injury can be established and ending
13 on the date of judgment, unless the court finds that
14 the award of all or part of such interest is unjust
15 under the circumstances.

16 (4) AWARD OF ATTORNEY'S FEES AND COSTS
17 OF SUIT.—

18 (A) IN GENERAL.—In any action under the
19 antitrust laws brought against a health care co-
20 operative venture for conduct that is within the
21 scope of a notification filed under subsection
22 (a), the court shall, at the conclusion of the ac-
23 tion—

24 (i) award to a substantially prevailing
25 claimant the cost of suit attributable to

1 such claim, including a reasonable attorney's fee, or
2

3 (ii) award to a substantially prevailing
4 party defending against such claim the
5 cost of such suit attributable to such claim,
6 including reasonable attorney's fee, if the
7 claim, or the claimant's conduct during
8 litigation of the claim, was frivolous, un-
9 reasonable, without foundation, or in bad
10 faith.

11 (B) OFFSET IN CASES OF BAD FAITH.—

12 The court may reduce an award made pursuant
13 to subparagraph (A) in whole or in part by an
14 award in favor of another party for any part of
15 the cost of suit (including a reasonable attorney's
16 fee) attributable to conduct during the
17 litigation by any prevailing party that the court
18 finds to be frivolous, unreasonable, without
19 foundation, or in bad faith.

20 (5) RESTRICTIONS ON ADMISSIBILITY OF INFORMATION.—
21

22 (A) IN GENERAL.—Any information disclosed
23 in a notification submitted under subsection
24 (a)(1) and the fact of the publication of
25 a notification by the Attorney General under

1 subsection (a)(4) shall only be admissible into
2 evidence in a judicial or administrative proceed-
3 ing for the sole purpose of establishing that a
4 party to a health care cooperative venture is en-
5 titled to the protections described in this sub-
6 section.

7 (B) ACTIONS OF ATTORNEY GENERAL.—
8 No action taken by the Attorney General pursu-
9 ant to this section shall be admissible into evi-
10 dence in any judicial or administrative proceed-
11 ing for the purpose of supporting or answering
12 any claim under the antitrust laws.

13 **SEC. 606. REVIEW AND REPORTS ON SAFE HARBORS AND**
14 **CERTIFICATES OF REVIEW.**

15 (a) IN GENERAL.—The Attorney General (in con-
16 sultation with the Secretary and the Chair) shall periodi-
17 cally review the safe harbors described in section 602, the
18 additional safe harbors designated under section 603, and
19 the certificates of review issued under section 604, and—

20 (1) with respect to the safe harbors described in
21 section 602, submit such recommendations to Con-
22 gress as the Attorney General considers appropriate
23 for modifications of such safe harbors;

24 (2) with respect to the additional safe harbors
25 under designated under section 603, issue proposed

1 revisions to such activities and publish the revisions
2 in the Federal Register; and

3 (3) with respect to the certificates of review,
4 submit a report to Congress on the issuance of such
5 certificates, and shall include in the report a descrip-
6 tion of the effect of such certificates on increasing
7 access to high quality health care services at reduced
8 costs.

9 (b) RECOMMENDATIONS FOR LEGISLATION.—The
10 Attorney General shall include in the reports submitted
11 under subsection (a)(3) any recommendations of the At-
12 torney General for legislation to improve the program for
13 the issuance of certificates of review established under this
14 title.

15 **SEC. 607. RULES, REGULATIONS, AND GUIDELINES.**

16 (a) SAFE HARBORS, CERTIFICATES, AND NOTIFICA-
17 TIONS.—The Attorney General, with the concurrence of
18 the Secretary, shall promulgate such rules, regulations,
19 and guidelines as are necessary to carry out sections 602,
20 603, 604, and 605, including guidelines defining or relat-
21 ing to relevant geographic and product markets for health
22 care services and providers of health care services.

23 (b) GUIDANCE FOR PROVIDERS.—

24 (1) IN GENERAL.—To promote greater cer-
25 tainty regarding the application of the antitrust laws

1 to activities in the health care market, the Attorney
2 General, in consultation with the Secretary and the
3 Chair, shall (not later than 1 year after the date of
4 the enactment of this Act), taking into account the
5 criteria used to designate additional safe harbors
6 under section 603 and grant certificates of review
7 under section 604, publish guidelines—

8 (A) to assist providers of health care serv-
9 ices in analyzing whether the activities of such
10 providers may be subject to a safe harbor under
11 sections 602 or 603; and

12 (B) describing specific types of activities
13 which would meet the requirements for a cer-
14 tificate of review under section 604, and sum-
15 marizing the factual and legal bases on which
16 the activities would meet the requirements.

17 (2) PERIODIC UPDATE.—The Attorney General
18 shall periodically update the guidelines published
19 under paragraph (1) as the Attorney General consid-
20 ers appropriate.

21 (3) WAIVER OF ADMINISTRATIVE PROCEDURE
22 ACT.—Section 553 of title 5, United States Code,
23 shall not apply to the issuance of guidelines under
24 paragraph (1).

1 **SEC. 608. DEFINITIONS.**

2 In this title, the following definitions shall apply:

3 (1) The term “antitrust laws”—

4 (A) has the meaning given it in subsection
5 (a) of the first section of the Clayton Act (15
6 U.S.C. 12(a)), except that such term includes
7 section 5 of the Federal Trade Commission Act
8 (15 U.S.C. 45) to the extent such section ap-
9 plies to unfair methods of competition; and

10 (B) includes any State law similar to the
11 laws referred to in subparagraph (A).

12 (2) The term “Chair” means the Chair of the
13 Federal Trade Commission.

14 (3) The term “health insurance plan” has the
15 meaning given such term in section 111(b).

16 (4) The term “health care cooperative venture”
17 means any activities, including attempts to enter
18 into or perform a contract or agreement, carried out
19 by 2 or more persons for the purpose of providing
20 health care services.

21 (5) The term “health care services” means any
22 services for which payment may be made under a
23 health insurance plan, including services related to
24 the delivery or administration of such services.

25 (6) The term “medical self-regulatory entity”
26 means a medical society or association, a specialty

1 board, a recognized accrediting agency, or a hospital
2 medical staff, and includes the members, officers,
3 employees, consultants, and volunteers or commit-
4 tees of such an entity.

5 (7) The term “person” includes a State or unit
6 of local government.

7 (8) The term “provider of health care services”
8 means any individual or entity that is engaged in the
9 delivery of health care services in a State and that
10 is required by State law or regulation to be licensed
11 or certified by the State to engage in the delivery of
12 such services in the State.

13 (9) The term “specialty group” means a medi-
14 cal specialty or subspecialty in which a provider of
15 health care services may be licensed to practice by
16 a State (as determined by the Secretary in consulta-
17 tion with the certification boards for such specialties
18 and subspecialties).

19 (10) The term “standard setting and enforce-
20 ment activities” means—

21 (A) accreditation of health care practition-
22 ers, health care providers, medical education in-
23 stitutions, or medical education programs,

24 (B) technology assessment and risk man-
25 agement activities,

1 (C) the development and implementation of
2 practice guidelines or practice parameters, or

3 (D) official peer review proceedings under-
4 taken by a hospital medical staff (or committee
5 thereof) or a medical society or association for
6 purposes of evaluating the professional conduct
7 or quality of health care provided by a medical
8 professional.

9 **TITLE VII—LONG-TERM CARE**

10 **SEC. 701. EXCLUSION FROM GROSS INCOME FOR AMOUNTS** 11 **WITHDRAWN FROM INDIVIDUAL RETIRE-** 12 **MENT PLANS OR 401(k) PLANS FOR LONG-** 13 **TERM CARE INSURANCE.**

14 (a) IN GENERAL.—Part III of subchapter B of chap-
15 ter 1 of the Internal Revenue Code of 1986 (relating to
16 items specifically excluded from gross income) is amended
17 by redesignating section 137 as section 138 and by insert-
18 ing after section 136 the following new section:

19 **“SEC. 137. DISTRIBUTIONS FROM INDIVIDUAL RETIREMENT** 20 **ACCOUNTS AND SECTION 401(k) PLANS FOR** 21 **LONG-TERM CARE INSURANCE.**

22 “(a) GENERAL RULE.—The amount includible in the
23 gross income of an individual for the taxable year by rea-
24 son of qualified distributions during such taxable year
25 shall not exceed the excess of—

1 “(1) the amount which would (but for this sec-
2 tion) be so includible by reason of such distributions,
3 over

4 “(2) the aggregate premiums paid by such indi-
5 vidual during such taxable year for any long-term
6 care insurance contract for the benefit of such indi-
7 vidual or the spouse of such individual.

8 “(b) QUALIFIED DISTRIBUTION.—For purposes of
9 this section, the term ‘qualified distribution’ means any
10 distribution to an individual from an individual retirement
11 account or a section 401(k) plan if such individual has
12 attained age 59½ on or before the date of the distribution
13 (and, in the case of a distribution used to pay premiums
14 for the benefit of the spouse of such individual, such
15 spouse has attained age 59½ on or before the date of the
16 distribution).

17 “(c) DEFINITIONS AND SPECIAL RULES RELATING
18 TO LONG-TERM INSURANCE CONTRACTS.—

19 “(1) LONG-TERM CARE INSURANCE CON-
20 TRACT.—

21 “(A) IN GENERAL.—For purposes of this
22 section, the term ‘long-term care insurance con-
23 tract’ means any insurance contract issued if—

24 “(i) the only insurance protection pro-
25 vided under such contract is coverage of

1 qualified long-term care services and bene-
2 fits incidental to such coverage,

3 “(ii) the maximum benefit under the
4 policy for expenses incurred for any day
5 does not exceed \$200,

6 “(iii) such contract does not cover ex-
7 penses incurred for services or items to the
8 extent that such expenses are reimbursable
9 under title XVIII of the Social Security
10 Act or would be so reimbursable but for
11 the application of a deductible or coinsur-
12 ance amount,

13 “(iv) such contract is guaranteed re-
14 newable,

15 “(v) such contract does not have any
16 cash surrender value, and

17 “(vi) all refunds of premiums, and all
18 policyholder dividends or similar amounts,
19 under such contract are to be applied as a
20 reduction in future premiums or to in-
21 crease future benefits.

22 “(B) SPECIAL RULES.—

23 “(i) PER DIEM, ETC. PAYMENTS PER-
24 MITTED.—A contract shall not fail to be
25 treated as described in subparagraph

1 (A)(i) by reason of payments being made
2 on a per diem or other periodic basis with-
3 out regard to the expenses incurred during
4 the period to which the payments relate.

5 “(ii) CONTRACT MAY COVER MEDI-
6 CARE REIMBURSABLE EXPENSES WHERE
7 MEDICARE IS SECONDARY PAYOR.—Sub-
8 paragraph (A)(iii) shall not apply to ex-
9 penses which are reimbursable under title
10 XVIII of the Social Security Act only as a
11 secondary payor.

12 “(iii) REFUNDS OF PREMIUMS.—Sub-
13 paragraph (A)(vi) shall not apply to any
14 refund of premiums on surrender or can-
15 cellation of the contract.

16 “(2) QUALIFIED LONG-TERM CARE SERVICES.—

17 For purposes of this subsection—

18 “(A) IN GENERAL.—The term ‘qualified
19 long-term care services’ means necessary diag-
20 nostic, preventive, therapeutic, and rehabilita-
21 tive services, and maintenance or personal care
22 services, which—

23 “(i) are required by a chronically ill
24 individual in a qualified facility, and

1 “(ii) are provided pursuant to a plan
2 of care prescribed by a licensed health care
3 practitioner.

4 “(B) CHRONICALLY ILL INDIVIDUAL.—

5 “(i) IN GENERAL.—The term ‘chron-
6 ically ill individual’ means any individual
7 who has been certified by a licensed health
8 care practitioner as—

9 “(I) being unable to perform
10 (without substantial assistance from
11 another individual) at least 2 activi-
12 ties of daily living (as defined in
13 clause (ii)) for a period of at least 90
14 days due to a loss of functional capac-
15 ity, or having a similar level of disabil-
16 ity (as determined by the Secretary in
17 consultation with the Secretary of
18 Health and Human Services), or

19 “(II) having a similar level of
20 disability due to cognitive impairment.

21 “(ii) ACTIVITIES OF DAILY LIVING.—
22 For purposes of clause (i), each of the fol-
23 lowing is an activity of daily living:

24 “(I) MOBILITY.—The process of
25 walking or wheeling on a level surface

1 which may include the use of an
2 assistive device such as a cane, walk-
3 er, wheelchair, or brace.

4 “(II) DRESSING.—The overall
5 complex behavior of getting clothes
6 from closets and drawers and then
7 getting dressed.

8 “(III) TOILETING.—The act of
9 going to the toilet room for bowel and
10 bladder function, transferring on and
11 off the toilet, cleaning after elimi-
12 nation, and arranging clothes or the
13 ability to voluntarily control bowel and
14 bladder function, or in the event of in-
15 continence, the ability to maintain a
16 reasonable level of personal hygiene.

17 “(IV) TRANSFER.—The process
18 of getting in and out of bed or in and
19 out of a chair or wheelchair.

20 “(V) EATING.—The process of
21 getting food from a plate or its equiv-
22 alent into the mouth.

23 “(C) QUALIFIED FACILITY.—The term
24 ‘qualified facility’ means—

1 “(i) a nursing, rehabilitative, hospice,
2 or adult day care facility (including a hos-
3 pital, retirement home, nursing home,
4 skilled nursing facility, intermediate care
5 facility, or similar institution)—

6 “(I) which is licensed under
7 State law, or

8 “(II) which is a certified facility
9 for purposes of title XVIII or XIX of
10 the Social Security Act, or

11 “(ii) an individual’s home if a licensed
12 health care practitioner certifies that with-
13 out home care the individual would have to
14 be cared for in a facility described in
15 clause (i).

16 “(D) MAINTENANCE OR PERSONAL CARE
17 SERVICES.—The term ‘maintenance or personal
18 care services’ means any care the primary pur-
19 pose of which is to provide needed assistance
20 with any of the activities of daily living de-
21 scribed in subparagraph (B)(ii).

22 “(E) LICENSED HEALTH CARE PRACTI-
23 TIONER.—The term ‘licensed health care practi-
24 tioner’ means any physician (as defined in sec-
25 tion 1861(r) of the Social Security Act) and

1 any registered professional nurse, licensed social
2 worker, or other individual who meets such re-
3 quirements as may be prescribed by the Sec-
4 retary.

5 “(3) INFLATION ADJUSTMENT OF \$200 BENEFIT
6 LIMIT.—

7 “(A) IN GENERAL.—In the case of a cal-
8 endar year after 1995, the \$200 amount con-
9 tained in paragraph (1)(A)(ii) shall be in-
10 creased for such calendar year by the medical
11 care cost adjustment for such calendar year. If
12 any increase determined under the preceding
13 sentence is not a multiple of \$10, such increase
14 shall be rounded to the nearest multiple of \$10.

15 “(B) MEDICAL CARE COST ADJUST-
16 MENT.—For purposes of subparagraph (A), the
17 medical care cost adjustment for any calendar
18 year is the percentage (if any) by which—

19 “(i) the medical care component of
20 the Consumer Price Index (as defined in
21 section 1(f)(5)) for August of the preced-
22 ing calendar year, exceeds

23 “(ii) such component for August of
24 1994.”

1 “(d) OTHER DEFINITIONS.—For purposes of this
2 section—

3 “(1) INDIVIDUAL RETIREMENT ACCOUNT.—The
4 term ‘individual retirement account’ has the mean-
5 ing given such term by section 408(a).

6 “(2) SECTION 401(k) PLAN.—The term ‘section
7 401(k) plan’ means any employer plan which meets
8 the requirements of section 401(a) and which in-
9 cludes a qualified cash or deferred arrangement (as
10 defined in section 401(k)).

11 “(e) SPECIAL RULES FOR SECTION 401(k) PLANS.—

12 “(1) WITHDRAWALS CANNOT EXCEED ELEC-
13 TIVE CONTRIBUTIONS UNDER QUALIFIED CASH OR
14 DEFERRED ARRANGEMENT.—This section shall not
15 apply to any distribution from a section 401(k) plan
16 to the extent the aggregate amount of such distribu-
17 tions for the use described in subsection (a) exceeds
18 the aggregate employer contributions made pursuant
19 to the employee’s election under section 401(k)(2).

20 “(2) WITHDRAWALS NOT TO CAUSE DISQUALI-
21 FICATION.—A plan shall not be treated as failing to
22 satisfy the requirements of section 401, and an ar-
23 rangement shall not be treated as failing to be a
24 qualified cash or deferred arrangement (as defined
25 in section 401(k)(2)), merely because under the plan

1 or arrangement distributions are permitted which
 2 are excludable from gross income by reason of this
 3 section.”

4 (b) CONFORMING AMENDMENTS.—

5 (1) Section 401(k) of such Code is amended by
 6 adding at the end the following new paragraph:

7 “(11) CROSS REFERENCE.—

“For provision permitting tax-free withdrawals
 for payment of long-term care premiums, see section
 137.”

8 (2) Section 408(d) of such Code is amended by
 9 adding at the end the following new paragraph:

10 “(8) CROSS REFERENCE.—

“For provision permitting tax-free withdrawals
 from individual retirement accounts for payment of
 long-term care premiums, see section 137.”

11 (3) The table of sections for such part III is
 12 amended by striking the last item and inserting the
 13 following new items:

“Sec. 137. Distributions from individual retirement accounts and
 section 401(k) plans for long-term care insurance.
 “Sec. 138. Cross references to other Acts.”

14 **SEC. 702. CERTAIN EXCHANGES OF LIFE INSURANCE CON-**
 15 **TRACTS FOR LONG-TERM CARE INSURANCE**
 16 **CONTRACTS NOT TAXABLE.**

17 Subsection (a) of section 1035 of the Internal Reve-
 18 nue Code of 1986 (relating to certain exchanges of insur-
 19 ance contracts) is amended by striking the period at the

1 end of paragraph (3) and inserting “; or”, and by adding
 2 at the end thereof the following new paragraph:

3 “(4) a contract of life insurance or an endow-
 4 ment or annuity contract for a long-term care insur-
 5 ance contract (as defined in section 137(c)(1)).”

6 **SEC. 703. TAX TREATMENT OF ACCELERATED DEATH BENE-**
 7 **FITS UNDER LIFE INSURANCE CONTRACTS.**

8 Section 101 of the Internal Revenue Code of 1986
 9 (relating to certain death benefits) is amended by adding
 10 at the end thereof the following new subsection:

11 “(g) TREATMENT OF CERTAIN ACCELERATED
 12 DEATH BENEFITS.—

13 “(1) IN GENERAL.—For purposes of this sec-
 14 tion, any amount paid or advanced to an individual
 15 under a life insurance contract on the life of an in-
 16 sured—

17 “(A) who is a terminally ill individual, or

18 “(B) who is a chronically ill individual (as
 19 defined in section 137(c)(2)(B)) who is confined
 20 to a qualified facility (as defined in section
 21 137(c)(2)(C)(i)),

22 shall be treated as an amount paid by reason of the
 23 death of such insured.

24 “(2) TERMINALLY ILL INDIVIDUAL.—For pur-
 25 poses of this subsection, the term ‘terminally ill indi-

1 vidual' means an individual who has been certified
 2 by a physician as having an illness or physical condi-
 3 tion which can reasonably be expected to result in
 4 death in 12 months or less.

5 “(3) PHYSICIAN.—For purposes of this sub-
 6 section, the term ‘physician’ has the meaning given
 7 to such term by section 137(c)(2)(E).”

8 **SEC. 704. EFFECTIVE DATE.**

9 The amendments made by this subtitle shall apply to
 10 taxable years beginning after December 31, 1994.

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