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102D CONGRESS
1ST SESSION

S. 1227

To amend the Public Health Service Act, the Social Security Act, and the Internal Revenue Code of 1986 to provide affordable health care of all Americans, to reduce health care costs, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JUNE 5 (legislative day, JUNE 3), 1991

Mr. MITCHELL (for himself, Mr. KENNEDY, Mr. RIEGLE, and Mr. ROCKEFELLER) introduced the following bill; which was read twice and ordered held at the desk until the close of business June 6, 1991

JUNE 6 (legislative day, JUNE 3), 1991

Referred to the Committee on Finance

A BILL

To amend the Public Health Service Act, the Social Security Act, and the Internal Revenue Code of 1986 to provide affordable health care of all Americans, to reduce health care costs, and for other purposes.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "HealthAmerica: Affordable Health Care for All Americans Act".

(b) REFERENCE TO ACT.—Hereafter this Act may be referred to as the "HealthAmerica Act".

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

Sec. 1. Short title; table of contents.

TITLE I—AMENDMENTS TO PUBLIC HEALTH SERVICE ACT

Sec. 101. Basic health benefits for employees and their families.
Sec. 102. Obligation to secure health insurance.

TITLE II—REQUIREMENTS FOR HEALTH BENEFIT PLANS

Sec. 201. Requirements for health benefit plans.

TITLE III—SPECIAL ASSISTANCE FOR SMALL AND MEDIUM-SIZED BUSINESS

Sec. 301. Preemption of State mandated benefit laws.

Subtitle A—Reform of Small Group Insurance

Sec. 311. Group health insurance standards.

Subtitle B—Tax Equity for Small and Medium-Sized Businesses

Sec. 321. Deductible health coverage provisions.
Sec. 322. Excise tax for violation of health benefit plan requirements.

Subtitle C—Opportunity for Voluntary Provision of Coverage

Sec. 331. Medium-sized employers.
Sec. 332. Measurement surveys.
Sec. 333. Small employers.
Sec. 334. Failure to make surveys.

Subtitle D—Small Business Tax Credit

Sec. 341. Allowance of a credit for small and medium-sized business group health plan expenditures.

Subtitle E—Additional Assistance to Small and Medium-Sized Businesses

Sec. 351. Opportunity to buy coverage at medicare rates.
Sec. 352. Special provisions for new small businesses.
Sec. 353. Small and medium-sized business advisory committee.

TITLE IV—REDUCING HEALTH CARE COST INFLATION

Subtitle A—Outcomes Research and Practice Guideline Development and Dissemination

Sec. 401. Initial guidelines and standards.
Sec. 402. Amendments to the Social Security Act.

Subtitle B—Federal Health Expenditure Board

Sec. 411. Federal Health Expenditure Board.

Subtitle C—State Purchasing Consortia

Sec. 421. State purchasing consortia.

Subtitle D—Cost Control Grant Program

Sec. 431. Cost Control Grant Program.

Subtitle E—Malpractice Reform

Sec. 441. Malpractice reform.
Sec. 442. Study of medical malpractice.

Subtitle F—Reducing the Administrative Cost of Assuring Appropriate Utilization of Health Care Services and Improving the Quality of Health Care Services

Sec. 451. Establishment of a quality improvement board.

Subtitle G—Use of Practice Guidelines in Federal Health Insurance and Service Programs

Sec. 461. Use of practice guidelines in Federal health insurance and service programs.

Subtitle H—National Standards for the Promotion of Managed Care

Sec. 471. National standards for the promotion of managed care.

Subtitle I—Expansion of Technology Assessment

Sec. 481. Expansion of technology assessment.

TITLE V—CONTRIBUTION TO PUBLIC PLAN BY EMPLOYERS NOT PROVIDING HEALTH COVERAGE

Sec. 501. Contribution by employers not providing required private health benefit plans.

TITLE VI—ASSURING PROVISION OF HEALTH BENEFITS TO ALL AMERICANS

Sec. 601. Establishment of AmeriCare.

TITLE VII—DEVELOPMENT OF HEALTH SERVICE CAPACITY

Sec. 701. Grants for expansion of availability of primary care services.

TITLE VIII—EFFECTIVE DATE

Sec. 801. Effective date.
Sec. 802. Policy respecting additional benefits.

TITLE I—AMENDMENTS TO PUBLIC HEALTH SERVICE ACT

SEC. 101. BASIC HEALTH BENEFITS FOR EMPLOYEES AND THEIR FAMILIES.

(a) REQUIREMENT.—The Public Health Service Act is amended—

(1) by redesignating title XXVII (42 U.S.C. 300cc et seq.) as title XXVIII; and

(2) by inserting after title XXVI the following new title:

"TITLE XXVII—BASIC HEALTH BENEFITS FOR EMPLOYEES AND THEIR FAMILIES

"PART A—REQUIREMENTS OF HEALTH BENEFITS

"SEC. 2701. HEALTH BENEFITS.

"(a) REQUIREMENT.—

"(1) IN GENERAL.—Except as provided in part B, each employer shall—

"(A) enroll each of its employees (other than part-time employees) and their families in a health benefit plan in accordance with part B; or

"(B) make a contribution under title V of the HealthAmerica Act, for the coverage for such employees and their families under the

public health insurance plan established under title XXI of the Social Security Act.

"(2) PART-TIME EMPLOYEES.—In meeting the requirements of paragraph (1) with respect to part-time employees, an employer may, except as provided in part B—

"(A) enroll all of its part-time employees and their families as required under paragraph (1)(A); or

"(B) make a contribution to the public health insurance plan referred to in paragraph (1)(B) on behalf of all such employees.

"(3) LIMITATION.—An employer providing health insurance coverage for pregnancy-related services and for services for children in the 1-year period prior to the date of enactment of this section may not terminate coverage for such services or reduce the financial contribution provided for the cost of coverage for such services prior to the time such employer is required to provide or contribute to coverage under paragraph (1).

"(b) COORDINATION WITH PUBLIC HEALTH INSURANCE PLAN.—An employer making a contribution for coverage under the public health insurance plan as provided for in subsection (a)(1)(B) shall follow such procedures

as the Secretary may prescribe to facilitate the enrollment of its employees in such public health insurance plan. Such procedures shall include—

"(1) the distribution of enrollment forms and information to employees;

"(2) notifying in writing each employee of the availability of premium and cost-sharing subsidies for low-income families;

"(3) notifying the State in which an employee resides concerning the identify of an employee on behalf of whom a contribution is being made;

"(4) submitting enrollment forms and information to the State agency administering the public health insurance plan established under title XXI of the Social Security Act on behalf of the employee and the employee's family, if required by the State in which the employee resides;

"(5) withholding, in the form of payroll deductions, an employee's share of the public health insurance plan premium and submitting such withholding to the administering State agency on behalf of the employee, if required by the State in which the employee resides; and

"(6) notifying the appropriate administering State agency of the public health insurance plan when an employee ceases to be an employee.

"(c) ENFORCEMENT.—Any employer that does not comply with subsections (a) and (b) shall be subject to section 2732.

"(d) DEFINITIONS.—The terms used in this section shall have the meanings prescribed for such terms by section 2713.".

(b) CONFORMING AMENDMENTS.—

(1) Sections 2701 through 2714 of the Public Health Service Act (42 U.S.C. 300cc through 300cc–15) are redesignated as sections 2801 through 2814, respectively.

(2)(A) Sections 465(f) and 497 of such Act (42 U.S.C. 286(f) and 289(f)) are amended by striking out "2701" each place that such appears and inserting in lieu thereof "2801".

(B) Section 305(i) of such Act (42 U.S.C. 242c(i)) is amended by striking out "2711" each place such appears and inserting in lieu thereof "2811".

SEC. 102. OBLIGATION TO SECURE HEALTH INSURANCE.

(a) FEDERAL PROGRAMS.—Beginning with the seventh full year after the date of enactment of this Act, to

be eligible for benefits under a Federal program, an individual seeking benefits under such program shall certify to the administrator of such program that such individual and the dependents of such individual possess health insurance coverage that meets the applicable minimum standards under this Act.

(b) INTERNAL REVENUE EXEMPTIONS.—To be eligible to claim the exemption amount to which an individual is entitled under section 151 of the Internal Revenue Code of 1986, such individual shall certify, as part of the personal income tax return filed by such individual with the Internal Revenue Service, that such individual is covered under a health insurance plan that meets the applicable minimum standards under this Act. A parent shall make such certification on behalf of a dependent child.

TITLE II—REQUIREMENTS FOR HEALTH BENEFIT PLANS

SEC. 201. REQUIREMENTS FOR HEALTH BENEFIT PLANS.

Title XXVII of the Public Health Service Act (as added by section 101) is amended by adding at the end thereof the following new part:

"PART B—REQUIREMENTS FOR HEALTH BENEFIT PLANS

"Subpart 1—Requirement and Definitions

"SEC. 2711. REQUIREMENT TO ENROLL EMPLOYEES AND FAMILIES.

"(a) IN GENERAL.—This part shall apply to employers required to enroll employees and their families in health benefit plans under section 2701(a).

"(b) TYPES OF PLANS PERMITTED.—Except as required under chapter 2 of subtitle A of title III of the HealthAmerica Act (relating to small and medium-sized business insurance), an employer may meet the requirements of this part by means of enrollment in any health benefit plan.

"(c) EXCEPTION FOR EMPLOYERS IN HAWAII.—Employers that have employees in the State of Hawaii shall be exempt from the requirements of this part with respect to such employees, for so long as the Hawaii Prepaid Health Care Act (Hawaii Rev. Stat. Chapter 393) remains in effect. This subsection shall not apply if the proportion of the population with health care coverage provided under such Act that is at least actuarially equivalent to the coverage required under this title is, or becomes, less than that required to be provided in other States under this title or the HealthAmerica Act.

"SEC. 2712. COVERAGE OF EMPLOYEES AND FAMILY MEMBERS.

"(a) REQUIREMENT.—Except as permitted under subsections (b) and (d) and section 2723(c)—

"(1) the enrollment of an employee in a health benefit plan under this part shall include the enrollment of the family of such employee in the plan; and

"(2) the enrollment of an employee or the family of an employee in a health benefit plan may not be waived by the employee.

"(b) EXCEPTIONS TO AVOID DUPLICATE FAMILY COVERAGE.—

"(1) SPOUSE OR PARENT EMPLOYED.—An employee may waive enrollment in a health benefit plan under this part for the spouse or a child of the employee but only for such period as the employee demonstrates that such spouse or child, respectively, is actually covered under a health benefit plan.

"(2) CHILD EMPLOYED.—A child who is employed (or a parent on behalf of the child) may waive enrollment in a health benefit plan provided by the employer of such child during any period in which the child otherwise is covered under a health benefit plan.

"(c) NONDISCRIMINATION BASED ON FAMILY STATUS.—An employer shall not fail or refuse to hire, and

shall not discharge or otherwise discriminate against, any individual because the individual has a spouse or child that would be required under this part to be enrolled by such employer in a health benefit plan.

"(d) WAIVER IN CASE OF MULTIPLE EMPLOYERS.—In the case of an individual who is an employee with respect to more than one employer and who is required to enroll in a health benefit plan, such employee may waive enrollment in the health benefit plan of any such employer, but only if such employee is, and certifies to the employer that such employee is, enrolled in the health benefit plan of one employer.

"SEC. 2713. DEFINITIONS.

"(a) IN GENERAL.—Unless otherwise specifically provided, as used in this title:

"(1) CHILD.—The term 'child' means, with respect to an employee, an individual—

"(A) who—

"(i) is under 19 years of age;

"(ii) is under [illegible] years of age and a full-time student; or

"(iii) is an unmarried, dependent child, regardless of age, who is incapable of self-support as a result of a mental or

physical disability that existed prior to the individual reaching 22 years of age; and

"(B)(i) who is the biological, adopted, or foster child of the employee or the spouse of the employee, or of the dependent child of the employee or the spouse of the employee;

"(ii) who is the legal ward of the employee or the spouse of the employee; or

"(iii) with respect to whom the employee or spouse of the employee, stands in loco parentis during the course of an adoption application.

"(2) EMPLOYEE.—

"(A) IN GENERAL.—Except as otherwise provided in this paragraph, the term 'employee' means, with respect to an employer, an individual who normally performs at least 1 hour of service per week for that employer.

"(B) HANDICAPPED WORKERS.—The term 'employee' does not include an individual described in section 14(c) of the Fair Labor Standards Act of 1938 (29 U.S.C. 214(c)).

"(C) CERTAIN EMPLOYEES.—The term 'employee' means, with respect to an employer described in section 3(37) of the Employee Retirement Income Security Act of 1974 (29

U.S.C. 1002(37)), an individual who performs—

"(i) 17.5 hours or more of service per week for the employer; or

"(ii) an equivalent amount of service during a 1-, 3-, or 6-month period for the employer, as determined under regulations issued by the Secretary.

"(D) LESS-THAN-FULL-TIME EMPLOYEE DEFINED.—The term 'less-than-full-time employee' means, with respect to an employer, an employee who normally performs on a monthly basis less than 25 hours of service per week but more than 17.5 hours per week for that employer.

"(E) CONSULTANTS AND CONTRACTORS.—The term 'employee' shall include an individual who is a consultant or independent contractor of an employer if the Secretary determines that the consulting arrangement or contract was entered into to avoid the requirements of this part.

"(F) PART-TIME EMPLOYEE.—The term 'part-time employee' means, with respect to an

employer, an individual who normally performs on a monthly basis—

"(i) less than 17.5 hours per week; and

"(ii) 1 hour or more per week for that employer.

"(3) EMPLOYER.—

"(A) IN GENERAL.—Except as otherwise provided in this paragraph, the term 'employer' means—

"(i) an entity that is required to pay the individuals it employs the minimum wage prescribed by section 6 of the Fair Labor Standards Act of 1938 (29 U.S.C. 206) (or would be required to pay such wage but for the dollar volume standards prescribed in section 3(s) of such Act (29 U.S.C. 203(s)) or the exemptions prescribed in section 13(a) of such Act (29 U.S.C. 213(a)); and

"(ii) any State or political subdivision thereof, or any agency or instrumentality thereof;

but such term does not include the Federal Government or a subdivision thereof.

"(B) OWNER-OPERATORS.—An owner-operator of a business shall be considered to be both an employer and employee with respect to himself or herself if the owner-operator has one or more other employees.

"(C) SMALL AND MEDIUM-SIZED EMPLOYERS.—The term 'small employer' means, with respect to a calendar year, an employer that normally employs fewer than 25 employees during the calendar year, and the term 'medium-sized employer' means, with respect to a calendar year, an employer that normally employs 25 or more employees, but not more than 100 employees, during the calendar year.

"(D) APPLICATION OF CONTROLLED GROUP RULES.—Section 607(4) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1167(4)) shall apply in the determination under this part of whether an employer is a small or medium-sized employer and the number of employees an employer normally employs.

"(E) FAMILY FARMERS.—

"(i) PRICE SUPPORT GREATER THAN 70 PERCENT OF PARITY.—The term 'employer' shall not include the owner or oper-

ator of a family farm unless the level of agricultural prices, or the minimum level of agricultural price support provided by the Secretary of Agriculture for loans and purchases, for the major commodity produced on the farm is equal to or greater than 70 percent of the parity price of the commodity as maintained by the Secretary during the preceding 2 crop years.

"(ii) PRICE SUPPORT LESS THAN 70 PERCENT OF PARITY.—Owners and operators of a family farm who do not receive minimum agricultural price support through loans and purchases that is equal to or greater than 70 percent of parity for the major commodity produced on the farm from the Secretary of Agriculture for the preceding crop year shall be included within the definition of the term 'employer' only if, based on a national referendum conducted by the Secretary of Agriculture, a majority of the owners and operators vote in favor of mandatory participation in the small business insurance program pro-

vided by part C and the HealthAmerica Act.

"(iii) NO COVERED EMPLOYEES.—Owners and operators of family farms with no employees required to be enrolled in health benefit plans under this part, shall be included in the definition of 'employee' under this part if, based on a national referendum conducted by the Secretary of Agriculture, a majority of farmers in the commodity group vote in favor of mandatory participation in the small business insurance program provided by part C and the HealthAmerica Act.

"(iv) DEFINITION OF FAMILY FARM.—As used in this subparagraph, the term 'family farm' means a farm with respect to which—

"(I) the operator or the family of the operator, or both (or, if the operator is a cooperative, corporation, partnership, or joint operation, the members, stockholders, partners, or joint operators, respectively) devote a sub-

stantial amount of time daily to the management or operation of the farm;

"(II) a majority of the hours of labor required annually for the (farm and nonfarm) enterprise of the farm is provided by the operator or the family of the operator, or both (or, if the operator is a cooperative, corporation, partnership, or joint operation, by the members, stockholders, partners, or joint operators, respectively, and the families of such individuals); and

"(III) the value of the gross annual sales of agricultural commodities produced on the farm is not more than $750,000.

"(4) FAMILY AND FAMILY MEMBER.—The terms 'family' and 'family member' mean, with respect to an employee, the spouse and children of the employee.

"(5) HEALTH BENEFIT PLAN.—The term 'health benefit plan' means an employee welfare benefit plan (as defined in section 3(1) of the Employee

Retirement Income Security Act of 1974 (29 U.S.C. 1002(1)) that—

"(A) provides medical care to participants or beneficiaries directly or through insurance, reimbursement, or otherwise; and

"(B) meets the requirements of section 2721.

"(6) INSURER.—The term 'insurer' means an entity qualified under the laws of a State to offer insurance or provide health benefits in that State.

"(7) MANAGED CARE.—

"(A) MANAGED CARE ENTITY.—The term 'managed care entity' means an insurer, health maintenance organization, preferred provider organization, dental plan organization, or other entity licensed to do business in a State, that markets managed care plans to groups or individuals or an employer, labor union or other State licensed entity that provides managed care plans for its employees or members.

"(B) MANAGED CARE PLAN.—The term 'managed care plan' means a health benefit plan—

"(i) in which the insurer—

"(I) utilizes explicit standards for the selection and recertification of participating providers;

"(II) has organizational arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for its health services, which program (aa) stresses health outcomes, and (bb) provides review by physicians and other health professionals of the process followed in the provision of health services; and

"(III) contains significant incentives to use the participating providers and procedures provided for by the plan; and

"(ii) which, if it limits coverage of services to those provided by participating providers or permits deductibles and coinsurance with respect to basic health services provided by persons who are not participating providers which are in excess of those permitted under health benefit plans—

"(I) has a sufficient number and distribution of participating providers to assure that all covered items and services are (aa) available and accessible to each enrollee, within the area served by the plan, with reasonable promptness and in a manner which assures continuity, and (bb) when medically necessary, available and accessible twenty-four hours a day and seven days a week; and

"(II) provides benefits for covered items and services not furnished by participating providers if the items and services are medically necessary and immediately required because of an unforeseen illness, injury, or condition.

"(C) PARTICIPATING PROVIDER.—The term 'participating provider' means a physician, hospital, health maintenance organization, pharmacy, laboratory, or other appropriately licensed provider of health care services or supplies, that has entered into an agreement with a managed care entity to provide such services

or supplies to a patient enrolled in a managed care plan.

"(D) UTILIZATION REVIEW.—The term 'utilization review' means a program for reviewing the necessity and appropriateness of health care services provided or proposed to be provided to a patient.

"(8) MENTAL DISORDER.—The term 'mental disorder' has the same meaning given such term in the International Classification of Diseases, 9th Revision, Clinical Modification.

"(9) NONGOVERNMENTAL EMPLOYER.—The term 'nongovernmental employer' means an employer not described in paragraph (3)(A)(ii).

"(10) PHYSICIAN SERVICES.—The term 'physician services' means professional medical services lawfully provided by a physician under State medical practice acts, and includes professional services provided by a dentist, licensed advanced-practice nurse, optometrist, podiatrist, or chiropractor acting within the scope of their practices (as determined under State law) if such services would be treated as physician services if furnished by a physician, except as provided in section 2722(e).

"(11) STATE.—

"(A) IN GENERAL.—The term 'State' means each of the several States and the District of Columbia.

"(B) ELECTION.—If the Governor of the Commonwealth of Puerto Rico or of any territory of the United States certifies to the President that Puerto Rico or such territory has enacted legislation stating that Puerto Rico or such territory desires to be included under the provisions of this Act, Puerto Rico or such territory shall be included under the definition of State for the purposes of this part beginning with January 1 of the first calendar year which begins later than 90 days after the President receives such notification.

"Subpart 2—Requirements for Health Benefit Plans

"SEC. 2721. GENERAL REQUIREMENTS; PERMITTING ACTUARIALLY EQUIVALENT PLANS.

"(a) GENERAL REQUIREMENTS.—Subject to subsections (b) and (c), in order for a health benefit plan to meet the requirements of this section, such plan shall—

"(1) provide benefits for items and services in accordance with section 2722;

"(2) provide coverage of employees and family enrolled in the plan in accordance with section 2723; and

"(3) provide for premiums, deductibles, copayments, and coinsurance in accordance with section 2724.

"(b) ACTUARIALLY EQUIVALENT PLANS PERMITTED.—

"(1) VARIATIONS IN PREMIUMS, DEDUCTIBLES, AND COST-SHARING.—A health benefit plan shall meet the requirements of this section, notwithstanding that such plan does not meet one or more of the requirements of section 2724 (relating to premiums, deductibles, copayments, coinsurance, and limit on out-of-pocket expenses) if the actuarial value of benefits provided under the plan (as defined in paragraph (8)) is not less than the equivalent of the actuarial value of benefits provided under the plan that would have applied if the plan met the requirements described in subsection (a).

"(2) MINIMUM REQUIREMENTS.—Nothing in this subsection shall be construed as not requiring each plan—

"(A) to meet the requirements of section 2723; or

"(B) to establish a limit on out-of-pocket expenses under section 2724(d), except that this subparagraph shall not be construed to require the establishment of the out-of-pocket limit described in section 2724(d)(5)(B).

"(3) MENTAL HEALTH BENEFITS.—Notwithstanding any other provision of this part or of the HealthAmerica Act, a health benefit plan may meet the requirements of section 2722(a)(6) by including payment for any reasonable combination of benefits described in subparagraphs (A) and (B) of such section if the plan includes payment for—

"(A) benefits the value of which is at least actuarially equivalent to the value of the benefits for which payment is otherwise required under such subparagraphs; and

"(B) both types of benefits described in each such subparagraph.

"(4) ADVISORY BOARD.—

"(A) ESTABLISHMENT.—The Secretary shall establish an Advisory Board to provide advice to the Secretary concerning the development of actuarial equivalency standards and such other matters relating to the administra-

tion of this part as the Secretary or the Board considers appropriate.

"(B) MEMBERSHIP.—The Advisory Board shall consist of 15 members appointed by the Secretary, of whom—

"(i) four members shall be representatives of employers, who shall be experienced in the administration of and knowledgeable about health insurance and actively engaged in the management or design of health insurance programs, of which—

"(I) two members shall be representatives of large businesses, as determined by the Secretary; and

"(II) two members shall be representatives of small and medium-sized businesses;

"(ii) two members shall be representatives of labor organizations, who shall possess qualifications of the type required for representatives under clause (i);

"(iii) four members shall be representatives of the insurance industry, at least

one of whom shall be knowledgeable about small group policies;

"(iv) two members shall be actuaries, who shall be experienced in the administration of and knowledgeable about health insurance programs; and

"(v) three members shall be representatives of consumers not described in clauses (i) through (iv).

"(C) TERMS.—Each member of the Advisory Board shall serve for a term of 4 years, except that members initially appointed shall serve for staggered terms, as designated by the Secretary. A member may serve on the Board after the expiration of the term of the member until a successor has taken office as a member of the Board.

"(D) COMPENSATION.—The members of the Advisory Board may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, while away from their homes or regular places of business, for each day (including travel time) during which they are attending meetings or conferences of the

Advisory Board or otherwise engaged in the business of the Board.

"(E) DEVELOPMENT OF ACTUARIAL EQUIVALENCY VARIATIONS.—Not later than 6 months before the effective date of this part, the Advisory Board shall develop and transmit to the Secretary—

"(i) at least three model health plans each with an actuarial value of benefits that is equivalent to the actuarial value of benefits of a basic plan (as defined in paragraph (9));

"(ii) a table of actuarial equivalency describing permitted expansions in covered services and variations in copayments, deductibles, limits on out-of-pocket expenses, and an employer's share of the premium or premiums under a health plan, as a percentage increase or decrease in the actuarial value of the basic plan, with the table describing as many expansions and variations as practicable in order to facilitate compliance with this section; and

"(iii) recommendations for procedures to facilitate the process by which an em-

ployer may certify actuarial equivalency for plan variations not provided in the model health plans or the table of actuarial equivalency and for the certification of multiple plans offered by the same employer.

"(F) REVIEW OF CHANGES.—The Advisory Board shall review proposed changes to the basic benefit package required of health benefit plans and transmit a cost benefit analysis of such changes, along with recommendations, to the appropriate committees of Congress and the Secretary.

"(5) TABLE OF ACTUARIAL EQUIVALENCY.—The Secretary shall publish, at least 3 months prior to the effective date of this part, a table that specifies the percentage increase or decrease in the actuarial value of benefits under a health benefit plan providing only the required benefits that would result from variations in covered services, copayments, deductibles, limits on out-of-pocket expenses, an employer's share of the premium or premiums under a health benefit plan, or any combination thereof. The table shall describe as many variations as feasible. In developing the table, the Secretary shall consider

the recommendations of the Advisory Board established under paragraph (4).

"(6) COMPLIANCE WITH FIDUCIARY DUTIES.—In the case of health benefit plan variations for which relative actuarial values are not expressly provided for in the table published under paragraph (5) or in the case of variations in which one or more elements of covered services, copayments, deductibles, and limits on out-of-pocket expenses are given a relative actuarial value by the plan administrator that is different from that provided by such table, the plan shall not be considered out of compliance with this section—

"(A) if, under a process consistent with the duties of a fiduciary under part 4 of title I of the Employee Retirement Income Security Act of 1974, it is established that, and an actuary meeting credentials established by the American Academy of Actuaries or by the Secretary has certified that, the actuarial value of the benefits of the plan is at least equivalent to the actuarial value of the benefits of a basic plan; and

"(B) until and unless the Secretary has determined that such variations are not in compliance with the requirements of this section.

"(7) MULTIPLE PLANS.—In the case of an employer that has a health benefit plan that meets the requirements of paragraph (6)(A) or is otherwise determined to have an actuarial value of benefits that is at least equivalent to the actuarial value of a basic plan, the Secretary shall establish by regulation streamlined procedures for the approval of additional health benefit plans the actuarial value of the benefits of which is at least equivalent to the actuarial value of the benefits of the approved health benefit plan.

"(8) ACTUARIAL VALUE OF BENEFITS DEFINED.—For purposes of this subsection, the "actuarial value of benefits" of a plan is the amount by which the total of the amounts payable as benefits under the plan exceeds the amount of the premiums, deductibles, copayments, and coinsurance payable by the employee under the plan, as determined on an actuarial basis per enrollee for a plan year.

"(9) BASIC PLAN DEFINED.—For purposes of this subsection, the term 'basic plan' means a health benefit plan that only provides the basic benefits required under this part.

"SEC. 2722. REQUIREMENTS RELATING TO COVERED ITEMS AND SERVICES.

"(a) IN GENERAL.—Except as otherwise provided in this section, a health benefit plan shall include payment for—

"(1) inpatient and outpatient hospital care, except that treatment for a mental disorder is subject to the special limitations described in paragraph (6)(A);

"(2) inpatient and outpatient physician services, except that psychotherapy or counseling for a mental disorder is subject to the special limitations described in paragraph (6)(B);

"(3) diagnostic tests;

"(4) prenatal care and well-baby care provided to children who are 1 year of age or younger;

"(5) preventive services, limited to—

"(A) well child care;

"(B) pap smears; and

"(C) mammograms; and

"(6)(A) inpatient hospital care for a mental disorder for not less than 45 days per year, except that days of partial hospitalization or residential care may be substituted for days of inpatient care according to a ratio established by the Secretary; and

"(B) outpatient psychotherapy and counseling for a mental disorder for not less than 20 visits per year provided by a provider who is acting within the scope of State law and who—

"(i) is a physician; or

"(ii) meets the standards of subsection (g)(2)(B) and is a duly licensed or certified clinical psychologist or a duly licensed or certified clinical social worker, a duly licensed or certified equivalent mental health professional, or a clinic or center providing duly licensed or certified mental health services.

"(b) EXCEPTIONS.—Subsection (a) shall not be construed as requiring a plan to include payment for—

"(1) items and services that are not medically necessary;

"(2) routine physical examinations or preventive care (other than care and services described in paragraphs (4) and (5) of subsection (a); or

"(3) experimental services and procedures, except that this paragraph shall not apply to routine medical costs associated with peer-reviewed and approved protocols conducted in connection with peer-reviewed and approved research programs, pursuant to standards established by the Secretary.

"(c) AMOUNT, SCOPE, AND DURATION OF CERTAIN BENEFITS.—Except as provided in subsection (b), a health benefit plan shall place no limits on the amount, scope, or duration of benefits described in paragraphs (1) through (3) of subsection (a).

"(d) AMOUNT, SCOPE, AND DURATION OF PREVENTIVE SERVICES.—A health benefit plan may limit the amount, scope, and duration of preventive services described in subsection (a)(5) pursuant to regulations of the Secretary specifying the amount, scope, and duration of such care. The Secretary shall develop such regulations after consultation with appropriate medical experts.

"(e) LIMITATIONS.—

"(1) PANELS AND MANAGED CARE SYSTEMS.—Nothing in this title or the HealthAmerica Act, shall prohibit a health benefit plan from providing benefits for the items and services described in this section through a managed care system, and from selecting particular health care providers or types, classes, or categories of health care providers to participate in such managed care system. Such managed care system shall provide, in accordance with regulations issued by the Secretary, reasonable access to care by plan enrollees.

"(2) DIFFERENT LEVELS OF PAYMENTS.—Nothing in this title or the HealthAmerica Act, shall prohibit a health benefit plan from establishing a different level of payments for reimbursement for different health care providers furnishing the benefits for the items and services described in this section.

"(3) HEALTH CARE PROVIDERS.—Nothing in this title or the HealthAmerica Act, shall be construed to require a health benefit plan to utilize any health care provider (or type, class, or category of health care provider) to provide benefits for the items and services described in this section that were provided by the plan before the effective date of this part, other than the health care providers being utilized by the health benefit plan on such effective date, except that this paragraph shall not apply to duly licensed or certified clinical psychologists (acting within the scope of State law) after the end of the 5-year period beginning on the effective date of this part. This paragraph shall not apply to plans offered under part C.

"(4) DENIAL OF PAYMENT TO EXCLUDED PROVIDERS.—Nothing in this title or the HealthAmerica Act, shall require a health benefit plan to make pay-

ment to any health care provider that is excluded from participation in any Federal health care program.

"(f) BASIS OF PAYMENT MAY DIFFER FROM ACTUAL CHARGES.—The requirement of payment for services described in subsection (a) shall not prevent an employer from establishing a fee schedule or other basis of payment that is different from actual charges, but only if such fee schedule or other basis provides, pursuant to regulations of the Secretary, for payment at a level sufficient to achieve adequate access to services covered by the plan without additional out-of-pocket expenses for the covered service (but for copayments and deductibles permitted under section 2724).

"(g) MENTAL HEALTH CARE.—

"(1) INPATIENT CARE.—Subject to the provisions of subsection (e), inpatient hospital care described in subsection (a)(6)(A) shall include reimbursement for professional care provided to the individual while the individual is receiving such inpatient care, by a physician or duly licensed or certified clinical psychologist operating within the scope of practice of the physician or psychologist, as determined appropriate under State law. Nothing in this subsection shall be construed to modify hospital practices

with regard to scope of practice, admitting privileges, or billing arrangements.

"(2) OUTPATIENT CARE.—

"(A) USE OF PROVIDERS.—Subject to the provisions of subsection (e), a health benefit plan that provided benefits with respect to outpatient psychotherapy described in subsection (a)(6)(B) prior to January 1, 1991, shall not be required under such subsection to provide benefits for outpatient psychotherapy provided by any health care provider (or type, class, or category of health care provider) described in subsection (a)(6)(B)(ii), other than duly licensed or certified clinical psychologists and health care providers being utilized by the plan on January 1, 1991. This subparagraph shall not apply to plans offered under part C.

"(B) STANDARDS FOR CERTAIN PROVIDERS.—The Secretary shall establish standards that providers referred to in subsection (a)(6)(B)(ii) must meet to be eligible for payment under a health benefit plan and such standards shall require that such providers have training and education equivalent to a licensed

clinical social worker (as defined in title XVIII of the Social Security Act).

"(h) STUDIES.—

"(1) SERVICES.—The Secretary shall periodically review the appropriateness of the preventive services required to be covered under this section and prepare and submit to the appropriate committees of Congress a report concerning any recommendations for changes in the list of such services that are required to be covered.

"(2) COVERAGE FOR CERTAIN SERVICES.—Not later than 1 year after the date of enactment of this part, the Secretary shall prepare and submit to the appropriate committees of Congress a report concerning the cost-effectiveness and desirability of coverage of colorectal cancer screening, prostate cancer screening, osteoporosis screening, and outpatient prescription drugs.

"SEC. 2723. REQUIREMENTS RELATING TO TIMING OF COVERAGE AND PROHIBITION OF PREEXISTING CONDITION LIMITATIONS.

"(a) DATE OF INITIAL COVERAGE.—In the case of an employee (and family members) enrolled under a health benefit plan provided by an employer, the coverage under

the plan shall begin not later than the latest of the following:

"(1) 30 days after the date on which the employee first performs an hour of service as an employee of that employer, or in a case where an employer does not provide immediate coverage under the plan, on the day on which an employee who has performed an hour of service for the employer agrees to pay 100 percent of the normal employer and employee premium for the period prior to the normal beginning of coverage under the plan. The employer shall notify the employee on the first day on which the employee first performs an hour of service for the employer of the rights of the employee under this subsection.

"(2) The first day on which the employer is required to meet the requirements of this part.

"(3) In the case of an employer described in section 2713(a)(2)(C)—

"(A) 90 days after the date on which the employee first performs an hour of plan-covered service as an employee of the employer, except that if the initial waiting period is greater than 30 days, coverage under the plan shall continue for an equivalent period after the last day on

which the employee performs an hour of plan-covered service as an employee of the employer; or

"(B) 180 days after the date on which the employee first performs an hour of plan-covered service, except that if the initial waiting period is greater than 30 days, coverage under the plan shall continue for an equivalent period after the last day on which the employee performs an hour of plan-covered service.

"(4) Subject to section 2712(b), in the case of a child, coverage applies for any period during which the employee, who is the parent of the child, is covered.

"(b) PROHIBITION OF PREEXISTING CONDITION PROVISIONS.—A health benefit plan shall not exclude or otherwise limit any individual from coverage under the plan on the basis that the individual has (or at any time has had) any disease, disorder, or condition.

"(c) RIGHT TO WAIVE ENROLLMENT.—

"(1) LESS-THAN-FULL-TIME OR PART-TIME EMPLOYEES WITH INCREASED PREMIUMS.—In the case of a less-than-full-time or part-time employee who is subject to, and is charged, an increased premium under section 2724(b)(5), the employee may, not-

withstanding any other provision of this part, waive enrollment under this part. Such waiver shall be exercised in such form and manner as the Secretary shall specify and shall terminate on the date the employee is no longer being subject to, and charged, such an increased premium.

"(2) EMPLOYER CONTRIBUTION TO PUBLIC HEALTH INSURANCE PLAN.—In the case of a less-than-full-time or part-time employee who waives enrollment under paragraph (1), the employer shall, in a manner required by the Secretary, make a payment under title V of the HealthAmerica Act equal to the minimum amount the employer would have made towards the actuarial cost of coverage of the employee if the employee had not waived such enrollment.

"(d) CONTINUED COVERAGE.—If an employee's coverage or coverage for the family members of an employee would normally terminate during a period of hospitalization, such coverage shall continue until the employee or family member is discharged from the hospital.

"SEC. 2724. REQUIREMENTS RELATING TO PREMIUMS, DEDUCTIBLES, COPAYMENTS, COINSURANCE, AND LIMIT ON OUT-OF-POCKET EXPENSES.

"(a) ENROLLEE COST-SHARING PERMITTED.—A health benefit plan may require an enrollee to pay for premiums, deductibles, copayments, and coinsurance amounts for coverage under the plan, but only if such premiums, deductibles, copayments, and coinsurance do not exceed the limitations imposed under this section.

"(b) LIMITATION ON PREMIUMS.—

"(1) MONTHLY PREMIUM LIMITED TO 20 PERCENT OF ACTUARIAL RATE.—

"(A) IN GENERAL.—Subject to paragraphs (4) and (5), a health benefit plan shall not require an employee to pay a premium—

"(i) for coverage for a period of longer than one month; or

"(ii) the amount of which on a monthly basis exceeds 20 percent of the monthly actuarial rate defined under subparagraph (B).

"(B) MONTHLY ACTUARIAL RATE DEFINED.—For purposes of this subsection, the term 'monthly actuarial rate' means, with respect to a health benefit plan in a plan year, the average monthly per enrollee amount that

the employer providing the plan estimates, based on actuarial calculations conducted in conformity with requirements established by the Secretary, for enrollees under the plan during the year, would be necessary to pay for the total benefits required under the plan (including administrative costs for the provision of such benefits and an appropriate amount for a contingency margin) during the year.

"(C) APPLICATION ON BASIS OF FAMILY STATUS.—For purposes of this paragraph, a health benefits plan may provide for the premium to be applied, and the monthly actuarial rate to be computed—

"(i) separately for employees who have family members covered under the plan and for employees who do not have family members covered under the plan; and

"(ii) with respect to employees with such covered family members, separately—

"(I) for employees who have a covered spouse and one or more covered children;

"(II) for employees who have a covered spouse but no covered children; and

"(III) for employees who do not have a covered spouse but have one or more covered children.

"(D) ADJUSTMENT FOR COVERED SPOUSE WITH OTHER COVERAGE.—For purposes of this paragraph, if a health benefit plan charges an employee for a share of the premium, the plan shall establish a separate premium category (or categories) for family coverage in the case of a covered spouse who is receiving primary health insurance coverage from another health benefit plan. The premium for such categories shall be established based on actual or projected plan experience or according to a formula established by the Secretary, and shall take into account the reduction in health insurance costs resulting from such coverage.

"(E) ADJUSTMENT OF PREMIUMS FOR EMPLOYED RETIREES UNDER HEALTH BENEFIT PLANS.—If an employer provides a health benefit plan with respect to retirees and the plan charges a retiree for a share of the premium of

the plan, in the case of such a retiree who is enrolled as an employee (or dependent) under another health benefit plan under this part, the health benefit plan with respect to the retiree shall provide for an adjustment of the amount of the premium paid by the retiree to take into account the reduction in health insurance costs resulting from such coverage.

"(2) PAYMENT OF PREMIUMS.—An employee enrolled under a health benefit plan is liable for payment of premiums required under that plan in accordance with this subsection.

"(3) WITHHOLDING PERMITTED.—No provision of State law shall prevent an employer of an employee enrolled under a health benefit plan established under this part from withholding the amount of any premium due by the employee from the payroll of the employee.

"(4) SPECIAL RULE FOR LESS-THAN-FULL-TIME EMPLOYEES.—In the case of a less-than-full-time employee (as defined in section 2713(3)(D)), a health benefit plan may require the employee to pay a premium the amount of which (on a monthly basis) does not exceed—

"(A) 100 percent, minus

"(B) 80 percent, multiplied by the ratio of—

"(i) the average number of hours per week the employee is normally employed by the employer in the calendar quarter; to

"(ii) 25,

of the monthly actuarial rate (as defined in paragraph (1)(B)).

"(5) PART-TIME EMPLOYEES.—In the case of a part-time employee, a health benefit plan may require the employee to pay a premium amount that does not exceed 50 percent of the monthly actuarial rate (as defined in paragraph (1)(B)).

"(c) LIMITATION ON DEDUCTIBLES.—

"(1) IN GENERAL.—Except as permitted under paragraph (2), a health benefit plan shall not provide, for benefits provided in any plan year, for a deductible amount that exceeds—

"(A) with respect to benefits payable for items and services furnished to any employee with no family member enrolled under the plan, for a plan year beginning in—

"(i) the first calendar year that begins more than 1 year after the effective date of this Act, $250; or

"(ii) for a subsequent calendar year, the limitation of deductions specified in this subparagraph for the previous calendar year increased by the percentage increase in the consumer price index for all urban consumers (United States city average, as published by the Bureau of Labor Statistics) for the 12-month period ending on September 30 of the preceding calendar year; and

"(B) with respect to benefits payable for items and services furnished to any employee with a family member enrolled under the plan, for a plan year beginning in—

"(i) the first calendar year that begins more than 1 year after the effective date of this part, $250 per family member and $500 per family; or

"(ii) for a subsequent calendar year, the limitation of deductions specified in this subparagraph for the previous calendar year increased by the percentage increase in the consumer price index for all urban consumers (United States city average, as published by the Bureau of Labor

Statistics) for the 12-month period ending on September 30 of the preceding calendar year.

If the limitation of deductions computed under subparagraph (A)(ii) or (B)(ii) is not a multiple of $10, it shall be rounded to the next highest multiple of $10.

"(2) WAGE-RELATED DEDUCTIBLE.—A health benefit plan may provide for any other deductible amount instead of the limitations under—

"(A) paragraph (1)(A), if such amount does not exceed (on an annualized basis) 1 percent of the total wages paid to the employee in the plan year; or

"(B) paragraph (1)(B), if such amount does not exceed (on an annualized basis) 1 percent per family member or 2 percent per family of the total wages paid to the employee in the plan year.

"(d) LIMITATION ON COPAYMENTS AND COINSURANCE.—

"(1) IN GENERAL.—Subject to paragraphs (2) through (4), a health benefit plan shall not—

"(A) require the payment of any copayment or coinsurance for an item or service

for which coverage is required by this part in an amount that exceeds 20 percent of the cost of the item or service; or

"(B) require the payment of any copayment or coinsurance for items and services required under section 2722 to be furnished in a plan year for an employee after the employee has incurred out-of-pocket expenses under the plan that are equal to the out-of-pocket limit (as defined in paragraph (5)(B)).

"(2) EXCEPTION FOR PREFERRED PROVIDERS.—If a health benefit plan establishes reasonable classifications of participating and nonparticipating providers of items and services, the plan may require payments in excess of the amount permitted under paragraph (1) in the case of items and services furnished by nonparticipating providers.

"(3) EXCEPTION FOR IMPROPER UTILIZATION.—A health benefit plan may provide for copayment or coinsurance in excess of the amount permitted under paragraph (1) for any item or service that an individual obtains without complying with any reasonable procedures established by the plan to ensure the efficient and appropriate utilization of covered services.

"(4) MENTAL HEALTH CARE.—In the case of care provided under section 2722(a)(6)(B), a health benefit plan shall not require payment of any copayment or coinsurance for an item or service for which coverage is required by this part in an amount that exceeds 50 percent of the cost of the item or service.

"(5) LIMIT ON OUT-OF-POCKET EXPENSES.—

"(A) OUT-OF-POCKET EXPENSES DEFINED.—As used in this section, the term 'out-of-pocket expenses' means, with respect to an employee in a plan year, amounts payable under the plan as deductibles and coinsurance with respect to items and services provided under the plan and furnished in the plan year on behalf of the employee and family covered under the plan.

"(B) OUT-OF-POCKET LIMIT DEFINED.—As used in this section and except as provided in subparagraph (C), the term 'out-of-pocket limit' means for a plan year beginning in—

"(i) the first calendar year that begins more than 1 year after the effective date of this part, $3,000; or

"(ii) for a subsequent calendar year, the out-of-pocket limit specified in this subparagraph for the previous calendar year increased by the percentage increase in the consumer price index for all urban consumers (United States city average, as published by the Bureau of Labor Statistics) for the 12-month period ending on September 30 of the preceding calendar year.

If the out-of-pocket limit computed under clause (ii) is not a multiple of $10, it shall be rounded to the next highest multiple of $10.

"(C) ALTERNATIVE OUT-OF-POCKET LIMIT.—A health benefit plan may provide for an out-of-pocket limit other than that defined in subparagraph (B) if, for a plan year with respect to an employee and the family of the employee, the limit does not exceed (on an annualized basis) 10 percent of the total wages paid to the employee in the plan year.

"SEC. 2725. ENROLLEE PROTECTION.

"(a) ADMINISTRATION.—

"(1) INSURANCE COMMISSIONER.—The requirements and standards established under this section

shall be administered in a State by the insurance commissioner of that State, or by any other State agency, as designated by the chief executive officer of the State.

"(2) NONCOMPLIANCE.—If the State fails to comply with the requirements of paragraph (1), or, in the judgment of the Secretary, fails to adequately perform the administrative functions required under such paragraph, the Secretary shall assume the administrative responsibilities and duties required under such paragraph in that State.

"(b) INFORMATIONAL REQUIREMENT.—

"(1) SUMMARY OF HEALTH PLAN.—

"(A) REQUIREMENT.—Not later than 30 days after the date on which the coverage of an employee under a health benefit plan under this part begins, the employer of such employee shall provide the employee with a copy of the health benefit plan and a summary of such plan in accordance with subparagraph (B).

"(B) CONTENTS.—The plan and summary provided under subparagraph (A) shall be written in a manner reasonably assumed to be understandable by the average individual. Such summary and plan shall be sufficiently accurate

and comprehensive to reasonably apprise individuals of their rights and obligations under the plan.

"(2) AVAILABILITY OF SUBSIDY.—Not later than 30 days after the date on which coverage of an employee under a health benefit plan under this part begins, the employer shall notify the employee of the availability of low-income subsidies for employees, through the public health insurance plan established under title XXI of the Social Security Act, to cover all or part of the cost of the employee's share of the premium for such health benefit plan and of any cost-sharing under such plan. Such notification shall be provided in such form as the Secretary shall require.

"(3) CHANGES IN PLAN.—An employee shall be notified in writing of any changes in the terms of their health benefit plan, not less than 30 days in advance of the implementation of such changes.

"(4) FAILURE TO PAY PREMIUMS.—With respect to a health benefit plan, the insurer issuing such plan shall notify the employee and the Secretary of the failure of the employer to make timely premium payments on behalf of the employee and the employee's family members as required under

such plan. Such notification shall be provided not less that 30 days prior to any termination of coverage by the insurer as the result of such nonpayment of premiums.

"(5) FINANCIAL STATEMENT.—An employee shall be entitled to receive, on request, a copy of the most recent financial statement prepared for the health benefit plan under which such employee is covered. An employee shall be entitled to no more than one such request during each 1-year period.

"(6) AVAILABILITY OF INFORMATION.—

"(A) FILING WITH SECRETARY AND PROVISION TO STATES.—A copy of each health benefit plan provided under this part, and any additional information prepared under this subsection concerning such plans, shall be filed with the Secretary who shall make such information available to the State or States in which the employees eligible for benefits under such plans are employed.

"(B) PROVISION TO EMPLOYEES.—Employees not receiving the information required under this subsection may request such information from the State, or, if the program in

such State is administered by the Secretary, from the Secretary.

"(c) STANDARDS AND TECHNICAL ASSISTANCE.—

"(1) MODEL PLANS AND SUMMARIES.—Not later than 9 months after the date of enactment of this part, the Secretary shall establish and make available model language for health benefit plans and the summaries of such plans.

"(2) PLAN INFORMATION.—Not later than 9 months after the date of enactment of this part, the Secretary shall promulgate regulations that describe the health benefit plan information that shall be provided to employees under this section, that shall include—

"(A) the name and address of the administrator of the plan;

"(B) the requirements of the plan with respect to eligibility;

"(C) the benefits to be provided under the plan;

"(D) the procedures for filing claims for benefits under the plan;

"(E) the procedures for appealing the denial of any claim filed under the plan; and

"(F) other information determined appropriate by the Secretary.

"(d) RIGHT TO ASSISTANCE.—

"(1) DESIGNATION OF INDIVIDUAL.—Each health benefit plan provided under this part shall designate an appropriate individual or individuals who shall be available to answer questions concerning the plan or the applicable plan requirements.

"(2) TIMELY RESPONSE.—Employees shall have the right to receive a timely written response to any questions that such employees may submit concerning their rights under the health benefits plan. Employees shall be able to rely on such written responses.

"(3) ASSISTANCE BY ADMINISTERING AUTHORITY.—The authority designated under subsection (a) shall provide assistance to employees in that State with respect to their rights under such plans and under Federal or State law.

"(e) RIGHT TO REVIEW DENIED CLAIMS.—

"(1) NOTICE.—An administrator under a health benefit plan under this part shall provide an employee with written notice concerning the denial of a claim submitted by such employee. Such notice shall include the reasons for such denial.

"(2) PROCESS FOR REVIEW.—Each health benefit plan provided under this part shall utilize a fair process for the timely review of claims denied under such plan.

"(3) CLAIM FOR CARE NEEDED FOR LIFE-THREATENING ILLNESS.—In cases in which the failure to provide health care promptly would be life-threatening or result in a risk of permanent disability, the beneficiary under the health benefit plan shall be entitled to a decision as to whether care will be provided under such plan not later than 1 day after supplying the insurer with all requested information. In the event of a denial of coverage for such care, the beneficiary shall be entitled to an expedited review of an appeal of such denial within 5 days.

"(4) APPEALS.—Individuals shall be entitled to appeal the denial of a claim submitted by such individual to the authority administering the requirements and standards under subsection (a). The Secretary shall promulgate regulations establishing procedures to be utilized for appealing denials of claims under a health benefit plan under this part that are similar to the procedures established under title XVIII of the Social Security Act for appealing deni-

als of claims under such title XVIII, including the right to a trial de novo.

"(f) RIGHT TO CHOICE.—

"(1) NONMANAGED CARE PLANS.—An employer may offer its employees a nonmanaged care plan that meets the requirements of this part as well as a managed care plan.

"(2) USE OF PROVIDERS.—If a nonmanaged care plan is not offered by an employer, the managed care plan or plans offered by such employer shall permit the utilization of providers not participating in the plan for services otherwise covered under the plan. If an employee elects to utilize such out-of-plan providers, the plan may provide for cost sharing that shall not exceed 200 percent of the normal cost-sharing imposed under the plan or 200 percent of the cost-sharing permitted under the minimum plan established under this part, whichever is greater.

"(g) RIGHT TO CONFIDENTIALITY OF MEDICAL RECORDS.—Health benefit plans under this title shall provide for the confidentiality of any medical records released under such plan.

"Subpart 3—Regulations and Enforcement

"SEC. 2731. REGULATIONS.

"(a) PROPOSED RULES.—Not later than 4 months after the date of enactment of this part, the Secretary shall publish in the Federal Register a notice of proposed rulemaking to carry out this part.

"(b) FINAL RULES.—Not later than 9 months after the date of enactment of this part, the Secretary shall promulgate final rules to carry out this part. Such notice and final rules shall be made in accordance with section 553 of title 5, United States Code.

"(c) EFFECT OF FAILURE TO PROMULGATE RULES.—The failure of the Secretary to promulgate final rules under this part shall not relieve any person or entity to which the provisions of this part apply of any obligations under this part.

"SEC. 2732. ENFORCEMENT.

"(a) CIVIL MONEY PENALTY AGAINST PRIVATE EMPLOYERS.—

"(1) 15 PERCENT OF TOTAL WAGES.—Any employer that does not comply with section 2712(c) or the requirements of section 2701(a) in any calendar year shall be subject to a civil penalty of not more than 15 percent of the total amount of the expenditures of the employer for wages for employees in that year.

"(2) INVESTIGATIONS.—The Secretary may conduct investigation under this section. In conducting such investigations, the Secretary—

"(A) shall have reasonable access to examine evidence of any person or entity being investigated; and

"(B) may, if necessary, compel by subpoena the attendance of witnesses and the production of evidence at any designated place.

"(3) ASSESSMENT PROCEDURE.—A civil money penalty under this subsection shall be assessed by the Secretary and collected in a civil action brought by the United States in a United States district court. The Secretary shall not assess such a penalty on an employer until the employer has been given notice and an opportunity for a hearing on such charge.

"(4) AMOUNT OF PENALTY.—In determining the amount of the penalty, or the amount agreed on in settlement, the Secretary shall consider the gravity of the noncompliance and the demonstrated good faith of the employer charged in attempting to achieve rapid compliance after notification of noncompliance by the Secretary.

"(5) JUDICIAL REVIEW.—In any civil action brought to review the assessment of such a penalty or to collect such a penalty, the court shall, at the request of any party to such action, hold a trial de novo on the assessment of the penalty, unless in a prior action such a trial de novo was held on the assessment.

"(6) USE OF AMOUNTS COLLECTED.—Civil money penalties collected under this subsection shall be credited to the account maintained to provide health benefits under the program established under title XXI of the Social Security Act.

"(b) LIABILITY TO INDIVIDUALS FOR DAMAGES.—Any employer that knowingly does not comply with section 2712(c) or the requirements of section 2701(a) shall be liable for damages (including health care costs incurred) to the employee or the family of the employee resulting from such failure to comply. Such an employee or family member may bring a civil action to recover damages resulting from an employers failure to comply with such requirements.".

TITLE III—SPECIAL ASSISTANCE FOR SMALL AND MEDIUM-SIZED BUSINESSES

SEC. 301. PREEMPTION OF STATE MANDATED BENEFIT LAWS.

(a) IN GENERAL.—Section 514(b)(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(2)) is amended—

(1) in subparagraph (A), by striking out "subparagraph (B)" and inserting in lieu thereof "subparagraphs (B) and (C)"; and

(2) by adding at the end thereof the following new subparagraph:

"(C) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) any provision of the law of any State to the extent that such provision regulates, or otherwise provides any requirement relating to, the benefits to be provided under contracts or policies of insurance issued to or under a health benefit plan under part B of title XXVII of the Public Health Service Act.".

(b) CONFORMING AMENDMENT.—Paragraph (1) of section 3 of such Act (29 U.S.C. 1002(1)) is amended by adding at the end thereof the following new sentence: "Such terms include a health benefit plan established in

accordance with part B of title XXVII of the Public Health Service Act.".

Subtitle A—Reform of Small Group Insurance

SEC. 311. GROUP HEALTH INSURANCE STANDARDS.

(a) PUBLIC HEALTH SERVICE ACT.—Title XXVII of the Public Health Service Act (as added under section 101 and amended by section 201) is further amended by adding at the end thereof the following new part:

"PART C—GROUP HEALTH INSURANCE STANDARDS

"Subpart 1—General Standards; Definitions

"SEC. 2741. APPLICATION OF REQUIREMENTS TO HEALTH BENEFIT PLANS.

"(a) PLAN UNDER STATE REGULATORY PROGRAM OR CERTIFIED BY THE SECRETARY.—

"(1) IN GENERAL.—No health benefit plan may be issued in a State on or after the effective date specified in subsection (c) (and no new contract may be offered under such plan with respect to any small employer beginning on or after such effective date) unless—

"(A) the Secretary determines that the State has established a regulatory program that provides for the application and enforcement of the applicable standards established under sec-

tion 2742 (to carry out the requirements of this part) and that meets the requirements of section 2742(b) by such effective date, or

"(B) if the State has not established such a program, the plan has been certified by the Secretary (in accordance with such procedures as the Secretary establishes) as meeting the applicable standards established under section 2742 by such effective date.

"(2) PLAN DISAPPROVED UNDER LOOK-BEHIND AUTHORITY.—If the Secretary determines, under section 2742(c), that a health benefit plan does not meet the applicable requirements of this part on or after such effective date, regardless of whether or not the State has taken any action with respect to such noncompliance, no new contracts may be offered to small employers under the plan on or after the date of the determination.

"(b) SANCTIONS.—

"(1) COMPLAINTS AND INVESTIGATIONS.—The Secretary shall establish procedures—

"(A) for individuals and entities to file written, signed complaints with the Secretary respecting potential violations of the requirements of this part;

"(B) for the investigation of those complaints which have a substantial probability of validity; and

"(C) for the investigation of such other violations of the requirements of this part as the Secretary determines to be appropriate.

"(2) AUTHORITY IN INVESTIGATIONS.—In conducting investigations and hearings under this subsection—

"(A) agents of the Secretary and administrative law judges shall have reasonable access to examine evidence of any person or entity being investigated; and

"(B) administrative law judges, may, if necessary, compel by subpoena the attendance of witnesses and the production of evidence at any designated place or hearing.

In case of contumacy or refusal to obey a subpoena lawfully issued under this subsection and upon application of the Secretary, an appropriate district court of the United States may issue an order requiring compliance with such subpoena and any failure to obey such order may be punished by such court as a contempt thereof.

"(3) HEARING.—

"(A) IN GENERAL.—Before imposing an order described in paragraph (4) against a carrier under this subsection for a violation of the requirements of this part, the Secretary shall provide the carrier with notice and, upon request made within a reasonable time (of not less than 30 days, as established by the Secretary) of the date of the notice, a hearing respecting the violation.

"(B) CONDUCT OF HEARING.—Any hearing so requested shall be conducted before an administrative law judge. If no hearing is so requested, the Secretary's imposition of the order shall constitute a final and unappealable order.

"(C) ISSUANCE OF ORDERS.—If the administrative law judge determines, upon the preponderance of the evidence received, that a carrier named in the complaint has violated the requirements of this part, the administrative law judge shall state the findings of fact and issue and cause to be served on such carrier an order described in paragraph (4).

"(4) ENFORCEMENT AND CIVIL MONEY PENALTY.—

"(A) ENFORCEMENT.—Subject to the provisions of this paragraph, an order issued under this subsection—

"(i) shall require the carrier—

"(I) to cease and desist from such violations; and

"(II) to pay a civil penalty as required in paragraph (9); and

"(ii) may require the carrier to take such other corrective action as is appropriate.

"(B) CORRECTIONS WITHIN 30 DAYS.—No order shall be imposed under this subsection by reason of any violation if the carrier establishes to the satisfaction of the Secretary that—

"(i) such violation was due to reasonable cause and not to willful neglect; and

"(ii) such violation is corrected within the 30-day period beginning on earliest date the carrier knew, or exercising reasonable diligence could have known, that such a violation was occurring.

"(C) WAIVER BY SECRETARY.—In the case of a violation which is due to reasonable cause and not to willful neglect, the Secretary may

waive part or all of the civil money penalty imposed by paragraph (9) to the extent that payment of such penalty would be grossly excessive relative to the violation involved and to the need for deterrence of violations.

"(5) ADMINISTRATIVE APPELLATE REVIEW.—The decision and order of an administrative law judge under this subsection shall become the final agency decision and order of the Secretary unless, within 30 days, the Secretary modifies or vacates the decision and order, in which case the decision and order of the Secretary shall become a final order under this subsection.

"(6) JUDICIAL REVIEW.—A carrier adversely affected by a final order issued under this subsection may, within 45 days after the date the final order is issued, file a petition in the Court of Appeals for the appropriate circuit for review of the order.

"(7) ENFORCEMENT OF ORDERS.—If a carrier fails to comply with a final order issued under this section against the carrier, the Secretary shall file a suit to seek compliance with the order in any appropriate district court of the United States. In any such suit, the validity and appropriateness of the final order shall not be subject to review.

"(8) USE OF AMOUNTS COLLECTED.—Civil money penalties collected under this subsection shall be credited to the AmeriCare Trust Fund.

"(9) AMOUNT OF CIVIL MONEY PENALTY.—The amount of any civil money penalty imposed under this subsection shall not exceed $25,000 for each carrier with respect to which a violation occurs. Such amount may take into account the penalties imposed by a State with respect to the same such violation.

"(10) NOTICE TO CARRIER IN THE CASE OF INSURED PLANS.—As part of any order issued under this subsection in the case of a health benefit plan, the order shall require that notice be provided to the carrier of the findings in the order.

"(11) LOSS OF STATUS AS A HEALTH BENEFIT PLAN.—If a carrier is not in compliance with subsection (a) and is not determined to have come into compliance with the applicable standards within 30 days after the date of the initial determination of such a violation, such carrier shall be subject to the provisions of this subsection.

"(c) EFFECTIVE DATE.—The effective date specified in this subsection is January 1 of the third full year that begins after the date of the enactment of this subpart.

"SEC. 2742. ESTABLISHMENT OF STANDARDS.

"(a) ESTABLISHMENT OF STANDARDS.—

"(1) NAIC.—The Secretary shall request the NAIC—

"(A) to develop specific standards, in the form of a model Act and model regulations, to implement the requirements of this part; and

"(B) to report to the Secretary on such development;

by not later than October 1 of the year following the year in which this part is enacted. If the NAIC develops such standards within such period and the Secretary finds that such standards implement the requirements of this part, such standards shall be the standards applied under section 2741.

"(2) SECRETARY.—If the NAIC fails to develop and report on such standards by such date or the Secretary finds that such standards do not implement the requirements of this part, the Secretary shall develop and publish, by not later than November 15 of the year following the year in which this part is enacted, such standards. Such standards shall then be the standards applied under section 2741.

"(b) ADDITIONAL ELEMENTS OF REGULATORY PROGRAMS.—

"(1) IN GENERAL.—A State regulatory program shall include the following:

"(A) The enforcement under the program—

"(i) shall be designed in a manner so as to secure compliance with the standards within 30 days after the date of a finding of noncompliance with such standards; and

"(ii) shall provide for notice to the Secretary in cases where such compliance is not secured within such 30-day period.

"(B) A toll-free telephone number which provides—

"(i) for a system for the receipt and disposition of consumer complaints or inquiries regarding compliance of health benefit plans with the requirements of this part; and

"(ii) information to small employers and consumers about carriers that offer health benefit plans in the area covered by the regulatory authority.

Such system shall provide for the recording of consumer complaints in accordance with a uni-

form methodology developed by the NAIC and recognized by the Secretary.

"(2) SECRETARIAL AUTHORITY.—In the case of a State without a regulatory program approved under subsection (a), the Secretary shall provide for the establishment of the toll-free telephone information and complaint system described in paragraph (1).

"(c) SECRETARIAL REVIEW.—

"(1) PERIODIC REVIEW OF STATE REGULATORY PROGRAMS.—The Secretary periodically shall review State regulatory programs to determine if they continue to meet the standards referred to in subsection (a) and the requirements of subsection (b). If the Secretary finds that a State regulatory program no longer meets such standards and requirements, before making a final determination, the Secretary shall provide the State an opportunity to adopt such a plan of correction as would permit the program to continue to meet such standards and requirements. If the Secretary makes a final determination that the State regulatory program, after such an opportunity, fails to meet such standards and requirements, the Secretary shall assume responsibility

under section 2741(a)(1)(B) with respect to plans in the State.

"(2) LOOK-BEHIND AUTHORITY.—In the case of a State with a regulatory program found by the Secretary to meet the standards and requirements under this part, the Secretary nonetheless is authorized to determine whether or not health benefit plans offered by carriers in the State have failed to comply with the applicable requirements of this part.

"(d) GAO AUDITS.—The Comptroller General shall conduct periodic audits on a sample of State regulatory programs to determine their compliance with the requirements of this section. The Comptroller General shall report to the Secretary and Congress on the findings in such audits.

"SEC. 2743. TRANSITIONAL REQUIREMENTS APPLICABLE TO ALL HEALTH BENEFIT PLANS ISSUED TO SMALL EMPLOYERS.

"(a) APPLICATION.—The requirements of this section shall apply only to health benefit plans offered to small employers during the period that begins on the effective date of this part and ends in the case of a small employer, on the date that begins the fifth full year after the date of enactment of this part.

"(b) NO DISCRIMINATION BASED ON HEALTH STATUS FOR CERTAIN SERVICES.—

"(1) IN GENERAL.—Except as provided under paragraph (2), health benefit plans offered to small employers by carriers may not deny, limit, or condition the coverage under (or benefits of) the plan with respect to basic health services based on the health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability, of an individual.

"(2) TREATMENT OF PREEXISTING CONDITION EXCLUSIONS FOR ALL SERVICES.—

"(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph, health benefit plans provided to small employers by carriers may exclude coverage with respect to services related to treatment of a preexisting condition, but the period of such exclusion may not exceed 6 months.

"(B) NONAPPLICATION TO NEWBORNS AND SUNSET OF PREEXISTING CONDITION EXCLUSIONS FOR BASIC HEALTH SERVICES.—The exclusion of coverage permitted under subparagraph (A) shall not apply to—

"(i) services furnished to newborns, or

"(ii) basic health services furnished on or after July 1 of the sixth full year beginning after the date of the enactment of this part.

"(C) CREDITING OF PREVIOUS COVERAGE.—

"(i) IN GENERAL.—A health benefit plan issued to a small employer by a carrier shall provide that if an individual under such plan is in a period of continuous coverage (as defined in clause (ii)(I)) with respect to particular services as of the date of initial coverage under such plan, any period of exclusion of coverage with respect to a preexisting condition for such services or type of services shall be reduced by 1 month for each month in the period of continuous coverage.

"(ii) DEFINITIONS.—As used in this subparagraph:

"(I) PERIOD OF CONTINUOUS COVERAGE.—The term 'period of continuous coverage' means, with respect to particular services, the period beginning on the date an individual is

enrolled under a health benefit plan issued to a small employer by a carrier which provides the same or substantially similar benefits with respect to such services and ends on the date the individual is not so enrolled for a continuous period of more than 3 months.

"(II) PREEXISTING CONDITION.—The term 'preexisting condition' means, with respect to coverage under a health benefit plan issued to a small employer by a carrier, a condition which has been diagnosed or treated during the 3-month period ending on the day before the first date of such coverage, except that such term does not include a condition which was first diagnosed or treated during a period of continuous coverage.

"(iii) STANDARDS FOR SIMILAR BENEFITS.—The standards established under section 2742 shall establish such criteria for determining if benefits are substantial-

ly similar as may be necessary to carry out this subparagraph.

"(c) PERMITTING COVERAGE DURING WAITING PERIOD.—

"(1) IN GENERAL.—If a health benefit plan issued to a small employer by a carrier imposes a waiting period before an eligible individual may be covered under the plan, the plan—

"(A) must make available to the individual coverage (including coverage of dependents) equivalent to the coverage available to the employee upon the completion of any applicable waiting period; and

"(B) may not impose for such coverage charges that exceed the cost under the plan of providing such coverage with respect to the employee if such waiting period did not apply.

Nothing in this paragraph shall be construed as requiring a health benefit plan issued to a small employer by a carrier to make coverage available to an individual who no longer has an employment relationship (or who is the spouse or dependent of such an individual) with respect to the plan.

"(2) ELIGIBLE INDIVIDUAL DEFINED.—In paragraph (1), the term 'eligible individual' means,

with respect to a health benefit plan, an individual who, but for a waiting period, would be eligible for immediate coverage under the plan.

"SEC. 2744. DEFINITIONS.

"(a) HEALTH BENEFIT PLAN AND OTHER DEFINITIONS RELATING TO HEALTH PLANS.—As used in this part:

"(1) HEALTH BENEFIT PLAN.—The term 'health benefit plan' means any hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, health maintenance subscriber contract, other employee welfare plan (as defined in the Employee Retirement Income Security Act of 1964), or any other health insurance arrangement, and includes an employment-related reinsurance plan (as defined in paragraph (3)), but does not include—

"(A) accident-only, credit, dental, or disability income insurance,

"(B) coverage issued as a supplement to liability insurance,

"(C) worker's compensation or similar insurance, or

"(D) automobile medical-payment insurance;

that is offered by a carrier.

"(2) SMALL EMPLOYER.—The term 'small employer' means, with respect to a calendar year, an employer that normally employs fewer than 100 employees on during the calendar year.

"(3) MANAGED CARE PLAN.—The term 'managed care plan' has the same meaning given such term by section 2713(7).

"(4) REINSURANCE PLAN.—The term 'reinsurance plan' means any reinsurance or similar mechanism that underwrites a portion of the risk for a health benefit plan, if the mechanism is offered directly to a small employer.

"(5) SELF-INSURED HEALTH BENEFIT PLAN.—The term 'self-insured health benefit plan' means a health benefit plan in which the small employer or employment-related group assumes the underwriting risk for the plan (whether or not there is any reinsurance or similar mechanism to underwrite a portion of that risk).

"(b) CARRIER; HEALTH MAINTENANCE ORGANIZATION; AND OTHER DEFINITIONS RELATING TO CARRIERS.—As used in this part:

"(1) CARRIER.—The term 'carrier' means any person that offers a health benefit plan, whether

through insurance or otherwise, including a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization, a self-insurer carrier, a reinsurance carrier, and a multiple small employer welfare arrangement (a combination of small employers associated for the purpose of providing health benefit plan coverage for their employees).

"(2) EMPLOYER CARRIER.—The term 'employer carrier'—

"(A) means any carrier which offers health benefit plans, and

"(B) includes (unless the context otherwise requires)—

"(i) a self-insurer carrier offering such a plan, or

"(ii) a reinsurance carrier offering an health benefit plan that is an reinsurance plan.

"(3) HEALTH MAINTENANCE ORGANIZATION.—The term 'health maintenance organization' has the meaning given the term 'eligible organization' in section 1876(b) of the Social Security Act.

"(4) REINSURANCE CARRIER.—The term 'reinsurance carrier' means the entity assuming responsi-

bility for underwriting under an employment-related reinsurance plan, but does not include a carrier insofar as it directly offers a health benefit plan.

"(5) SELF-INSURER CARRIER.—The term 'self-insurer carrier' means a carrier that is not a licensed insurance company, a prepaid hospital or medical service plan, or a health maintenance organization, that offers a health benefit plan directly with respect to an employment-related group.

"(c) GENERAL DEFINITIONS.—As used in this part:

"(1) APPLICABLE REGULATORY AUTHORITY.—The term 'applicable regulatory authority' means, with respect to a health benefit plan offered in a State, the State commissioner or superintendent of insurance or other State authority responsible for regulation of health insurance, or, if the Secretary is exercising authority under section 2741(a)(1)(B) in the State, the Secretary.

"(2) BLOCK OF BUSINESS.—The term 'block of business' means all, or a distinct grouping of, small employers as shown on the records of the small employer carrier, if established consistent with section 2752(b)(3).

"(3) COMMUNITY.—The term 'community' means a geographic area designated by the Secretary as—

"(A) encompassing one or more adjacent metropolitan statistical areas; or

"(B) the remaining area within each State (that is not designated within any community under subparagraph (A));

except that the Secretary may designate an entire State as a community if such a designation would better carry out the purposes of this part. The Secretary from time to time may change the boundaries of communities designated under subparagraph (A) or (B) for such purposes. There shall be no administrative or judicial review of the designation of communities under this subsection.

"(4) FULL-TIME EMPLOYEE.—The term 'full-time employee' means, with respect to an employer, an employee who normally performs on a monthly basis at least 25 hours of service per week for that employer.

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

"(6) REFERENCE PREMIUM RATE.—The term 'reference premium rate' means, for each block of

business for a rating period in a community, the lowest premium rate charged or which could have been charged by the small employer carrier to small employers in that block under a rating system for that block of business in the community for health benefit plans with the same or similar coverage. The reference premium rate is determined without regard to any adjustment for age or sex described in section 2752(c) and without regard to any adjustment effected under section 2752(d).

"(7) STATE.—The term 'State' means the 50 States and the District of Columbia.

"Subpart 2—Small Employer Health Insurance Reform

"SEC. 2751. ENROLLMENT PRACTICE AND GUARANTEED RENEWABILITY REQUIREMENTS FOR HEALTH BENEFIT PLANS ISSUED TO SMALL EMPLOYERS.

"(a) REGISTRATION WITH APPLICABLE REGULATORY AUTHORITY.—

"(1) IN GENERAL.—Each carrier (as defined in section 2744(b)(1)) shall register with the applicable regulatory authority for each State in which it issues or offers a health benefit plans to small employers.

"(2) NO PREEMPTION OF STATE INFORMATION REQUIREMENTS.—Nothing in paragraph (1) shall be construed as preventing the applicable regulatory authority from requiring, in the case of carriers that are not self-insurance carriers, such additional information in conjunction with, or apart from, the registration required under paragraph (1) as the applicable regulatory authority may be authorized to require under State law.

"(b) GUARANTEED ISSUE.—

"(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, a carrier that offers a health benefit plan (including a reinsurance plan) to small employers located in a community must offer the same plan to any other small employer located in the community.

"(2) TREATMENT OF HEALTH MAINTENANCE ORGANIZATIONS.—

"(A) GEOGRAPHIC LIMITATIONS.—A health maintenance organization may deny coverage under a health benefit plan to a small employer whose employees are located outside the service area of the organization, but only if such denial is applied uniformly without regard to health status or insurability.

"(B) SIZE LIMITS.—A health maintenance organization may apply to the applicable regulatory authority to cease enrolling new small employer groups in its health benefit plan (or in a geographic area served by the plan) if it can demonstrate that its financial or administrative capacity to serve previously enrolled groups and individuals (and additional individuals who will be expected to enroll because of affiliation with such previously enrolled groups) will be impaired if it is required to enroll new groups.

"(3) GROUNDS FOR REFUSAL TO ISSUE OR RENEW.—

"(A) IN GENERAL.—A carrier may refuse to issue or renew or terminate a health benefit plan under this part only for—

"(i) nonpayment of premiums,

"(ii) fraud or misrepresentation, and

"(iii) failure to meet minimum participation rates (consistent with subparagraph (B)).

"(B) MINIMUM PARTICIPATION RATES.—A carrier may require, within the transition period described in section 2743(a), with respect to a health benefit plan, that a minimum percentage

of full-time, permanent employees eligible to enroll under the plan be enrolled, so long as such percentage is enforced uniformly for all employment groups of comparable size.

"(c) MINIMUM PLAN PERIOD.—A carrier may not offer to, or issue with respect to, a small employer a health benefit plan with a term of less than 12 months.

"(d) GUARANTEED RENEWABILITY.—

"(1) IN GENERAL.—

"(A) GENERAL RULE.—Subject to the succeeding provisions of this subsection, a carrier shall ensure that a health benefit plan issued to a small employer be renewed, at the option of the small employer, unless the plan is terminated for the reasons specified in subsection (a)(3)(A) or under subparagraph (B).

"(B) TERMINATION OF BLOCK OF BUSINESS.—A carrier need not renew a health benefit plan with respect to such a small employer if the carrier—

"(i) is terminating the block of business that includes the plan; and

"(ii) provides notice to the small employer covered under the plan of such ter-

mination at least 90 days before the date of expiration of the plan.

In the case of such a termination, the carrier may not provide for issuance of any health benefit plan in any block of business during the 5-year period beginning on the date of termination of such block of business.

"(C) CONSTRUCTION RESPECTING ADDITIONAL STATE DISCLOSURE REQUIREMENTS.—Subparagraph (B)(ii) shall not be construed as preventing the applicable regulatory authority from specifying the information to be included in the notice under such subparagraph or in requiring such notice to be provided at an earlier date.

"(2) NOTICE AND SPECIFICATION OF RATES AND ADMINISTRATIVE CHANGES.—

"(A) NOTICE.—A carrier offering health benefit plans to small employers shall provide for notice, at least 30 days before the date of expiration of the health benefit plan, of the terms for renewal of the plan. Except with respect to rates and administrative changes, the terms of renewal (including benefits) shall be the same as the terms of issuance.

"(B) RENEWAL RATES SAME AS ISSUANCE RATES.—The carrier may change the terms for such renewal, but the premium rates charged with respect to such renewal shall be the same as that for a new issue.

"(C) RATES CANNOT CHANGE MORE OFTEN THAN MONTHLY.—

"(i) IN GENERAL.—A carrier may not change the premium rates established with respect to health benefit plans offered for any block of business more often than monthly.

"(ii) APPLICATION OF NEW RATES.—A carrier that offers health benefit plans to small employers which becomes effective in a month, shall ensure that the premium rates established under clause (i) for that month shall apply to all months during the 12-month period beginning with that month. In the case of a plan renewal which is effective for a 12-month period beginning with a month, the premium rates established under clause (i) with respect to that month shall apply to all months during 12-month renewal period.

"(3) PERIOD OF RENEWAL.—The period of renewal of each health benefit plan offered by a carrier to a small employer shall be for a period of not less than 12 months.

"SEC. 2752. RATING PRACTICES FOR HEALTH BENEFIT PLANS OFFERED TO SMALL EMPLOYERS.

"(a) COHESIVE RATING SYSTEM AND ACTURIAL CERTIFICATION.—

"(1) IN GENERAL.—The premiums (including reference premium rate, as defined in section 2744(c)(6), age adjustments under subsection (c), and reductions provided under subsection (d)) for all health benefit plans offered to small employers by carriers shall—

"(A) be established based on a single cohesive rating system which is applied consistently for all small employer groups and is designed not to treat groups, after the second effective year (as defined in subsection (f)), differently based on health status or risk status; and

"(B) be actuarially certified annually.

"(2) ACTUARIAL CERTIFIED DEFINED.—For purposes of paragraph (1)(B), a health benefit plan is considered to be 'actuarially certified' if there is a written statement, by a member of the American

Academy of Actuaries or other individual acceptable to the applicable regulatory authority that a carrier is in compliance with this section, based upon the individual's examination, including a review of the appropriate records and of the actuarial assumptions and methods utilized by the carrier in establishing premium rates for applicable health benefit plans.

"(b) USE OF COMMUNITY-RATING.—

"(1) IN GENERAL.—Except as provided in paragraph (2) and subsection (c):

"(A) COMMUNITY RATING WITHIN A BLOCK OF BUSINESS.—The reference premium rate charged for health benefit plans offered with similar benefits to small employers in a community within a block of business for a type of family enrollment (described in subsection (e)) shall be the same for all small employers.

"(B) LIMITING VARIATION ON REFERENCE PREMIUM RATES AMONG BLOCKS OF BUSINESS.—

"(i) IN GENERAL.—Except as provided in clause (iii), the reference premium rate charged for health benefit plans offered with similar benefits to small employers in any community for a type of family

enrollment for the most expensive block of business shall not exceed 120 percent of such rate charged for such plan for the same type of family enrollment for the least expensive block of business.

"(ii) ROLE OF REGULATORY AUTHORITY.—An applicable regulatory authority that is a State may reduce or eliminate the percent variation otherwise permitted under clause (i).

"(iii) EXCEPTION.—Clause (i) shall not apply to health benefit plans offered by carriers to small employers in a block of business—

"(I) if the block is one for which the carrier does not reject, and never has rejected, small employers included within the definition of small employers eligible for the block of business or otherwise eligible employees and dependents who enroll on a timely basis,

"(II) the carrier does not involuntarily transfer, and never has involuntarily transferred, a health benefit

plan into or out of the block of business, and

"(III) that block of business was available for purchase as of the date of the enactment of this part.

"(2) TRANSITION.—Notwithstanding paragraph (1)—

"(A) during the first effective year (as defined in subsection (f)), the premium rate under a health benefit plan issued by a carrier to any small employer may be as much as, but may not exceed, 150 percent of the reference premium rate for such plans in the same community for similar benefits in the same block of business; or

"(B) during the second effective year, the premium rate under such a policy for any small employer may be as much as, but may not exceed, 122 percent of the reference premium rate for such plans in the same community for similar benefits in the same block of business.

"(3) ESTABLISHMENT OF BLOCKS OF BUSINESS.—For the purpose of establishing premiums for small employer health benefit plans with similar coverage, the carrier may establish blocks of busi-

ness based only on one or more of the following characteristics:

"(A) Plans that are marketed by clearly different sales forces.

"(B) Plans that have been acquired from another carrier as a distinct group.

"(C) Plans that are managed care plans.

"(D) Plans within another distinct group, if the applicable regulatory authority finds that establishment of such a group will enhance the efficiency and fairness of the small employer insurance marketplace.

"(c) ADJUSTMENTS TO COMMUNITY-RATING.—

"(1) IN GENERAL.—Subject to paragraph (2), a health benefit plan offered by a carrier to a small employer may provide for an adjustment to the reference premium rate based on the age and gender of covered individuals. Any such adjustment shall be applied by the carrier consistently to all small employers, except that gender adjustments may only be made during the transition period.

"(2) LIMITATION ON ADJUSTMENT.—

"(A) IN GENERAL.—The adjustment under paragraph (1) may not result, with respect to health benefit plans with similar benefits of-

fered by carriers to small employers in the same block of business in a community, in a premium rate for the most expensive age group exceeding the applicable percent (as defined in subparagraph (B)) of the premium rate for the least expensive age group.

"(B) APPLICABLE PERCENT DEFINED.—In subparagraph (A) but subject to subparagraph (C), the term 'applicable percent' means—

"(i) for the first effective year (as defined in subsection (f)), 200 percent,

"(ii) for the second effective year, 150 percent, and

"(iii) for any subsequent year, 110 percent.

"(C) ROLE OF REGULATORY AUTHORITY.—An applicable regulatory authority that is a State may reduce or eliminate the applicable percent otherwise applied.

"(d) ADJUSTMENT IN RATES PERMITTED IN CASE OF MEDICARE REIMBURSEMENT ELECTION.—A health benefit plan offered by a carrier to a small employer may compute premiums based upon a percentage of the reference premium rate otherwise applicable if the small employer to which the plan is being offered makes the reim-

bursement election described in section 2744. Any such adjustment shall be applied consistently to all small employers.

"(e) TYPES OF FAMILY ENROLLMENT.—Each health benefit plan offered by a carrier to a small employer shall permit enrollment of (and shall compute premiums separately for) individuals based on each of the following beneficiary classes:

"(1) 1 adult.

"(2) A married couple without children.

"(3) 1 adult and 1 child.

"(4) A married couple with 1 or more children, or 1 adult with 2 or more children.

"(f) EFFECTIVE YEARS DEFINED.—In this section, the terms 'first effective year' and 'second effective year' mean the third and fourth full years beginning after the date of the enactment of this part.

"(g) EXCEPTION FOR SELF-INSURED CARRIERS.—The requirements of this section shall apply to reinsurance carriers and health benefit plans offered by such carriers to small employers.

"SEC. 2753. BASIC BENEFIT PACKAGE FOR HEALTH BENEFIT PLANS OFFERED TO SMALL EMPLOYERS.

"(a) IN GENERAL.—

"(1) BENEFITS AND COST-SHARING IN HEALTH BENEFIT PLANS.—Except as provided in paragraph (2) and in section 2743(a), no health benefit plan offered by carriers to small employers may be issued to a small employer unless—

"(A) the plan provides for benefits for all basic health services as defined in part B;

"(B) the plan does not impose cost-sharing with respect to basic health services in excess of the deductibles and coinsurance permitted under part B respect to such services; and

"(C) the carrier makes available to the small employer a health benefit plan that, subject to paragraph (2)(C), only provides the benefits for basic health services and the maximum cost-sharing consistent with subparagraphs (A) and (B).

"(2) EXCEPTIONS.—

"(A) REQUIRED OFFERING DOES NOT APPLY TO HMO'S.—Paragraph (1)(C) shall not apply to a health maintenance organization.

"(B) ADDITIONAL, OPTIONAL MINIMUM SERVICES.—In meeting the requirement of paragraph (1)(C), a health benefit plan offered by a carrier to a small employer may include

such additional items and services as the carrier can demonstrate to the satisfaction of the applicable regulatory authority that inclusion of such items and services will facilitate appropriate hospital discharges or avoid unnecessary hospitalization.

"(b) MANAGED CARE OPTION.—If a carrier (other than a health maintenance organization or reinsurance carrier) offers health benefit plans to an employer that is not a small employer, in a community a health benefit plan that is a managed care plan, the carrier must make available to small employers in the community a health benefit plan that is such a managed care plan .

"(c) EXCEPTION FOR REINSURANCE CARRIERS AND PLANS.—The requirements of this section shall not apply to reinsurance carriers and reinsurance plans.

"(d) STANDARDIZATION OF BENEFIT PACKAGES.—The NAIC shall develop a model to standardize benefits to be made available under health benefit plans offered by carriers to small employers in order to promote consumer understanding and comparison among such plans.

"SEC. 2754. TIME-LIMITED MEDICARE REIMBURSEMENT OPTION FOR HEALTH BENEFIT PLANS OFFERED TO SMALL EMPLOYERS NOT PREVIOUSLY OFFERING INSURANCE COVERAGE.

"(a) OPTION MUST BE OFFERED.—Each carrier offering a health benefit plan to small employers meeting the requirements of section 351(a) of the HealthAmerica Act shall offer the small employer the option of having payment under the plan made for basic health benefits at rates no higher than the payment rates established under part B for such services. The provisions of section 1848(g)(3) of the Social Security Act shall not be considered to apply under this subsection.

"(b) APPLICATION OF MEDICARE BILLING LIMITATIONS.—In the case of a small employer that elects the option offered under subsection (a) with respect to a health benefit plan, the limitations on charges that may be made under medicare shall apply to individuals receiving benefits under the plan.

"(c) EXCEPTION FOR REINSURANCE PLAN.—Subsection (a) shall not apply to reinsurance plans.

"SEC. 2755. MISCELLANEOUS DISCLOSURE AND RECORDKEEPING REQUIREMENTS FOR HEALTH BENEFIT PLANS OFFERED TO SMALL EMPLOYERS.

"(a) DISCLOSURE.—

"(1) GENERAL DISCLOSURE.—Each carrier offering health benefit plans to small employers shall disclose to each small employer before issuing such a plan the following:

"(A) The availability (pursuant to the requirement of section 2753(a)(1)(C)) of a plan including only basic benefits.

"(B) Whether any plan that is a managed care plan or provides for a utilization review program, or both, is available, as required under section 2753(b).

"(C) The option of electing the reimbursement rules, as required under section 2754.

"(D) The limits, imposed under section 2752, on the premiums permitted to be charged for such plans.

"(E) The rights of guaranteed issue and renewability provided under section 2751.

Such disclosure shall be in addition to any disclosure required generally of health benefit plans under part B.

"(2) SPECIFIC DISCLOSURE UPON REQUEST.—Each carrier offering health benefit plans to small employers shall disclose to small employer, upon request, information concerning the blocks of business

established with respect to such plans and the applicable premiums for such plans.

"(3) STANDARD FORMAT.—The disclosure under paragraph (1) shall be made in a uniform format established by the Secretary, after consultation with the NAIC.

"(4) EXCEPTIONS.—Paragraph (1) (other than subparagraphs (D) and (E)) shall not apply to a reinsurance carrier with respect to a reinsurance plan.

"(b) INFORMATION FILED WITH APPLICABLE REGULATORY AUTHORITY.—

"(1) IN GENERAL.—Each carrier offering health benefit plans to small employers shall disclose to the applicable regulatory authority, in a manner specified by the Secretary, information concerning—

"(A) blocks of business established; and

"(B) applicable premiums for health benefit plans.

"(2) ADDITIONAL INFORMATION.—Nothing in this subsection shall be construed as limiting the information which an applicable regulatory authority may require to be reported by carriers.

"SEC. 2756. NONAPPLICATION IN PUERTO RICO AND THE TERRITORIES.

"This subpart shall not apply outside the 50 States or the District of Columbia.

"Subpart 3—Encouraging Development of Reinsurance Systems

"SEC. 2758. ENCOURAGING DEVELOPMENT OF REINSURANCE SYSTEMS.

"(a) DEVELOPMENT OF MODELS.—

"(1) IN GENERAL.—Not later than October 1 of the year following the year in which this part is enacted, the NAIC shall develop several models of legislation for the enactment of reinsurance systems that may be used by States with respect to health insurance policies (including health benefit plans offered to small employers).

"(2) SPECIFIC MODELS.—Such models shall include at least 1 of each of the following 3 models:

"(A) A model providing for voluntary participation by insurers.

"(B) A model providing for insurer participation on a retrospective basis.

"(C) A model providing for the case management of services for individual claims or groups which are reinsured through the system.

"(3) TERMS OF MODELS.—Each of the models—

"(A) shall be consistent with the provisions of this part (including those relating to community-rated premiums), and

"(B) shall include deductibles and coinsurance which—

"(i) limit the amount of risk ceded to the reinsurance system; and

"(ii) encourage insurers to manage health care costs.

"(b) PROTECTION OF HEALTH MAINTENANCE ORGANIZATIONS UNDER REINSURANCE SYSTEMS.—No State may establish or enforce a reinsurance system with respect to health insurance policies unless the system provides for an adjustment in reinsurance premiums (or, in the event of losses to the system, assessments) charged to health maintenance organizations that takes into account—

"(1) the higher premiums charged by such organizations due to the greater coverage provided by such organizations as required by law,

"(2) the limitations under title XIII on the amount of risk which such an organization can reinsure, and

"(3) the ability of such organizations to manage risk internally.

"(c) EFFECTIVE DATE.—This section shall take effect on the date of the enactment of this part.".

(b) SOCIAL SECURITY ACT.—The Social Security Act is amended by inserting after title XII the following new title:

"TITLE XIII—GROUP HEALTH INSURANCE STANDARDS

"PART A—GENERAL STANDARDS; DEFINITIONS

"APPLICATION OF REQUIREMENTS TO HEALTH BENEFIT PLANS

"SEC. 1301. (a) PLAN UNDER STATE REGULATORY PROGRAM OR CERTIFIED BY THE SECRETARY.—

"(1) IN GENERAL.—No health benefit plan may be issued in a State on or after the effective date specified in subsection (c) (and no new contract may be offered under such plan with respect to any small employer beginning on or after such effective date) unless—

"(A) the Secretary determines that the State has established a regulatory program that provides for the application and enforcement of the applicable standards established under section 1302 (to carry out the requirements of this

title) and that meets the requirements of section 1302(b) by such effective date, or

"(B) if the State has not established such a program, the plan has been certified by the Secretary (in accordance with such procedures as the Secretary establishes) as meeting the applicable standards established under section 1302 by such effective date.

"(2) PLAN DISAPPROVED UNDER LOOK-BEHIND AUTHORITY.—If the Secretary determines, under section 1302(c), that a health benefit plan does not meet the applicable requirements of this title on or after such effective date, regardless of whether or not the State has taken any action with respect to such noncompliance, no new contracts may be offered to small employers under the plan on or after the date of the determination.

"(b) SANCTIONS.—

"(1) COMPLAINTS AND INVESTIGATIONS.—The Secretary shall establish procedures—

"(A) for individuals and entities to file written, signed complaints with the Secretary respecting potential violations of the requirements of this title;

"(B) for the investigation of those complaints which have a substantial probability of validity; and

"(C) for the investigation of such other violations of the requirements of this title as the Secretary determines to be appropriate.

"(2) AUTHORITY IN INVESTIGATIONS.—In conducting investigations and hearings under this subsection—

"(A) agents of the Secretary and administrative law judges shall have reasonable access to examine evidence of any person or entity being investigated; and

"(B) administrative law judges, may, if necessary, compel by subpoena the attendance of witnesses and the production of evidence at any designated place or hearing.

In case of contumacy or refusal to obey a subpoena lawfully issued under this subsection and upon application of the Secretary, an appropriate district court of the United States may issue an order requiring compliance with such subpoena and any failure to obey such order may be punished by such court as a contempt thereof.

"(3) HEARING.—

"(A) IN GENERAL.—Before imposing an order described in paragraph (4) against a carrier under this subsection for a violation of the requirements of this title, the Secretary shall provide the carrier with notice and, upon request made within a reasonable time (of not less than 30 days, as established by the Secretary) of the date of the notice, a hearing respecting the violation.

"(B) CONDUCT OF HEARING.—Any hearing so requested shall be conducted before an administrative law judge under section 201. If no hearing is so requested, the Secretary's imposition of the order shall constitute a final and unappealable order.

"(C) ISSUANCE OF ORDERS.—If the administrative law judge determines, upon the preponderance of the evidence received, that a carrier named in the complaint has violated the requirements of this title, the administrative law judge shall state the findings of fact and issue and cause to be served on such carrier an order described in paragraph (4).

"(4) ENFORCEMENT AND CIVIL MONEY PENALTY.—

"(A) ENFORCEMENT.—Subject to the provisions of this paragraph, an order issued under this subsection—

"(i) shall require the carrier—

"(I) to cease and desist from such violations; and

"(II) to pay a civil penalty as required in paragraph (9); and

"(ii) may require the carrier to take such other corrective action as is appropriate.

"(B) CORRECTIONS WITHIN 30 DAYS.—No order shall be imposed under this subsection by reason of any violation if the carrier establishes to the satisfaction of the Secretary that—

"(i) such violation was due to reasonable cause and not to willful neglect; and

"(ii) such violation is corrected within the 30-day period beginning on earliest date the carrier knew, or exercising reasonable diligence could have known, that such a violation was occurring.

"(C) WAIVER BY SECRETARY.—In the case of a violation which is due to reasonable cause and not to willful neglect, the Secretary may

waive part or all of the civil money penalty imposed by paragraph (9) to the extent that payment of such penalty would be grossly excessive relative to the violation involved and to the need for deterrence of violations.

"(5) ADMINISTRATIVE APPELLATE REVIEW.—The decision and order of an administrative law judge under this subsection shall become the final agency decision and order of the Secretary unless, within 30 days, the Secretary modifies or vacates the decision and order, in which case the decision and order of the Secretary shall become a final order under this subsection.

"(6) JUDICIAL REVIEW.—A carrier adversely affected by a final order issued under this subsection may, within 45 days after the date the final order is issued, file a petition in the Court of Appeals for the appropriate circuit for review of the order.

"(7) ENFORCEMENT OF ORDERS.—If a carrier fails to comply with a final order issued under this section against the carrier, the Secretary shall file a suit to seek compliance with the order in any appropriate district court of the United States. In any such suit, the validity and appropriateness of the final order shall not be subject to review.

"(8) USE OF AMOUNTS COLLECTED.—Civil money penalties collected under this subsection shall be credited to the AmeriCare Trust Fund.

"(9) AMOUNT OF CIVIL MONEY PENALTY.—The amount of any civil money penalty imposed under this subsection shall not exceed $25,000 for each carrier with respect to which a violation occurs. Such amount may take into account the penalties imposed by a State with respect to the same such violation.

"(10) NOTICE TO CARRIER IN THE CASE OF INSURED PLANS.—As part of any order issued under this subsection in the case of a health benefit plan, the order shall require that notice be provided to the carrier of the findings in the order.

"(11) LOSS OF STATUS AS A HEALTH BENEFIT PLAN.—If a carrier is not in compliance with subsection (a) and is not determined to have come into compliance with the applicable standards within 6 months after the date of the initial determination of such a violation, such carrier shall be subject to the provision of this subsection.

"(12) EXCISE TAX.—A carrier that is not in compliance with subsection (a) shall be subject to

the tax described in section 4980C of the Internal Revenue Code of 1986.

"(c) EFFECTIVE DATE.—The effective date specified in this subsection is January 1 of the third full year that begins after the date of the enactment of this part.

"ESTABLISHMENT OF STANDARDS

"SEC. 1302. (a) ESTABLISHMENT OF STANDARDS.—

"(1) NAIC.—The Secretary shall request the NAIC—

"(A) to develop specific standards, in the form of a model Act and model regulations, to implement the requirements of this title; and

"(B) to report to the Secretary on such development;

by not later than October 1 of the year following the year in which this title is enacted. If the NAIC develops such standards within such period and the Secretary finds that such standards implement the requirements of this title, such standards shall be the standards applied under section 1301.

"(2) SECRETARY.—If the NAIC fails to develop and report on such standards by such date or the Secretary finds that such standards do not implement the requirements of this title, the Secretary shall develop and publish, by not later than November 15 of the year following the year in which this

title is enacted, such standards. Such standards shall then be the standards applied under section 1301.

"(b) ADDITIONAL ELEMENTS OF REGULATORY PROGRAMS.—

"(1) IN GENERAL.—A State regulatory program shall include the following:

"(A) The enforcement under the program—

"(i) shall be designed in a manner so as to secure compliance with the standards within 30 days after the date of a finding of noncompliance with such standards; and

"(ii) shall provide for notice to the Secretary in cases where such compliance is not secured within such 30-day period.

"(B) A toll-free telephone number which provides—

"(i) for a system for the receipt and disposition of consumer complaints or inquiries regarding compliance of health benefit plans with the requirements of this title; and

"(ii) information to small employers and consumers about carriers that offer

health benefit plans in the area covered by the regulatory authority.

Such system shall provide for the recording of consumer complaints in accordance with a uniform methodology developed by the NAIC and recognized by the Secretary.

"(2) SECRETARIAL AUTHORITY.—In the case of a State without a regulatory program approved under subsection (a), the Secretary shall provide for the establishment of the toll-free telephone information and complaint system described in paragraph (1).

"(c) SECRETARIAL REVIEW.—

"(1) PERIODIC REVIEW OF STATE REGULATORY PROGRAMS.—The Secretary periodically shall review State regulatory programs to determine if they continue to meet the standards referred to in subsection (a) and the requirements of subsection (b). If the Secretary finds that a State regulatory program no longer meets such standards and requirements, before making a final determination, the Secretary shall provide the State an opportunity to adopt such a plan of correction as would permit the program to continue to meet such standards and requirements. If the Secretary makes a final determination that

the State regulatory program, after such an opportunity, fails to meet such standards and requirements, the Secretary shall assume responsibility under section 1301(a)(1)(B) with respect to plans in the State.

"(2) LOOK-BEHIND AUTHORITY.—In the case of a State with a regulatory program found by the Secretary to meet the standards and requirements under this title, the Secretary nonetheless is authorized to determine whether or not health benefit plans offered by carriers in the State have failed to comply with the applicable requirements of this title.

"(d) GAO AUDITS.—The Comptroller General shall conduct periodic audits on a sample of State regulatory programs to determine their compliance with the requirements of this section. The Comptroller General shall report to the Secretary and Congress on the findings in such audits.

"TRANSITIONAL REQUIREMENTS APPLICABLE TO ALL HEALTH BENEFIT PLANS ISSUED TO SMALL EMPLOYERS

"SEC. 1303. (a) APPLICATION.—The requirements of this section shall apply only to health benefit plans offered to small employers during the period that begins on the effective date of this title and ends in the case of a small employer, on the date that begins the fifth full year after the date of enactment of this title.

"(b) NO DISCRIMINATION BASED ON HEALTH STATUS FOR CERTAIN SERVICES.—

"(1) IN GENERAL.—Except as provided under paragraph (2), health benefit plans offered to small employers by carriers may not deny, limit, or condition the coverage under (or benefits of) the plan with respect to basic health services based on the health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability, of an individual.

"(2) TREATMENT OF PREEXISTING CONDITION EXCLUSIONS FOR ALL SERVICES.—

"(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph, health benefit plans provided to small employers by carriers may exclude coverage with respect to services related to treatment of a preexisting condition, but the period of such exclusion may not exceed 6 months.

"(B) NONAPPLICATION TO NEWBORNS AND SUNSET OF PREEXISTING CONDITION EXCLUSIONS FOR BASIC HEALTH SERVICES.—The exclusion of coverage permitted under subparagraph (A) shall not apply to—

"(i) services furnished to newborns, or

"(ii) basic health services furnished on or after July 1 of the sixth full year beginning after the date of the enactment of this title.

"(C) CREDITING OF PREVIOUS COVERAGE.—

"(i) IN GENERAL.—A health benefit plan issued to a small employer by a carrier shall provide that if an individual under such plan is in a period of continuous coverage (as defined in clause (ii)(I)) with respect to particular services as of the date of initial coverage under such plan, any period of exclusion of coverage with respect to a preexisting condition for such services or type of services shall be reduced by 1 month for each month in the period of continuous coverage.

"(ii) DEFINITIONS.—As used in this subparagraph:

"(I) PERIOD OF CONTINUOUS COVERAGE.—The term 'period of continuous coverage' means, with respect to particular services, the period beginning on the date an individual is

enrolled under a health benefit plan issued to a small employer by a carrier which provides the same or substantially similar benefits with respect to such services and ends on the date the individual is not so enrolled for a continuous period of more than 3 months.

"(II) PREEXISTING CONDITION.—The term 'preexisting condition' means, with respect to coverage under a health benefit plan issued to a small employer by a carrier, a condition which has been diagnosed or treated during the 3-month period ending on the day before the first date of such coverage, except that such term does not include a condition which was first diagnosed or treated during a period of continuous coverage.

"(iii) STANDARDS FOR SIMILAR BENEFITS.—The standards established under section 1302 shall establish such criteria for determining if benefits are substantial-

ly similar as may be necessary to carry out this subparagraph.

"(c) PERMITTING COVERAGE DURING WAITING PERIOD.—

"(1) IN GENERAL.—If a health benefit plan issued to a small employer by a carrier imposes a waiting period before an eligible individual may be covered under the plan, the plan—

"(A) must make available to the individual coverage (including coverage of dependents) equivalent to the coverage available to the employee upon the completion of any applicable waiting period; and

"(B) may not impose for such coverage charges that exceed the cost under the plan of providing such coverage with respect to the employee if such waiting period did not apply.

Nothing in this paragraph shall be construed as requiring a health benefit plan issued to a small employer by a carrier to make coverage available to an individual who no longer has an employment relationship (or who is the spouse or dependent of such an individual) with respect to the plan.

"(2) ELIGIBLE INDIVIDUAL DEFINED.—In paragraph (1), the term 'eligible individual' means,

with respect to a health benefit plan, an individual who, but for a waiting period, would be eligible for immediate coverage under the plan.

"DEFINITIONS

"SEC. 1304. (a) HEALTH PLAN AND OTHER DEFINITIONS RELATING TO HEALTH PLANS.—As used in this title:

"(1) HEALTH BENEFIT PLAN.—The term 'health benefit plan' means any hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, health maintenance subscriber contract, other employee welfare plan (as defined in the Employee Retirement Income Security Act of 1964), or any other health insurance arrangement, and includes an employment-related reinsurance plan (as defined in paragraph (3)), but does not include—

"(A) accident-only, credit, dental, or disability income insurance,

"(B) coverage issued as a supplement to liability insurance,

"(C) worker's compensation or similar insurance, or

"(D) automobile medical-payment insurance;

that is offered by a carrier.

"(2) SMALL EMPLOYER.—The term 'small employer' means, with respect to a calendar year, an employer that normally employs fewer than 100 employees on during the calendar year.

"(3) MANAGED CARE PLAN.—The term 'managed care plan' has the same meaning given such term by section 2108(a)(6).

"(4) REINSURANCE PLAN.—The term 'reinsurance plan' means any reinsurance or similar mechanism that underwrites a portion of the risk for a health benefit plan, if the mechanism is offered directly to a small employer.

"(5) SELF-INSURED HEALTH BENEFIT PLAN.—The term 'self-insured health benefit plan' means a health benefit plan in which the small employer or employment-related group assumes the underwriting risk for the plan (whether or not there is any reinsurance or similar mechanism to underwrite a portion of that risk).

"(b) CARRIER; HEALTH MAINTENANCE ORGANIZATION; AND OTHER DEFINITIONS RELATING TO CARRIERS.—As used in this title:

"(1) CARRIER.—The term 'carrier' means any person that offers a health benefit plan, whether through insurance or otherwise, including a licensed

insurance company, a prepaid hospital or medical service plan, a health maintenance organization, a self-insurer carrier, a reinsurance carrier, and a multiple small employer welfare arrangement (a combination of small employers associated for the purpose of providing health benefit plan coverage for their employees).

"(2) EMPLOYER CARRIER.—The term 'employer carrier'—

"(A) means any carrier which offers health benefit plans, and

"(B) includes (unless the context otherwise requires)—

"(i) a self-insurer carrier offering such a plan, or

"(ii) a reinsurance carrier offering an health benefit plan that is an reinsurance plan.

"(3) HEALTH MAINTENANCE ORGANIZATION.—The term 'health maintenance organization' has the meaning given the term 'eligible organization' in section 1876(b).

"(4) REINSURANCE CARRIER.—The term 'reinsurance carrier' means the entity assuming responsibility for underwriting under an employment-related

reinsurance plan, but does not include a carrier insofar as it directly offers a health benefit plan.

"(5) SELF-INSURER CARRIER.—The term 'self-insurer carrier' means a carrier that is not a licensed insurance company, a prepaid hospital or medical service plan, or a health maintenance organization, that offers a health benefit plan directly with respect to an employment-related group.

"(c) GENERAL DEFINITIONS.—As used in this title:

"(1) APPLICABLE REGULATORY AUTHORITY.—The term 'applicable regulatory authority' means, with respect to a health benefit plan offered in a State, the State commissioner or superintendent of insurance or other State authority responsible for regulation of health insurance, or, if the Secretary is exercising authority under section 1301(a)(1)(B) in the State, the Secretary.

"(2) BLOCK OF BUSINESS.—The term 'block of business' means all, or a distinct grouping of, small employers as shown on the records of the small employer carrier, if established consistent with section 1312(b)(3).

"(3) COMMUNITY.—The term 'community' means a geographic area designated by the Secretary as—

"(A) encompassing one or more adjacent metropolitan statistical areas; or

"(B) the remaining area within each State (that is not designated within any community under subparagraph (A));

except that the Secretary may designate an entire State as a community if such a designation would better carry out the purposes of this title. The Secretary from time to time may change the boundaries of communities designated under subparagraph (A) or (B) for such purposes. There shall be no administrative or judicial review of the designation of communities under this subsection.

"(4) FULL-TIME EMPLOYEE.—The term 'full-time employee' means, with respect to an employer, an employee who normally performs on a monthly basis at least 25 hours of service per week for that employer.

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

"(6) REFERENCE PREMIUM RATE.—The term 'reference premium rate' means, for each block of business for a rating period in a community, the lowest premium rate charged or which could have been charged by the small employer carrier to small

employers in that block under a rating system for that block of business in the community for health benefit plans with the same or similar coverage. The reference premium rate is determined without regard to any adjustment for age or sex described in section 1312(c) and without regard to any adjustment effected under section 1312(d).

"(7) STATE.—The term 'State' means the 50 States and the District of Columbia.

"PART B—SMALL EMPLOYER HEALTH INSURANCE REFORM

"ENROLLMENT PRACTICE AND GUARANTEED RENEWABILITY REQUIREMENTS FOR HEALTH BENEFIT PLANS ISSUED TO SMALL EMPLOYERS

"SEC. 1311. (a) REGISTRATION WITH APPLICABLE REGULATORY AUTHORITY.—

"(1) IN GENERAL.—Each carrier (as defined in section 1304(b)(1)) shall register with the applicable regulatory authority for each State in which it issues or offers a health benefit plan to small employers.

"(2) NO PREEMPTION OF STATE INFORMATION REQUIREMENTS.—Nothing in paragraph (1) shall be construed as preventing the applicable regulatory authority from requiring, in the case of carriers that are not self-insurance carriers, such additional infor-

mation in conjunction with, or apart from, the registration required under paragraph (1) as the applicable regulatory authority may be authorized to require under State law.

"(b) GUARANTEED ISSUE.—

"(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, a carrier that offers a health benefit plan (including a reinsurance plan) to small employers located in a community must offer the same plan to any other small employer located in the community.

"(2) TREATMENT OF HEALTH MAINTENANCE ORGANIZATIONS.—

"(A) GEOGRAPHIC LIMITATIONS.—A health maintenance organization may deny coverage under a health benefit plan to a small employer whose employees are located outside the service area of the organization, but only if such denial is applied uniformly without regard to health status or insurability.

"(B) SIZE LIMITS.—A health maintenance organization may apply to the applicable regulatory authority to cease enrolling new small employer groups in its health benefit plan (or in a geographic area served by the plan) if it can

demonstrate that its financial or administrative capacity to serve previously enrolled groups and individuals (and additional individuals who will be expected to enroll because of affiliation with such previously enrolled groups) will be impaired if it is required to enroll new groups.

"(3) GROUNDS FOR REFUSAL TO ISSUE OR RENEW.—

"(A) IN GENERAL.—A carrier may refuse to issue or renew or terminate a health benefit plan under this part only for—

"(i) nonpayment of premiums,

"(ii) fraud or misrepresentation, and

"(iii) failure to meet minimum participation rates (consistent with subparagraph (B)).

"(B) MINIMUM PARTICIPATION RATES.—A carrier may require, within the transition period described in section 1303(a), with respect to a health benefit plan, that a minimum percentage of full-time, permanent employees eligible to enroll under the plan be enrolled, so long as such percentage is enforced uniformly for all employment groups of comparable size.

"(c) MINIMUM PLAN PERIOD.—A carrier may not offer to, or issue with respect to, a small employer a health benefit plan with a term of less than 12 months.

"(d) GUARANTEED RENEWABILITY.—

"(1) IN GENERAL.—

"(A) GENERAL RULE.—Subject to the succeeding provisions of this subsection, a carrier shall ensure that a health benefit plan issued to a small employer be renewed, at the option of the small employer, unless the plan is terminated for the reasons specified in subsection (a)(3)(A) or under subparagraph (B).

"(B) TERMINATION OF BLOCK OF BUSINESS.—A carrier need not renew a health benefit plan with respect to such a small employer if the carrier—

"(i) is terminating the block of business that includes the plan; and

"(ii) provides notice to the small employer covered under the plan of such termination at least 90 days before the date of expiration of the plan.

In the case of such a termination, the carrier may not provide for issuance of any health benefit plan in any block of business during the 5-

year period beginning on the date of termination of such block of business.

"(C) CONSTRUCTION RESPECTING ADDITIONAL STATE DISCLOSURE REQUIREMENTS.—Subparagraph (B)(ii) shall not be construed as preventing the applicable regulatory authority from specifying the information to be included in the notice under such subparagraph or in requiring such notice to be provided at an earlier date.

"(2) NOTICE AND SPECIFICATION OF RATES AND ADMINISTRATIVE CHANGES.—

"(A) NOTICE.—A carrier offering health benefit plans to small employers shall provide for notice, at least 30 days before the date of expiration of the health benefit plan, of the terms for renewal of the plan. Except with respect to rates and administrative changes, the terms of renewal (including benefits) shall be the same as the terms of issuance.

"(B) RENEWAL RATES SAME AS ISSUANCE RATES.—The carrier may change the terms for such renewal, but the premium rates charged with respect to such renewal shall be the same as that for a new issue.

"(C) RATES CANNOT CHANGE MORE OFTEN THAN MONTHLY.—

"(i) IN GENERAL.—A carrier may not change the premium rates established with respect to health benefit plans offered for any block of business more often than monthly.

"(ii) APPLICATION OF NEW RATES.—A carrier that offers health benefit plans to small employers which becomes effective in a month, shall ensure that the premium rates established under clause (i) for that month shall apply to all months during the 12-month period beginning with that month. In the case of a plan renewal which is effective for a 12-month period beginning with a month, the premium rates established under clause (i) with respect to that month shall apply to all months during 12-month renewal period.

"(3) PERIOD OF RENEWAL.—The period of renewal of each health benefit plan offered by a carrier to a small employer shall be for a period of not less than 12 months.

"RATING PRACTICES FOR HEALTH BENEFIT PLANS OFFERED TO SMALL EMPLOYERS

"SEC. 1312. (a) COHESIVE RATING SYSTEM AND ACTURIAL CERTIFICATION.—

"(1) IN GENERAL.—The premiums (including reference premium rate, as defined in section 1304(c)(6), age adjustments under subsection (c), and reductions provided under subsection (d)) for all health benefit plans offered to small employers by carriers shall—

"(A) be established based on a single cohesive rating system which is applied consistently for all small employer groups and is designed not to treat groups, after the second effective year (as defined in subsection (f)), differently based on health status or risk status; and

"(B) be actuarially certified annually.

"(2) ACTUARIAL CERTIFIED DEFINED.—For purposes of paragraph (1)(B), a health benefit plan is considered to be 'actuarially certified' if there is a written statement, by a member of the American Academy of Actuaries or other individual acceptable to the applicable regulatory authority that a carrier is in compliance with this section, based upon the individual's examination, including a review of the ap-

propriate records and of the actuarial assumptions and methods utilized by the carrier in establishing premium rates for applicable health benefit plans.

"(b) USE OF COMMUNITY-RATING.—

"(1) IN GENERAL.—Except as provided in paragraph (2) and subsection (c):

"(A) COMMUNITY RATING WITHIN A BLOCK OF BUSINESS.—The reference premium rate charged for health benefit plans offered with similar benefits to small employers in a community within a block of business for a type of family enrollment (described in subsection (e)) shall be the same for all small employers.

"(B) LIMITING VARIATION ON REFERENCE PREMIUM RATES AMONG BLOCKS OF BUSINESS.—

"(i) IN GENERAL.—Except as provided in clause (iii), the reference premium rate charged for health benefit plans offered with similar benefits to small employers in any community for a type of family enrollment for the most expensive block of business shall not exceed 120 percent of such rate charged for such plan for the

same type of family enrollment for the least expensive block of business.

"(ii) ROLE OF REGULATORY AUTHORITY.—An applicable regulatory authority that is a State may reduce or eliminate the percent variation otherwise permitted under clause (i).

"(iii) EXCEPTION.—Clause (i) shall not apply to health benefit plans offered by carriers to small employers in a block of business—

"(I) if the block is one for which the carrier does not reject, and never has rejected, small employers included within the definition of small employers eligible for the block of business or otherwise eligible employees and dependents who enroll on a timely basis,

"(II) the carrier does not involuntarily transfer, and never has involuntarily transferred, a health benefit plan into or out of the block of business, and

"(III) that block of business was available for purchase as of the date of the enactment of this title.

"(2) TRANSITION.—Notwithstanding paragraph (1)—

"(A) during the first effective year (as defined in subsection (f)), the premium rate under a health benefit plan issued by a carrier to any small employer may be as much as, but may not exceed, 150 percent of the reference premium rate for such plans in the same community for similar benefits in the same block of business; or

"(B) during the second effective year, the premium rate under such a policy for any small employer may be as much as, but may not exceed, 122 percent of the reference premium rate for such plans in the same community for similar benefits in the same block of business.

"(3) ESTABLISHMENT OF BLOCKS OF BUSINESS.—For the purpose of establishing premiums for small employer health benefit plans with similar coverage, the carrier may establish blocks of business based only on one or more of the following characteristics:

"(A) Plans that are marketed by clearly different sales forces.

"(B) Plans that have been acquired from another carrier as a distinct group.

"(C) Plans that are managed care plans.

"(D) Plans within another distinct group, if the applicable regulatory authority finds that establishment of such a group will enhance the efficiency and fairness of the small employer insurance marketplace.

"(c) ADJUSTMENTS TO COMMUNITY-RATING.—

"(1) IN GENERAL.—Subject to paragraph (2), a health benefit plan offered by a carrier to a small employer may provide for an adjustment to the reference premium rate based on the age and gender of covered individuals. Any such adjustment shall be applied by the carrier consistently to all small employers, except that adjustment based on gender may only be made during the transition period.

"(2) LIMITATION ON ADJUSTMENT.—

"(A) IN GENERAL.—The adjustment under paragraph (1) may not result, with respect to health benefit plans with similar benefits offered by carriers to small employers in the same block of business in a community, in a premium

rate for the most expensive age group exceeding the applicable percent (as defined in subparagraph (B)) of the premium rate for the least expensive age group.

"(B) APPLICABLE PERCENT DEFINED.—In subparagraph (A) but subject to subparagraph (C), the term 'applicable percent' means—

"(i) for the first effective year (as defined in subsection (f)) 200 percent,

"(ii) for the second effective year, 150 percent, and

"(iii) for any subsequent year, 110 percent.

"(C) ROLE OF REGULATORY AUTHORITY.—An applicable regulatory authority that is a State may reduce or eliminate the applicable percent otherwise applied.

"(d) ADJUSTMENT IN RATES PERMITTED IN CASE OF MEDICARE REIMBURSEMENT ELECTION.—A health benefit plan offered by a carrier to a small employer may compute premiums based upon a percentage of the reference premium rate otherwise applicable if the small employer to which the plan is being offered makes the reimbursement election described in section 1314. Any such

adjustment shall be applied consistently to all small employers.

"(e) TYPES OF FAMILY ENROLLMENT.—Each health benefit plan offered by a carrier to a small employer shall permit enrollment of (and shall compute premiums separately for) individuals based on each of the following beneficiary classes:

"(1) 1 adult.

"(2) A married couple without children.

"(3) 1 adult and 1 child.

"(4) A married couple with 1 or more children, or 1 adult with 2 or more children.

"(f) EFFECTIVE YEARS DEFINED.—In this section, the terms 'first effective year' and 'second effective year' mean the third and fourth full years beginning after the date of the enactment of this part.

"(g) EXCEPTION FOR SELF-INSURED CARRIERS.—The requirements of this section shall apply to reinsurance carriers and health benefit plans offered by such carriers to small employers.

"BASIC BENEFIT PACKAGE FOR HEALTH BENEFIT PLANS OFFERED TO SMALL EMPLOYERS

"SEC. 1313. (a) IN GENERAL.—

"(1) BENEFITS AND COST-SHARING IN HEALTH BENEFIT PLANS.—Except as provided in paragraph (2) and in section 1303(a), no health benefit plan of-

fered by carriers to small employers may be issued to a small employer unless—

"(A) the plan provides for benefits for all basic health services as defined in section 1182(1);

"(B) the plan does not impose cost-sharing with respect to basic health services in excess of the deductibles and coinsurance permitted under section 2103 with respect to such services; and

"(C) the carrier makes available to the small employer a health benefit plan that, subject to paragraph (2)(C), only provides the benefits for basic health services and the maximum cost-sharing consistent with subparagraphs (A) and (B).

"(2) EXCEPTIONS.—

"(A) REQUIRED OFFERING DOES NOT APPLY TO HMO'S.—Paragraph (1)(C) shall not apply to a health maintenance organization.

"(B) ADDITIONAL, OPTIONAL MINIMUM SERVICES.—In meeting the requirement of paragraph (1)(C), a health benefit plan offered by a carrier to a small employer may include such additional items and services as the carrier

can demonstrate to the satisfaction of the applicable regulatory authority that inclusion of such items and services will facilitate appropriate hospital discharges or avoid unnecessary hospitalization.

"(b) MANAGED CARE OPTION.—If a carrier (other than a health maintenance organization or reinsurance carrier) offers health benefit plans to employers that are not small employers, in a community a health benefit plan that is a managed care plan, the carrier must make available to small employers in the community a health benefit plan that is such a managed care plan.

"(c) EXCEPTION FOR REINSURANCE CARRIERS AND PLANS.—The requirements of this section shall not apply to reinsurance carriers and reinsurance plans.

"(d) STANDARDIZATION OF BENEFIT PACKAGES.—The NAIC shall develop a model to standardize benefits to be made available under health benefit plans offered by carriers to small employers in order to promote consumer understanding and comparison among such plans.

"TIME-LIMITED MEDICARE REIMBURSEMENT OPTION FOR HEALTH BENEFIT PLANS OFFERED TO SMALL EMPLOYERS NOT PREVIOUSLY OFFERING INSURANCE COVERAGE

"SEC. 1314. (a) OPTION MUST BE OFFERED.—Each carrier offering a health benefit plan to small employers meeting the requirements of section 351(a) of the HealthAmerica Act shall offer the small employer the option of having payment under the plan made for basic health services at rates no higher than the payment rates established under title XVIII for such benefits. The provisions of section 1848(g)(3) shall not be considered to apply under this subsection.

"(b) APPLICATION OF MEDICARE BILLING LIMITATIONS.—In the case of a small employer that elects the option offered under subsection (a) with respect to a health benefit plan, the limitations on charges that may be made under medicare shall apply to individuals receiving benefits under the plan. The sanctions imposed under the medicare program (and title XI), including exclusion under such program and the imposition of civil money penalties for violations of such limitations, apply to violations of the limitations imposed under this subsection.

"(c) EXCEPTION FOR REINSURANCE PLAN.—Subsection (a) shall not apply to reinsurance plans.

"MISCELLANEOUS DISCLOSURE AND RECORD-KEEPING REQUIREMENTS FOR HEALTH BENEFIT PLANS OFFERED TO SMALL EMPLOYERS

"SEC. 1315. (a) DISCLOSURE.—

"(1) GENERAL DISCLOSURE.—Each carrier offering health benefit plans to small employers shall disclose to each small employer before issuing such a plan the following:

"(A) The availability (pursuant to the requirement of section 1313(a)(1)(C)) of a plan including only basic benefits.

"(B) Whether any plan that is a managed care plan or provides for a utilization review program, or both, is available, as required under section 1313(b).

"(C) The option of electing the reimbursement rules, as required under section 1314.

"(D) The limits, imposed under section 1312, on the premiums permitted to be charged for such plans.

"(E) The rights of guaranteed issue and renewability provided under section 1311.

Such disclosure shall be in addition to any disclosure required generally of health benefit plans under section 2725 of the Public Health Service Act.

"(2) SPECIFIC DISCLOSURE UPON REQUEST.—Each carrier offering health benefit plans to small employers shall disclose to small employer, upon request, information concerning the blocks of business established with respect to such plans and the applicable premiums for such plans.

"(3) STANDARD FORMAT.—The disclosure under paragraph (1) shall be made in a uniform format established by the Secretary, after consultation with the NAIC.

"(4) EXCEPTIONS.—Paragraph (1) (other than subparagraphs (D) and (E)) shall not apply to a reinsurance carrier with respect to a reinsurance plan.

"(b) INFORMATION FILED WITH APPLICABLE REGULATORY AUTHORITY.—

"(1) IN GENERAL.—Each carrier offering health benefit plans to small employers shall disclose to the applicable regulatory authority, in a manner specified by the Secretary, information concerning—

"(A) blocks of business established; and

"(B) applicable premiums for health benefit plans.

"(2) ADDITIONAL INFORMATION.—Nothing in this subsection shall be construed as limiting the in-

formation which an applicable regulatory authority may require to be reported by carriers.

"NONAPPLICATION IN PUERTO RICO AND THE TERRITORIES

"SEC. 1316. This part shall not apply outside the 50 States or the District of Columbia.

"PART C—ENCOURAGING DEVELOPMENT OF REINSURANCE SYSTEMS

"ENCOURAGING DEVELOPMENT OF REINSURANCE SYSTEMS

"SEC. 1321. (a) DEVELOPMENT OF MODELS.—

"(1) IN GENERAL.—Not later than October 1 of the year following the year in which this title is enacted, the NAIC shall develop several models of legislation for the enactment of reinsurance systems that may be used by States with respect to health insurance policies (including health benefit plans offered to small employers).

"(2) SPECIFIC MODELS.—Such models shall include at least 1 of each of the following 3 models:

"(A) A model providing for voluntary participation by insurers.

"(B) A model providing for insurer participation on a retrospective basis.

"(C) A model providing for the case management of services for individual claims or groups which are reinsured through the system.

"(3) TERMS OF MODELS.—Each of the models—

"(A) shall be consistent with the provisions of this title (including those relating to community-rated premiums), and

"(B) shall include deductibles and coinsurance which—

"(i) limit the amount of risk ceded to the reinsurance system; and

"(ii) encourage insurers to manage health care costs.

"(b) PROTECTION OF HEALTH MAINTENANCE ORGANIZATIONS UNDER REINSURANCE SYSTEMS.—No State may establish or enforce a reinsurance system with respect to health insurance policies unless the system provides for an adjustment in reinsurance premiums (or, in the event of losses to the system, assessments) charged to health maintenance organizations that takes into account—

"(1) the higher premiums charged by such organizations due to the greater coverage provided by such organizations as required by law,

"(2) the limitations under title XIII of the Public Health Service Act on the amount of risk which such an organization can reinsure, and

"(3) the ability of such organizations to manage risk internally.

"(c) EFFECTIVE DATE.—This section shall take effect on the date of the enactment of this title.".

Subtitle B—Tax Equity for Small and Medium-Sized Business

SEC. 321. DEDUCTIBLE HEALTH COVERAGE PROVISIONS.

(a) INCREASE IN DEDUCTIBLE HEALTH INSURANCE COSTS FOR SELF-EMPLOYED INDIVIDUALS WITHOUT EMPLOYEES.—

(1) IN GENERAL.—Paragraph (1) of section 162(l) of the Internal Revenue Code of 1986 (relating to special rules for health insurance costs of self-employed individuals) is amended by striking out "25 percent" and all that follows and inserting in lieu thereof "100 percent of—

"(A) the cost of the lowest cost plan meeting the requirements of the subtitle A of title III of the HealthAmerica Act available in the geographic area in which the individual resides or conducts business, or

"(B) if such individual is enrolled in AmeriCare, the cost of AmeriCare,

paid during the taxable year for the taxpayer, his spouse, and dependents.".

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to taxable years beginning in the third full calendar year after the date of enactment of this Act.

(b) DEDUCTION ALLOWABLE FOR CERTAIN GROUP HEALTH PLAN CONTRIBUTIONS BY SELF-EMPLOYED INDIVIDUALS.—

(1) IN GENERAL.—Section 162 of the Internal Revenue Code of 1986 (relating to trade or business expenses) is amended by redesignating subsection (m) as subsection (n) and by inserting after subsection (l) (relating to special rules for health insurance costs of self-employed individuals) the following new subsection:

"(m) DEDUCTION ALLOWABLE FOR CERTAIN GROUP HEALTH PLAN CONTRIBUTIONS FOR THE BENEFIT OF SELF-EMPLOYED INDIVIDUALS.—

"(1) IN GENERAL.—For purposes of this section and sections 212, 104, 105, and 106, in the case of a qualified group health plan which provides

medical care benefits for any self-employed individual—

"(A) such individual shall be treated as an employee,

"(B) the employer of such individual shall be the person treated as the employer under section 301(c)(4), and

"(C) contributions to such plan for medical benefits for such individual shall be treated as meeting the requirements of subsection (a) and section 212 to the extent such contributions during the taxable year do not exceed the lowest per employee contribution for employees working 25 hours a week or more to the plan made by the employer during such year.

"(2) DEDUCTION CANNOT EXCEED TAXABLE INCOME FROM ACTIVITY.—The deduction allowed to any individual by reason of this subsection for any taxable year shall not exceed the portion of the taxable income of such individual (determined without regard to this subsection) for such year which is allocable or apportionable to such individual's interest in the employer.

"(3) QUALIFIED GROUP HEALTH PLAN.—

"(A) IN GENERAL.—For purposes of this subsection, the term 'qualified group health plan' means, with respect to any self-employed individual, any group health plan (as defined in section 5000(b)(1)) of an employer if—

"(i) such plan is not a self-insured plan, and

"(ii) such plan meets the requirements of subparagraphs (B) and (C).

"(B) ONE-HALF OF PARTICIPANTS MUST BE EMPLOYEES WHO ARE NOT SELF-EMPLOYED INDIVIDUALS OR EMPLOYEE FAMILY MEMBERS OF SUCH INDIVIDUALS.—

"(i) IN GENERAL.—A plan meets the requirements of this subparagraph with respect to any self-employed individual only if at least half of the participants in the plan (on each day of the taxable year of such individual) are employees who are not—

"(I) self-employed individuals to whom a deduction is allowable by reason of this subsection with respect to contributions to such plan, or

"(II) family members of any self-employed individual described in subclause (I).

"(ii) FAMILY MEMBER.—For purposes of clause (i), the term 'family member' means, with respect to an individual, such individual's brothers and sisters (whether by the whole or half blood), spouse, ancestors, and lineal descendants.

"(C) SELF-INSURED PLAN.—The term 'self-insured plan' means any plan under which medical care benefits are not provided under a policy of accident and health insurance.

"(4) LOWEST PER EMPLOYEE CONTRIBUTION.—

"(A) IN GENERAL.—For purposes of this subsection, the term 'lowest per employee contribution' means, with respect to any taxable year of a self-employed individual, the smallest contribution made by the employer during such taxable year to the plan with respect to any employee—

"(i) who is not a self-employed individual,

"(ii) with respect to whom a contribution to the plan was made during such year, and

"(iii) who is in the same category of coverage as the self-employed individual.

"(B) CATEGORIES OF COVERAGE.—For purposes of subparagraph (A), the categories of coverage are—

"(i) self only, and

"(ii) self and family.

"(C) SELF-EMPLOYED INDIVIDUALS WHO ARE PARTICIPANTS FOR LESS THAN ENTIRE TAXABLE YEAR.—In the case of a self-employed individual who is a participant in the plan for less than the entire taxable year, the lowest per employee contribution applicable to such individual shall be the same portion of amount determined under subparagraph (A) as the portion of the taxable year during which such individual was a participant in the plan bears to the entire taxable year.

"(D) SPECIAL RULES.—For purposes of subparagraph (A)—

"(i) only contributions for coverage during the taxable year shall be taken into account, and

"(ii) the contributions with respect to any employee who is not a participant in the plan for the entire taxable year shall be determined on an annualized basis.

"(5) OTHER DEFINITIONS.—For purposes of this subsection—

"(A) SELF-EMPLOYED INDIVIDUAL.—The term 'self-employed individual' has the meaning given such term by section 301(c)(1)(B).

"(B) MEDICAL CARE BENEFITS.—The term 'medical care benefits' means, with respect to any self-employed individual, compensation for the medical care (as defined in section 213(d)) of such individual, the spouse of such individual, and dependents of such individual.

"(C) DEPENDENT.—The term 'dependent' has the meaning given such term by section 152. Any child to whom section 152(e) applies shall be treated as a dependent of both parents.

"(6) SPECIAL RULES.—

"(A) COORDINATION WITH SECTION 213.—Any amount allowed as a deduction by reason

of this subsection shall not be treated as an amount paid for medical care under section 213.

"(B) AGGREGATION OF EMPLOYER PLANS.—If any self-employed individual is a participant in 2 or more qualified group health plans of the employer, all such plans shall be treated as 1 plan for purposes of this subsection.".

(2) TECHNICAL AMENDMENT.—Subsection (g) of section 105 of the Internal Revenue Code of 1986 (relating to self-employed individual not considered an employee) is amended by striking out "For purposes of this section" and inserting in lieu thereof "Except as provided in section 162(m)(1), for purposes of this section".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning in the third full year after the date of enactment of this Act.

SEC. 322. EXCISE TAX FOR VIOLATION OF HEALTH BENEFIT PLAN REQUIREMENTS.

(a) IN GENERAL.—

(1) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 (relating to qualified pension,

etc., plans) is amended by adding at the end thereof the following new section:

"SEC. 4980C. VIOLATION OF HEALTH BENEFIT PLAN REQUIREMENTS.

"(a) IMPOSITION OF TAX.—There is hereby imposed a tax on an entity's violation of subsection (a) of section 1301 of the Social Security Act. The determination of whether there has been such a violation shall be made by the Secretary of Health and Human Services under such section.

"(b) AMOUNT OF TAX.—The tax imposed by subsection (a) shall be equal to 25 percent of the amounts received by the entity (during the period such a violation persists) for providing any health plan for all blocks of business in all communities.

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

"(d) EXCEPTIONS.—

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

"(A) such violation was due to reasonable cause and not to willful neglect, and

"(B) such violation is corrected within the 30-day period beginning on earliest date the en-

tity knew, or exercising reasonable diligence could have known, that such a violation was occurring.

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

"(e) DEFINITIONS.—For purposes of this section, the definitions in title XXIII of the Social Security Act shall apply under this section.".

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

"Sec. 4980C. Violation of health plan requirements.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall become effective on January 1 of the 4th year beginning after the date of the enactment of this Act.

Subtitle C—Opportunity for Voluntary Provision of Coverage

SEC. 331. MEDIUM-SIZED EMPLOYERS.

(a) EMPLOYERS WITH BETWEEN 25 AND 100 EMPLOYEES.—

(1) IN GENERAL.—No medium-sized employer shall be required to provide a health benefit plan under section 2701 of the Public Health Service Act or make a contribution in lieu of coverage under title V of this Act until the fifth calendar year after the date of enactment of this Act.

(2) APPLICATION OF REQUIREMENTS.—If, during the fourth calendar year after the date of enactment of this Act, the Secretary finds that the total number of employees, excluding part-time employees, of all such employers that have no employment-based health insurance coverage provided through the employers of such employees has been reduced to 25 percent or less of the number of such uninsured employees that existed during the calendar year in which this Act was enacted, the requirement to provide coverage or make a contribution under title V shall apply to employers described in paragraph (1).

(3) PERCENTAGES DURING SUBSEQUENT YEARS.—An employer described in paragraph (1) shall provide the health benefits coverage under this Act, or an amendment made by this Act, or make a contribution under title V if the percentage of the uninsured employees during the fifth calendar year or any subsequent calendar year after the date of

the enactment of this Act is more than the 25 percent level described in paragraph (2).

(b) UNINSURED EMPLOYEES.—

(1) YEAR OF ENACTMENT.—For purposes of subsection (a), employees shall be considered uninsured during the calendar year in which this Act is enacted if such employees are not covered under any employment-based health insurance coverage provided through their employer.

(2) FOURTH YEAR.—For purposes of subsection (a), employees shall be considered uninsured during the fourth calendar year after the date of the enactment of this Act if such employees are not covered under any employment-based health insurance coverage provided through their employer that meets the requirements of this Act and the amendments made by this Act.

SEC. 332. MEASUREMENT SURVEYS.

(a) ANNOUNCEMENT.—Not later than 6 months after the date of enactment of this Act, the Secretary shall publish in the Federal Register an announcement of the survey or surveys to be used by such Secretary in the coverage level of employees described in section 331, and the criteria that will be used to determine such level.

(b) CRITERIA.—The announcement of criteria under subsection (a) shall include a determination, based on the availability of the most reliable survey data available, as to whether the determination of the coverage level shall be based on a measurement of insurance coverage at a point in time or during the course of all or part of a calendar year.

(c) APPLICATION OF ACT.—If the percentage of uninsured employees in the fourth calendar year after the date of the enactment of this Act is equal to or less than the 25 percent level described in section 331(a), the Secretary shall repeat the measurement of such coverage level annually and if, in any calendar year, the Secretary does not find that the number of employees who do not have employer provided health insurance coverage is equal to or less than such 25 percent level, the requirements of this Act or section 2701 of the Public Health Service Act shall apply to all employers described in section 331(a).

SEC. 333. SMALL EMPLOYERS.

Sections 331 and 332 shall apply to small employers, except that the requirement to provide coverage or make a contribution in lieu of coverage under title V shall not be applied until the sixth calendar year after the date of enactment of this Act, and the Secretary shall make the determinations required under such sections to be made

in the fourth calendar year, in the fifth calendar year after the date of enactment of this Act.

SEC. 334. FAILURE TO MAKE SURVEYS.

The failure of the Secretary to make the surveys required under this subtitle shall not relieve an employer of the obligation of such employer to provide coverage or make a contribution in lieu of coverage absent a finding by the Secretary that the coverage target has been met.

Subtitle D—Small Business Tax Credit

SEC. 341. ALLOWANCE OF A CREDIT FOR SMALL AND MEDIUM-SIZED BUSINESS GROUP HEALTH PLAN EXPENDITURES.

(a) IN GENERAL.—Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to business related credits) is amended by inserting at the end thereof the following new section:

"SEC. 45. SMALL BUSINESS GROUP HEALTH PLAN EXPENDITURES.

"(a) ALLOWANCE OF CREDIT.—

"(1) IN GENERAL.—For purposes of section 38, in the case of an eligible small business, the amount of the qualified group health plan credit for the taxable year shall be an amount equal to the applicable

percentage of the qualified group health plan expenditures for such taxable year.

"(2) APPLICABLE PERCENTAGE DEFINED.—

"(A) IN GENERAL.—For purposes of paragraph (1), the term 'applicable percentage' means 25 percent reduced (but not below 0 percent) by 5 percent for—

"(i) each employee of the eligible small business in excess of 40, or

"(ii) each .1 by which the expanded profit ratio of such business exceeds 1.

"(B) COORDINATION OF MULTIPLE PHASEOUTS.—If an eligible small business is subject to subparagraphs (A)(i) and (A)(ii), the applicable percentage shall be determined by multiplying the resulting applicable percentage under subparagraph (A)(i) (expressed as a percentage of the credit remaining) by such applicable percentage under subparagraph (A)(ii).

"(C) EXPANDED PROFIT RATIO.—

"(i) IN GENERAL.—For purposes of this paragraph, the term 'expanded profit ratio' means the expanded profit of the eligible small business for the taxable year divided by the qualified group health plan

expenditures of such business for such year.

"(ii) EXPANDED PROFIT.—For purposes of clause (i), the term 'expanded profit' means the sum of—

"(I) the taxable income of the eligible small business,

"(II) the amount of earned income exceeding the applicable contribution base (as defined in section 3121(x)(1)) for each 5-percent owner of such business, plus

"(III) the total amount of interest and dividends distributed to all owners of such business.

"(b) QUALIFIED GROUP HEALTH PLAN EXPENDITURES; ELIGIBLE SMALL BUSINESS.—For purposes of this section—

"(1) QUALIFIED GROUP HEALTH PLAN EXPENDITURES.—

"(A) IN GENERAL.—The term 'qualified group health plan expenditures' means the aggregate amount of expenditures paid or incurred by the eligible small business for the taxable year for coverage of its employees under a

group health plan (as defined in section 5000(b)(1)) which is a health benefit plan (as defined in section 2713(a)(5)) of the Public Health Service Act to the extent such expenditures do not exceed $3,000 for each employee, reduced (but not below zero) by 5 percent for each $250 (or fraction thereof) by which the amount of wages paid to such employee by the eligible small business in such taxable year exceeds $15,000.

"(B) LIMIT INDEXED.—In the case of any taxable year beginning in a calendar year after the effective date of this section, the $3,000 amount in subparagraph (A) shall be increased by an amount equal to

"(i) such amount, multiplied by

"(ii) the increase (if any) in the wage index for such calendar year.

"(2) ELIGIBLE SMALL BUSINESS.—

"(A) IN GENERAL.—The term 'eligible small business' means any person which, on an average business day during the preceding taxable year, had no more than 60 employees.

"(B) AGGREGATION RULES.—All members of the same controlled group of corporations

(within the meaning of section 52(a)) and all persons under common control (within the meaning of section 52(b)) shall be treated as 1 person.

"(C) EMPLOYEE.—The term 'employee'—

"(i) shall include a self-employed individual as defined in section 401(c)(1), but

"(ii) shall not include an employee who works less than 25 hours per week.

"(c) COORDINATION WITH DEDUCTION.—Any deduction allowable under this chapter for any qualified group health plan expenditures shall be in addition to any credit under section 38 attributable to such expenditures.".

(b) CONFORMING AMENDMENTS.—

(1) Section 38(b) of such Code is amended—

(A) by striking "plus" at the end of paragraph (6),

(B) by striking "plus" at the end of paragraph (7), and inserting a comma and "plus", and

(C) by adding at the end thereof the following new paragraph:

"(8) the small business group health plan expenditures credit determined under section 45.".

(2) The table of sections for subpart D of part IV of subchapter A of chapter 1 of such Code is amended by inserting after the item relating to section 44 the following new item:

"Sec. 45. Small business group health plan expenditures."

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning in the third full calendar year after the date of the enactment of this Act.

Subtitle E—Additional Assistance to Small and Medium-Sized Businesses

SEC. 351. OPPORTUNITY TO BUY COVERAGE AT MEDICARE RATES.

(a) ELIGIBILITY.—Businesses with fewer than 100 employees that have not provided coverage to their employees in the calendar year preceding the date of enactment of this Act shall be eligible to buy private health insurance coverage from a small or medium-sized business insurer under which providers of health care services are paid at rules based on Medicare rates as provided for in part C of title XXVII of the Public Health Service Act and title XIII of the Social Security Act, for a period of not to exceed 5 years.

(b) DEFINITION.—As used in this section the term "not provided coverage in the calendar year preceding the

date of enactment of this Act" means, with respect to a business, that less than 25 percent of employees working more than 17.5 hours per week for the business received coverage from the business in each of the years.

SEC. 352. SPECIAL PROVISION FOR NEW SMALL BUSINESSES.

In the case of a small employer that normally employs 24 or fewer employees during a year, and that has been an employer for not more than 3 years, such employer shall not be required to provide coverage under this Act or the amendment made by this Act or make a contribution in lieu of coverage under title V for the first two years in which the employer has been an employer. Such employer shall be permitted to meet the requirements of part B of title XXVII of the Public Health Service Act by making a contribution at a rate that is ½ of the rate that would otherwise be required to be paid under this Act.

SEC. 353. SMALL AND MEDIUM-SIZED BUSINESS ADVISORY COMMITTEE.

(a) ESTABLISHMENT.—The Secretary shall establish a small and medium-sized business advisory committee (hereafter referred to in this section as the "committee") that shall provide advice to such Secretary and to the appropriate committees of Congress concerning all provisions

of this Act that relate to small and medium-sized businesses.

(b) MEMBERSHIP.—

(1) IN GENERAL.—The Secretary shall jointly appoint individuals to serve on the committee, of which—

(A) seven individuals shall be representatives of small or medium-sized businesses;

(B) two individuals shall be representatives of employees of small or medium-sized businesses;

(C) two individuals shall be knowledgeable concerning the small and medium-sized business insurance market; and

(D) two individuals shall be members of the general public.

(2) SMALL AND MEDIUM-SIZED BUSINESS REPRESENTATIVES.—Individuals appointed under paragraph (1)(A) shall—

(A) be selected from geographically diverse regions of the country;

(B) include at least one representative of small or medium-sized businesses that are located in rural areas and one representative of

small or medium-sized businesses located in urban areas;

(C) include at least one individual who represents the concerns of minority businesses; and

(D) represent a diversity of businesses.

(3) CHAIRPERSON.—The members of the committee shall elect an individual to serve as chairperson.

(4) COMPENSATION AND REIMBURSEMENT OF EXPENSES.—Members of the committee appointed under paragraph (1) shall receive compensation for each day (including travel time) engaged in carrying out the duties of the committee. Such compensation may not be in an amount in excess of the maximum rate of basic pay payable for GS–18 of the General Schedule.

(5) STAFF.—The Secretary shall provide to the committee such staff, information, and other assistance as may be necessary to carry out the duties of the committee.

(6) REGULATIONS.—The Secretary shall promulgate regulations that prescribe the terms to be served by the members of the committee, the procedure for filling vacancies on the committee, and the procedure for holding and administering meetings.

(c) DUTIES.—The committee shall—

(1) perform the advisory functions as described in subsection (a);

(2) analyze the impact of the implementation of this Act and the amendments made by this Act on small and medium-sized businesses and make recommendations to the Secretary and the appropriate committees of Congress concerning appropriate modifications to such Act;

(3) review and provide comments concerning the regulations promulgated pursuant to this Act that impact on small and medium-sized businesses;

(4) monitor the effectiveness of the small insurer reform program established under subtitle A, and make recommendations to the Secretary and the appropriate committees of Congress concerning appropriate modifications in such program;

(5) serve as a channel of communication between the Secretary and the small and medium-sized business communities; and

(6) perform such other functions as the Secretary considers appropriate.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

TITLE IV—REDUCING HEALTH CARE COST INFLATION

Subtitle A—Outcomes Research and Practice Guideline Development and Dissemination

SEC. 401. INITIAL GUIDELINES AND STANDARDS.

Subsection (d) of section 912 of the Public Health Service Act (as added by section 6103(a) of Public Law 101–239) is amended to read as follows:

"(d) INITIAL GUIDELINES AND STANDARDS.—

"(1) IN GENERAL.—Not later than January 1, 1992, the Administrator shall assure the development of an initial set of guidelines as described in subsection (a)(1) that shall include not less than three clinical treatments or conditions that—

"(A) account for a significant portion of national health expenditures;

"(B) have a significant variation in the frequency or the type of treatment provided; or

"(C) otherwise meet the needs and priorities described in this section.

"(2) MENTAL HEALTH SERVICES.—The Administrator, in consultation with the National Institute of Mental Health and mental health providers, shall develop outcomes research and practice parameters

for mental health services, including at least the diagnosis and treatment of childhood attention deficit disorders and manic depression.".

SEC. 402. AMENDMENTS TO THE SOCIAL SECURITY ACT.

Section 1142(i) of the Social Security Act (as added by section 6103(b) of Public Law 101–239) is amended—

(1) in paragraph (1), to read as follows:

"(1) IN GENERAL.—There are authorized to be appropriated to carry out this section—

"(A) $125,000,000 for fiscal year 1991;

"(B) $175,000,000 for fiscal year 1992;

"(C) $225,000,000 for fiscal year 1993; and

"(D) $275,000,000 for fiscal year 1994."; and

(2) in paragraph (2), by striking out "75 percent" and inserting in lieu thereof "50 percent".

Subtitle B—Federal Health Expenditure Board

SEC. 411. FEDERAL HEALTH EXPENDITURE BOARD.

(a) PUBLIC HEALTH SERVICE ACT.—Title XXVII of the Public Health Service Act (as added under section 101 and amended by section 201 and 311) is further amended by adding at the end thereof the following new part:

"PART D—FEDERAL HEALTH EXPENDITURE BOARD

"SEC. 2761. ESTABLISHMENT AND MEMBERSHIP.

"(a) ESTABLISHMENT.—There is established as an independent agency in the executive branch a Federal Health Expenditure Board (hereafter referred to in this part as the 'Board').

"(b) MEMBERSHIP.—

"(1) IN GENERAL.—

"(A) APPOINTMENT.—The Board shall be composed of 11 members to be appointed by the President, by and with the advice and consent of the Senate.

"(B) EX OFFICIO MEMBERS.—The Secretary, the Chairman of the Prospective Payment Assessment Commission and the Chairman of the Physician Payment Review Commission shall serve as ex officio members of the Board.

"(2) REPRESENTATION.—In appointing members to the Board under paragraph (1)(A), the President shall ensure that—

"(A) the interests of health care providers and purchasers are fairly represented; and

"(B) a majority of the members of the Board are experts in health care issues and fairly represent the interests of the general pub-

lic in having access to quality and affordable health care.

"(3) CHAIRPERSON.—The President shall appoint a member appointed under paragraph (1)(A) to serve as the Chairperson of the Board.

"(4) TERMS.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the members of the Board appointed under paragraph (1)(A) shall serve for terms of 7 years. Such members may be reappointed.

"(B) INITIAL MEMBERS.—Of the initial members of the Board appointed under paragraph (1)(A)—

"(i) three shall be appointed for a term of 2 years;

"(ii) three shall be appointed for a term of 4 years;

"(iii) three shall be appointed for a term of 6 years; and

"(iv) two shall be appointed for a term of 7 years;

as designated by the President at the time of appointment.

"(5) VACANCIES.—Any vacancy in the membership of the Board shall be filled in the same manner in which the original appointment was made. Any member appointed to fill a vacancy occurring before the expiration of the term of office for which such member's predecessor was appointed shall be appointed only for the remainder of such term.

"(6) QUORUM.—Six members of the Board appointed under paragraph (1)(A) shall constitute a quorum for purposes of conducting the business of the Board, but a lesser number may meet to hold hearings.

"(7) MEETINGS.—The Board shall meet at the call of the Chairperson, or upon motion by not less than six of the members of the Board appointed under paragraph (1)(A), to conduct the business of the Board.

"SEC. 2762. FUNCTIONS AND DUTIES OF THE BOARD.

"(a) IN GENERAL.—The Board shall—

"(1) develop national health care expenditure, access and quality goals;

"(2) convene and oversee negotiations between health care providers and purchasers to develop payment rates and perform other activities necessary to

achieve expenditure goals developed under paragraph (1);

"(3) establish recommended payment levels and other recommended measures that may include increased utilization of managed care, increased utilization of alternatives to institutionalization, and procedures for the allocation and limitation of capital investment necessary to achieve health care expenditure, quality and access targets subsequent to the conclusion of required negotiations;

"(4) develop goals for States and regions that are consistent with national goals established under paragraph (1);

"(5) prepare and submit, to the President, the appropriate committees of Congress and to the general public, an annual report concerning the success in achieving the goals established under paragraph (1), together with such recommendations as the Board considers appropriate to further the objectives of providing access to affordable, quality health care;

"(6) establish uniform billing and claim forms and mandatory reporting requirements to—

"(A) measure the success in meeting the goals established under paragraph (1);

"(B) permit the Board, to the extent practicable, to analyze data acquired under such reporting requirements for individual providers to assist purchasers and consumers in evaluating the quality and cost of care offered by different providers; and

"(C) reduce the administrative cost of the health care system;

"(7) recommend rates, budgets and such other measures as may be appropriate and consistent with expenditure goals developed by negotiators or the Board under this part to assure access to quality affordable health care under Federal health insurance programs and programs under which the Federal Government enters into contracts for the delivery of health care;

"(8) conduct studies, issue reports, and gather and disseminate data to the Congress, the President and the general public, to contribute to the objective of providing access to high-quality affordable health care;

"(9) cooperate with State-based consortium established under section 2781; and

"(10) carry out any other activities determined by the Board to be necessary to further the goal of

making available affordable, accessible, high quality health care in the United States.

"(b) PERSONNEL, SERVICES, REGULATIONS.—The Board may, for the purpose of performing its duties and carrying out its functions under this part—

"(1) employ such personnel as it considers necessary to perform administrative, clerical, technical and other duties;

"(2) procure the temporary and intermittent services of experts and consultants to the extent authorized by section 3109(b) of title 5, United States Code, at rates the Board determines to be reasonable; and

"(3) prescribe regulations necessary to carry out the functions and duties of the Board under this part.

"SEC. 2763. DEVELOPMENT OF NATIONAL HEALTH CARE EXPENDITURE, ACCESS, AND QUALITY GOALS.

"(a) EXPENDITURE GOALS.—

"(1) IN GENERAL.—The Board shall, to the extent practicable, develop national expenditure goals under section 2762(a)(1) applicable to the total amount to be expended in the United States for health care. To the extent practicable, such goals

shall contain a separate expenditure breakdown for—

"(A) hospital services;

"(B) physician services;

"(C) laboratory services;

"(D) pharmaceutical products;

"(E) durable medical equipment; and

"(F) such other health services or sectors, including subdivisions of the sectors described in this paragraph, other than long-term care services, as the Board determines appropriate.

"(2) CONSIDERATIONS.—In developing expenditure goals under paragraph (1), the Board shall take into consideration—

"(A) the aging of the population and such other factors as may affect the demand for health care in the future;

"(B) general inflation factors and the costs related to inflation in labor and other inputs used to produce health services;

"(C) technological advances that may increase or decrease health care costs;

"(D) appropriate improvements in health care productivity;

"(E) feasible reductions in unnecessary health care;

"(F) the need to assure that all sectors of the population have adequate access to health care services;

"(G) the impact and availability of such goals on the quality of health care; and

"(H) such other factors as the Board determines appropriate.

"(b) QUALITY GOALS.—

"(1) DEVELOPMENT.—The Board shall, to the extent practicable, develop national goals under section 2762(a)(1) for improving the quality of the health care system of the United States. Such goals shall include recommendations for improving the quality of health care provided in the United States and establish a system of measuring the progress made in achieving such goals.

"(2) DATA AND STUDIES.—The Board shall collect such data and conduct such studies as may be necessary to carry out paragraph (1).

"(c) ACCESS GOALS.—

"(1) DEVELOPMENT.—The Board shall, to the extent practicable, develop national goals under section 2762(a)(1) for improving access to the health

care system for all Americans. Such goals shall include recommendations for achieving such goals and establish a system of measuring progress made in achieving such goals.

"(2) DATA AND STUDIES.—The Board shall collect such data and conduct such studies as may be necessary to carry out paragraph (1).

"(d) STATE AND REGIONAL GOALS.—In carrying out its functions under this section, the Board shall develop separate goals for each State and region, based on an adjustment of the national goals, to reflect the demographic characteristics and other relevant characteristics of such States and regions.

"(e) TIMING.—The Board shall, not later than June 30 of each year, develop preliminary goals under this section and, not later than December 1 of each year, develop final goals and the recommended payment rates and other measures necessary to achieve such goals.

"SEC. 2764. HEALTH CARE PROVIDER AND PURCHASER NEGOTIATIONS.

"(a) REQUIREMENT OF NEGOTIATIONS TO ACHIEVE GOALS.—The Board shall convene appropriate representatives of health care providers and purchasers recognized or appointed as negotiators under section 2765 to negotiate concerning terms and conditions related to the provi-

sion of health care to achieve the expenditure goals developed under section 2763(a). The Board shall adopt a negotiating process that shall be followed by such negotiators.

"(b) OBLIGATION TO BARGAIN IN GOOD FAITH.—It shall be the obligation of negotiators participating in negotiations under subsection (a) to bargain in good faith and consistent with the processes established by the Board.

"(c) TIME FOR NEGOTIATIONS.—The negotiations required under subsection (a) shall be commenced not later than July 1, and shall be completed not later than September 31, of each year unless such time period is extended by the Board.

"(d) SECTORS FOR NEGOTIATIONS.—The Board shall require negotiations under subsection (a) for the achievement of the expenditure goals for physician and hospital care. The Board may require that negotiations also be convened under such subsection concerning other health care sectors of the type referred to in section 2763(a)(1), including subdivisions of sectors, to the extent determined to be appropriate and feasible by the Board.

"(e) CONTENT OF NEGOTIATIONS.—

"(1) IN GENERAL.—Negotiators participating in negotiations under subsection (a) shall attempt to agree on recommendations to be submitted to the

Board concerning a health care payment system and uniform payment rates, together with other appropriate recommendations for achieving the expenditure goals developed under section 2763(a).

"(2) ACHIEVEMENT OF GOALS.—In developing recommendations under paragraph (1), the negotiators shall attempt to ensure that such recommended payment system, payment rates, and other recommended measures will, if implemented, will result in the achievement of the expenditure goals developed under section 2763(a).

"SEC. 2765. NEGOTIATION REQUIREMENTS.

"(a) NEGOTIATION BY SECTOR.—In each sector selected by the Board under section 2764(d) as a sector in which negotiations shall be conducted, negotiators representing providers of health care and purchasers of health care shall be selected in accordance with this section. The Board shall determine which individuals, organizations, and institutions are eligible for representation as providers or purchasers in each sector.

"(b) HEALTH CARE PROVIDERS.—

"(1) IN GENERAL.—

"(A) PETITION.—An organization (through a representative of such organization) or an individual that desires to be a negotiator

on behalf of health care providers under this section shall submit a petition requesting such to the Board. Such petition shall include any authorizations of representation that such organization or individual has received on behalf of health care providers, in such form and meeting such requirements as the Board may require.

"(B) GENERAL APPROVAL.—An organization or individual submitting a petition under subparagraph (A) that contains authorizations of representation from not less than 25 percent of the health care providers in a sector, as determined by the Board, shall be approved by the Board as a negotiator for providers with respect to that sector.

"(C) EXCLUSIVE NEGOTIATOR.—An organization or individual submitting a petition under subparagraph (A) that contains authorizations of representation from not less than 50 percent of the health care providers in a sector, as determined by the Board, shall be approved by the Board as the exclusive negotiator for providers with respect to that sector.

"(D) APPOINTMENT.—If no organization or individual submits a petition under subpara-

graph (A) that contains authorizations of representation from 25 percent or more of the health care providers in a sector, as determined by the Board, the Board shall—

"(i) appoint a negotiator or negotiators to represent such providers; or

"(ii) establish an election procedure for the election of a negotiator or negotiators for such providers.

"(2) INSTITUTIONAL SECTORS.—In the case of a health care sector in which health care services are delivered primarily through institutions or organizations, the Board shall establish a procedure to select negotiators to represent such institutions and organizations that is based on a weighted designation of all such institutions and organizations after consideration of the revenues or number of patients served by such institutions or organizations or based on such other measure as the Board determines appropriate.

"(c) PURCHASERS.—

"(1) IN GENERAL.—

"(A) PETITION.—An organization (through a representative of such organization) or an individual that desires to be a negotiator

on behalf of health care purchasers under this section shall submit a petition requesting such to the Board. Such petition shall include any authorizations of representation that such organization or individual has received on behalf of health care purchasers.

"(B) GENERAL APPROVAL.—An organization or individual submitting a petition under subparagraph (A) that contains authorizations of representation from not less than 25 percent of the health care purchasers in a sector, as determined by the Board, shall be approved by the Board as a negotiator for purchasers with respect to that sector.

"(C) EXCLUSIVE NEGOTIATOR.—An organization or individual submitting a petition under subparagraph (A) that contains authorizations of representation from not less than 50 percent of the health care purchasers in a sector, as determined by the Board, shall be approved by the Board as the exclusive negotiator for purchasers with respect to that sector.

"(D) APPOINTMENT.—If no organization or individual submits a petition under subparagraph (A) that contains authorizations of repre-

sentation from 25 percent or more of the health care purchasers in a sector, as determined by the Board, the Board shall—

"(i) appoint a negotiator or negotiators to represent such purchasers; or

"(ii) establish an election procedure for the election of a negotiator or negotiators for such purchasers.

"(2) DETERMINATIONS.—If the Board designates employment-based health benefit plans as all or some of the purchasers entitled to be represented in negotiations for a sector, the Board shall establish a procedure for determining whether the 25 percent or 50 percent requirements are met for purposes of subparagraphs (B) and (C) of paragraph (1), based on a weighted designation that considers the number of individuals covered by the health benefits plan of the purchaser, the total expenditures under such plans, or such other measure as the Board determines appropriate. In the case of health benefit plans provided pursuant to a collective bargaining agreement, for purposes of the weighted designation, 50 percent of the costs of or individuals covered under such plan shall be assigned to the union and 50 percent to the appropriate employer or employ-

ers. If the Board designates other categories of purchasers, a similar procedure shall be utilized.

"(d) CONTINUED APPROVAL AS NEGOTIATORS, LIMITATION.—

"(1) ESTABLISHMENT OF PROCEDURES.—The Board shall establish procedures for the withdrawal of approvals granted to organizations or individuals under subsections (b)(1) or (c)(1).

"(2) EXCLUSIVE NEGOTIATORS.—

"(A) PETITION FOR INITIATION OF PROCEDURES.—The Board may initiate procedures under paragraph (1) to withdraw the approval of an exclusive negotiator under subsection (b)(1)(C) or (c)(1)(C), if not less than 30 percent of the health care providers or purchasers in the appropriate sector file a petition with the Board for such withdrawal.

"(B) VOTE ON WITHDRAWAL.—If the Board determines that a petition received under subparagraph (A) is valid, the Board shall arrange for a vote to take place among the appropriate purchasers or providers to determine whether to withdraw the approval that is the subject of such petition. If in excess of 50 percent of such providers or purchasers vote to

withdraw such approval, the Board shall certify that such approval is withdrawn and initiate procedures to select a new negotiator or negotiators.

"(3) LIMITATION AND ELECTION.—

"(A) LIMITATION.—With respect to a sector in which no exclusive negotiator has been approved under subsection (b)(1)(C) or (c)(1)(C), the Board may not grant approvals to organizations and individuals under paragraph (1)(B) of each such subsection, as applicable, in a manner that would result in the approval of individuals and organizations representing in excess of 100 percent of the purchasers or providers.

"(B) ELECTION.—In the event that petitions are received (whether or not approvals have previously been granted) under subsection (b)(1)(B) or (c)(1)(C), from organizations or individuals cumulatively representing in excess of 100 percent of the purchasers or providers in a sector the Board shall conduct an election among such qualified organizations or individuals to determine which such organizations and

individuals will be approved or have their approval continued.

"(4) PERIOD OF DESIGNATION.—No organization or individual shall be a negotiator or an exclusive negotiator for more than a 5-year period without being recertified as a negotiator or exclusive negotiator in the same manner as the original designation was made under this section.

"(5) TIMING.—Any vote or election held under this subsection to determine the negotiators for a particular year, shall be completed prior to June 30 of that year. Votes or elections completed after such date shall apply to the negotiations for the following year.

"SEC. 2766. REQUIREMENTS FOR RECOMMENDED PAYMENT SYSTEMS AND RATES.

"(a) HOSPITALS.—

"(1) NEGOTIATED AGREEMENT.—A payment system for hospitals that is recommended in an agreement negotiated pursuant to section 2767 shall be based on the hospital payment system established under title XVIII of the Social Security Act, except that the Board may approve or adopt an alternative payment system.

"(2) ALTERNATIVE PAYMENT SYSTEM.—An alternative payment system approved or adopted under paragraph (1) shall provide for the adjustment of payment rates to reflect the differences in costs between different types of hospitals to the extent that such costs represent appropriate differences in the costs of delivering care efficiently and effectively in different types of hospitals or are necessary to achieve other public policy objectives, as determined by the Board. Such a payment system shall reflect geographic differences in labor and to the extent feasible, other input costs, capital and other needs to maintain adequate access to care and quality of care. To the extent desirable and feasible, the negotiators shall recommend, and the Board shall approve, special treatment for managed care programs.

"(b) PHYSICIANS.—

"(1) NEGOTIATED AGREEMENT.—A payment system for physicians that is recommended in an agreement negotiated pursuant to section 2767 shall be based on the physician payment system established under title XVIII of the Social Security Act, except that the Board may approve or adopt an alternative payment system.

"(2) ALTERNATIVE PAYMENT SYSTEM.—An alternative payment system approved or adopted under paragraph (1) shall reflect geographic differences in practice costs insofar as those differences reflect the cost of economical and efficient provision of quality care, and shall promote an appropriate distribution of primary and specialty care. To the extent desirable and feasible, the negotiators shall recommend, and the Board shall approve, special treatment for managed care programs.

"SEC. 2767. OUTCOME OF NEGOTIATIONS, AGREEMENTS.

"(a) AGREEMENT.—If a majority of the negotiators (in the case of multiple negotiators) for the providers and a majority of the negotiators (in the case of multiple negotiators) for the purchasers, for a particular sector, agree to recommend a proposal under this part to the Board, such proposal shall be considered to have been agreed to by the negotiators.

"(b) BINDING NATURE OF AGREEMENTS.—If a negotiated agreement is reached, pursuant to subsection (a), concerning a health services rate structure, or concerning any other matter that would lead to the achievement of the goals developed by the Board under section 2763, or an alternative goal accepted by the Board under subsection (c), and such agreement, in the judgment of the

Board, will lead to the achievement of such goals, the Board shall promulgate regulations implementing such rates and other matters and such rates and other matters shall be binding on providers and purchasers in the sector to which such agreement applies.

"(c) AGREEMENT ON DIFFERENT GOAL.—If the negotiators reach an agreement, pursuant to subsection (a), concerning a goal that is different than a goal that has been developed by the Board under section 2763, the Board shall adopt such agreed upon goal if the Board determines that it would be in the best interest of the general public to adopt such goal. The Board, on a rejection of such alternative agreed upon goal, may request that the negotiators attempt to reach a negotiated agreement concerning the original goal under section 2763, and such other measures to achieve such original goal, and may promulgate regulations recommending rates and other matters to achieve the original goal.

"(d) EFFECT OF NO AGREEMENT.—

"(1) IN GENERAL.—If the negotiators for a particular sector fail to reach a negotiated agreement, pursuant to subsection (a), concerning a goal established under section 2763, the Board shall promulgate regulations recommending advisory rates and other matters necessary to achieve such goals.

Such advisory rates and other matters shall not be binding on health care providers and purchasers.

"(2) CONSTRUCTION.—Notwithstanding any other provision of law, health care purchasers may combine for the purpose of agreeing to pay health care providers for services at rates recommended pursuant to paragraph (1). Notwithstanding any other provision of law, health care providers may combine for the purpose of agreeing to charge for services at rates recommended pursuant to paragraph (1).

"(e) TECHNICAL ASSISTANCE.—The Board shall provide technical assistance to negotiators, including estimates of the effect on expenditure goals of alternative proposals and estimates of utilization changes that can be expected under different proposals. The Board may recommend a proposal to achieve expenditure goals for the consideration of the negotiators. The Board may make available professional mediation and conciliation services to the negotiators.

"SEC. 2768. ENFORCEMENT.

"(a) IN GENERAL.—A health care provider assessing rates other than those required under regulations promulgated by the Board under this part, or failing to comply in any other manner with such regulations, or a health

care purchaser paying rates other than those required under such regulations, except in the case of an alternative rate or method established under subsections (a)(2) and (b)(2) of section 2766, shall—

"(1) be ineligible for any assistance under this Act; and

"(2) be liable to the United States for a civil penalty for such failure in an amount not to exceed $50,000 in the case of an individual and $500,000 in the case of an organization, as provided for in subsection (b).

"(b) CIVIL ACTIONS.—

"(1) IN GENERAL.—A civil penalty under subsection (a)(2) shall be assessed by the Board on a health care provider or purchaser by an order made on the record after an opportunity for a hearing on any disputed issues of material fact and the amount of the penalty. In the course of any investigation or hearing under this paragraph, the Board or its designees may administer oaths and affirmations, examine witnesses, receive evidence, and issue subpoenas requiring the attendance and testimony of witnesses and the production of evidence that relates to the matter under investigation.

"(2) AMOUNT.—In determining the amount of a civil penalty under paragraph (1), the Board shall take into account the nature, circumstances, extent, and gravity of the act subject to penalty, the ability to pay, the effect on the ability to continue to do business, any history of prior, similar acts, and such other matters as the Board determines appropriate.

"(3) LIMITATION ON ACTIONS.—The Board may not initiate an action under this subsection with respect to any noncompliance described in subsection (a) that occurred before the date of the enactment of this section.

"(c) INJUNCTIVE RELIEF.—The Board shall have the power, upon the initiation of an action regarding noncompliance with a provision of this part, to petition any United States district court, within any district wherein such noncompliance is alleged to have occurred, for appropriate temporary injunctive relief. Upon the filing of any such petition, the court shall cause notice thereof to be served upon such person, and thereupon shall have jurisdiction to grant the Board such temporary injunctive relief as the court determines to be appropriate.

"(d) JUDICIAL REVIEW.—Any health care provider or purchaser that is the subject of an adverse decision under subsection (b)(1) or subsection (c) may obtain a review

of such decision by the United States Court of Appeals for the District of Columbia or for the circuit in which the provider or purchaser resides, by filing in such court (within 60 days following the date the purchaser or provider is notified of the decision of the Board) a petition requesting that the decision be modified or set aside.

"SEC. 2769. OTHER GOVERNMENT PROGRAMS.

"The Board shall promulgate regulations recommending advisory rates and other matters necessary to achieve the goals established under section 1172 for all Federal programs (other than the program under titles XVIII, XIX and XXI of the Social Security Act) that reimburse providers on a fee, charge, or cost basis or charge third-party providers on such basis. Such nonbinding rates shall be consistent with the rates promulgated by the Board under sections 1176 and 1178, except that Federal payments resulting from such rates shall be no greater than such payments would have been if determined without regard to this section through the fifth full fiscal year after the date of enactment of this section.

"SEC. 2770. ROLE OF STATES.

"(a) ALTERNATIVE SYSTEMS, ETC.—A State consortia established under section 2781 may, with the approval of the Board, establish an alternative payment system,

rates, and methods for achieving goals developed by the Board under section 2763.

"(b) APPROVAL.—The Board shall approve alternative payment systems, rates, and methods under subsection (a) if Board determines that such alternative systems, rates, or methods would result in a level of health care expenditures in the State that achieves the national goals developed under section 2763, adjusted to the State level. If the Board determines that such national goals would not be achieved through the proposed alternative systems, rates or methods, the rates or other matters that apply to the State under regulations promulgated by the Board shall remain binding in the State. Such Board approval is only necessary where binding payment systems, rates and methods are not promulgated under a negotiated agreement.

"(c) STANDARD FOR DETERMINATION.—In making a determination under subsection (b), the Board shall consider the effect of the alternative systems, rates or methods, with respect to the goals established under section 2763, on the State as a whole rather than on particular health care sectors in the State.

"SEC. 2771. UNIFORM BILLING AND MANDATORY REPORTING.

"(a) IN GENERAL.—The Board shall establish a system of uniform billing and reporting, as required under subsection (c), that will enable the Board to determine the progress made in meeting the goals established under section 2763, to provide information for health care providers and purchasers to assist such providers and purchasers in providing and obtaining efficiently provided quality health care, and to reduce administrative costs of the health care system.

"(b) GENERAL REPORTING AND DATA REQUIREMENTS.—The Board shall—

"(1) develop a computerized system for the collection, analysis, and dissemination of data required to be collected under this part;

"(2) establish one or more uniform claims and billing form as required in subsection (c)(2) to be utilized by all data sources and providers;

"(3) audit information provided by health care providers on a sample basis or in situations where there exists reasonable cause for such an audit; and

"(4) issue public reports concerning health care costs and the effectiveness of the health care provided by health care providers.

"(c) DATA COLLECTION.—

"(1) IN GENERAL.—Data sources shall submit to the Board, on the request of the Board, all data required to be submitted under this part in accordance with the uniform submission formats, coding systems, and other technical specifications established by the Board to assure that such incoming data is substantially valid, consistent, compatible and manageable.

"(2) UNIFORM CLAIMS AND BILLING FORMS.—Data shall be collected by the Board through the use of one or more Federal Uniform Claims and Billing Forms developed by the Board and utilized by providers and purchasers of health care that shall, at a minimum, include—

"(A) a uniform patient identifier;

"(B) the date of birth of the patient;

"(C) the gender of the patient;

"(D) the ZIP Code of the patient;

"(E) the date of admission of the patient for inpatient hospital services;

"(F) the date of discharge of the patient referred to in subparagraph (E);

"(G) the principal and secondary diagnoses of the patient;

"(H) the principal and secondary procedures to be followed in treating the patient;

"(I) a uniform health care facility identifier;

"(J) uniform identifiers of physicians and treating the patient;

"(K) for services provided in an inpatient setting, the total charges of the health care facility treating the patient, segregated into major categories determined appropriate by the Board;

"(L) the amounts of actual payments made to the treating health care facility;

"(M) the amounts of the charges of each physician or professional rendering service to the patient;

"(N) the services provided in an inpatient setting;

"(O) the amounts of actual payments made to each physician or professional rendering service to the patient;

"(P) a uniform identifier of the primary payor;

"(Q) the ZIP Code of the facility where service is rendered to the patient;

"(R) the patient discharge status; and

"(S) such other material as the Board determines necessary or useful to carry out the duties of the Board or to provide adequate information to purchasers of health care to assist such purchasers in appropriately paying for services.

"(3) MEASURE OF SERVICE EFFECTIVENESS.—

"(A) DEVELOPMENT OF METHODOLOGY.—To the extent practical and as rapidly as feasible, the Secretary shall develop and implement a methodology or methodologies that will measure the effectiveness of the health care service provided by health care providers.

"(B) INCLUSION IN UNIFORM BILLING FORM.—To the extent practical and as rapidly as feasible, the Secretary shall include in the uniform claims and billing forms or in other data collection instruments established under subsection (b) data necessary to provide the Secretary with information concerning each service provided by health care providers that is sufficient to enable the Secretary to analyze the quality, cost, and service effectiveness of the provider.

"(4) ADDITIONAL DATA.—The Board may collect additional data, including audited annual financial reports of all hospitals and ambulatory service facilities, medicare cost reports, information on capital expenditures, and any other data that the Board determines necessary to carry out its responsibilities under this part.

"(5) RECOMMENDATIONS.—The Board shall make recommendations to the committees of Congress, the President, and the insurance industry concerning methods to reduce the cost and burden of duplication or excessive reporting requirements imposed on health care providers.

"(d) REPORTS.—

"(1) IN GENERAL.—The Board, not less than once each calendar year, shall for every health care provider for which sufficient data is available, prepare and make available reports that shall, to the extent practicable and scientifically valid, contain data in a form that will provide the most useful information to purchasers of health care services regarding such providers to enable such purchasers to compare providers on the basis of cost and quality.

"(2) AVAILABILITY.—The Secretary shall advertise and make available all reports prepared

under paragraph (1) to the general public, including any dissents submitted by health care providers.

"(3) RECOMMENDATIONS.—The Board shall make recommendations to the appropriate committees of Congress, the President, and the insurance industry concerning methods to reduce the cost and burden of duplicative or excessive reporting requirements imposed on health care providers.

"(e) DEFINITION.—As used in this section, the term 'data sources' means classes of entities and individuals that the Board designates as data sources.

"SEC. 2772. ANNUAL REPORTS.

"Not later than June 30 of each year, the Board shall prepare and submit to the President, the appropriate committees of Congress and the general public, a report concerning the success in attaining expenditure, access, and quality goals developed under section 2763, and containing recommendations for additional measures, if any, that the Board determines are necessary to achieve such goals.

"SEC. 2773. DEFINITIONS.

"As used in this part:

"(1) PROVIDER.—The term 'provider' means a physician, hospital, health maintenance organization, pharmacy, laboratory, or other provider of health care services or supplies, that has entered into an

agreement with a managed care entity to provide such services or supplies to a patient enrolled in a managed care plan.

"(2) PURCHASER.—The term 'purchaser' means an entity the pays for the services of providers, including in the case of a health benefit plan provided pursuant to a collective bargaining agreement, the labor union that has negotiated for such plan on behalf of employees shall be considered to be a purchaser.

"SEC. 2774. EFFECTIVE DATES.

"The Board shall develop the goals under section 2763 for each calendar year beginning not later than the second full calendar year after the date of enactment of this part. The Board shall establish the negotiating procedures required under section 2714(a) for each calendar year beginning not later than the third calendar year after the date of enactment of this part.".

(b) SOCIAL SECURITY ACT.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end thereof the following new part:

"PART C—FEDERAL HEALTH EXPENDITURE BOARD

"FUNCTIONS AND DUTIES OF THE FEDERAL HEALTH EXPENDITURE BOARD

"SEC. 1171. (a) IN GENERAL.—The Federal Health Expenditure Board (hereafter in this part referred to as the 'Board') shall—

"(1) develop national health care expenditure, access and quality goals;

"(2) convene and oversee negotiations between health care providers and purchasers to develop payment rates and perform other activities necessary to achieve expenditure goals developed under paragraph (1);

"(3) establish recommended payment levels and other recommended measures that may include increased utilization of managed care, increased utilization of alternatives to institutionalization, and procedures for the allocation and limitation of capital investment necessary to achieve health care expenditure, quality, and access targets subsequent to the conclusion of required negotiations;

"(4) develop goals for States and regions that are consistent with national goals established under paragraph (1);

"(5) prepare and submit, to the President, the appropriate committees of Congress and to the general public, an annual report concerning the success in achieving the goals established under paragraph (1), together with such recommendations as the Board considers appropriate to further the objectives of providing access to affordable, quality health care;

"(6) establish uniform billing and claims forms and mandatory reporting requirements to—

"(A) measure the success in meeting the goals established under paragraph (1);

"(B) permit the Board, to the extent practicable, to analyze data acquired under such reporting requirements for individual providers to assist purchasers and consumers in evaluating the quality and cost of care offered by different providers; and

"(C) reduce the administrative cost of the health care system;

"(7) recommend rates, budgets, and such other measures as may be appropriate and consistent with expenditure goals developed by negotiators or the Board under this part to assure access to quality affordable health care under Federal health insurance programs and programs under which the Federal

Government enters into contracts for the delivery of health care;

"(8) conduct studies, issue reports, and gather and disseminate data to the Congress, the President, and the general public, to contribute to the objective of providing access to high-quality affordable health care;

"(9) cooperate with State-based consortium described under part D of this title; and

"(10) carry out any other activities determined by the Board to be necessary to further the goal of making available affordable, accessible, high quality health care in the United States.

"(b) PERSONNEL, SERVICES, REGULATIONS.—The Board may, for the purpose of performing its duties and carrying out its functions under this part—

"(1) employ such personnel as it considers necessary to perform administrative, clerical, technical and other duties;

"(2) procure the temporary and intermittent services of experts and consultants to the extent authorized by section 3109(b) of title 5, United States Code, at rates the Board determines to be reasonable; and

"(3) prescribe regulations necessary to carry out the functions and duties of the Board under this part.

"DEVELOPMENT OF NATIONAL HEALTH CARE EXPENDITURE, ACCESS, AND QUALITY GOALS

"SEC. 1172. (a) EXPENDITURE GOALS.—

"(1) IN GENERAL.—The Board shall, to the extent practicable, develop national expenditure goals under section 1171(a)(1) applicable to the total amount to be expended in the United States for health care. To the extent practicable, such goals shall contain a separate expenditure breakdown for—

"(A) hospital services;

"(B) physician services;

"(C) laboratory services;

"(D) pharmaceutical products;

"(E) durable medical equipment; and

"(F) such other health services or sectors, including subdivisions of the sectors described in this paragraph, other than long-term care services, as the Board determines appropriate.

"(2) CONSIDERATIONS.—In developing expenditure goals under paragraph (1), the Board shall take into consideration—

"(A) the aging of the population and such other factors as may affect the demand for health care in the future;

"(B) general inflation factors and the costs related to inflation in labor and other inputs used to produce health services;

"(C) technological advances that may increase or decrease health care costs;

"(D) appropriate improvements in health care productivity;

"(E) feasible reductions in unnecessary health care;

"(F) the need to assure that all sectors of the population have adequate access to health care services;

"(G) the impact of such goals on the quality and availability of health care; and

"(E) such other factors as the Board determines appropriate.

"(b) QUALITY GOALS.—

"(1) DEVELOPMENT.—The Board shall, to the extent practicable, develop national goals under section 1171(a)(1) for improving the quality of the health care system of the United States. Such goals shall include recommendations for improving the

quality of health care provided in the United States and establish a system of measuring the progress made in achieving such goals.

"(2) DATA AND STUDIES.—The Board shall collect such data and conduct such studies as may be necessary to carry out paragraph (1).

"(c) ACCESS GOALS.—

"(1) DEVELOPMENT.—The Board shall, to the extent practicable, develop national goals under section 1171(a)(1) for improving access to the health care system for all Americans. Such goals shall include recommendations for achieving such goals and establish a system of measuring progress made in achieving such goals.

"(2) DATA AND STUDIES.—The Board shall collect such data and conduct such studies as may be necessary to carry out paragraph (1).

"(d) STATE AND REGIONAL GOALS.—In carrying out its functions under this section, the Board shall develop separate goals for each State and region, based on an adjustment of the national goals, to reflect the demographic characteristics and other relevant characteristics of such States and regions.

"(e) TIMING.—The Board shall, not later than June 30 of each year, develop preliminary goals under this sec-

tion and, not later than December 1 of each year, develop final goals and the recommended payment rates and other measures necessary to achieve such goals.

"HEALTH CARE PROVIDER AND PURCHASER NEGOTIATIONS

"SEC. 1173. (a) REQUIREMENT OF NEGOTIATIONS TO ACHIEVE GOALS.—The Board shall convene appropriate representatives of health care providers and purchasers recognized or appointed as negotiators under section 1174 to negotiate concerning terms and conditions related to the provision of health care to achieve the expenditure goals developed under section 1172(a). The Board shall adopt a negotiating process that shall be followed by such negotiators.

"(b) OBLIGATION TO BARGAIN IN GOOD FAITH.—It shall be the obligation of negotiators participating in negotiations under subsection (a) to bargain in good faith and consistent with the processes established by the Board.

"(c) TIME FOR NEGOTIATIONS.—The negotiations required under subsection (a) shall be commenced not later than July 1, and shall be completed not later than September 31, of each year unless such time period is extended by the Board.

"(d) SECTORS FOR NEGOTIATIONS.—The Board shall require negotiations under subsection (a) for the achievement of the expenditure goals for physician and

hospital care. The Board may require that negotiations also be convened under such subsection concerning other health care sectors of the type referred to in section 1172(a)(1), including subdivisions of sectors, to the extent determined to be appropriate and feasible by the Board.

"(e) CONTENT OF NEGOTIATIONS.—

"(1) IN GENERAL.—Negotiators participating in negotiations under subsection (a) shall attempt to agree on recommendations to be submitted to the Board concerning a health care payment system and uniform payment rates, together with other appropriate recommendations for achieving the expenditure goals developed under section 1172(a).

"(2) ACHIEVEMENT OF GOALS.—In developing recommendations under paragraph (1), the negotiators shall attempt to ensure that such recommended payment system, payment rates, and other recommended measures will, if implemented, result in the achievement of the expenditure goals developed under section 1172(a).

"NEGOTIATION REQUIREMENTS

"SEC. 1174. (a) NEGOTIATION BY SECTOR.—In each sector selected by the Board under section 1173(d) as a sector in which negotiations shall be conducted, negotiators representing providers of health care and purchasers of health care shall be selected in accordance with this sec-

tion. The Board shall determine which individuals, organizations, and institutions are eligible for representation as providers or purchasers in each sector.

"(b) HEALTH CARE PROVIDERS.—

"(1) IN GENERAL.—

"(A) PETITION.—An organization (through a representative of such organization) or an individual that desires to be a negotiator on behalf of health care providers under this section shall submit a petition requesting such to the Board. Such petition shall include any authorizations of representation that such organization or individual has received on behalf of health care providers, in such form and meeting such requirements as the Board may require.

"(B) GENERAL APPROVAL.—An organization or individual submitting a petition under subparagraph (A) that contains authorizations of representation from not less than 25 percent of the health care providers in a sector, as determined by the Board, shall be approved by the Board as a negotiator for providers with respect to that sector.

"(C) EXCLUSIVE NEGOTIATOR.—An organization or individual submitting a petition

under subparagraph (A) that contains authorizations of representation from not less than 50 percent of the health care providers in a sector, as determined by the Board, shall be approved by the Board as the exclusive negotiator for providers with respect to that sector.

"(D) APPOINTMENT.—If no organization or individual submits a petition under subparagraph (A) that contains authorizations of representation from 25 percent or more of the health care providers in a sector, as determined by the Board, the Board shall—

"(i) appoint a negotiator or negotiators to represent such providers; or

"(ii) establish an election procedure for the election of a negotiator or negotiators for such providers.

"(2) INSTITUTIONAL SECTORS.—In the case of a health care sector in which health care services are delivered primarily through institutions or organizations, the Board shall establish a procedure to select negotiators to represent such institutions and organizations that is based on a weighted designation of all such institutions and organizations after consideration of the revenues or number of patients served

by such institutions or organizations or based on such other measure as the Board determines appropriate.

"(c) PURCHASERS.—

"(1) IN GENERAL.—

"(A) PETITION.—An organization (through a representative of such organization) or an individual that desires to be a negotiator on behalf of health care purchasers under this section shall submit a petition requesting such to the Board. Such petition shall include any authorizations of representation that such organization or individual has received on behalf of health care purchasers.

"(B) GENERAL APPROVAL.—An organization or individual submitting a petition under subparagraph (A) that contains authorizations of representation from not less than 25 percent of the health care purchasers in a sector, as determined by the Board, shall be approved by the Board as a negotiator for purchasers with respect to that sector.

"(C) EXCLUSIVE NEGOTIATOR.—An organization or individual submitting a petition under subparagraph (A) that contains author-

izations of representation from not less than 50 percent of the health care purchasers in a sector, as determined by the Board, shall be approved by the Board as the exclusive negotiator for purchasers with respect to that sector.

"(D) APPOINTMENT.—If no organization or individual submits a petition under subparagraph (A) that contains authorizations of representation from 25 percent or more of the health care purchasers in a sector, as determined by the Board, the Board shall—

"(i) appoint a negotiator or negotiators to represent such purchasers; or

"(ii) establish an election procedure for the election of a negotiator or negotiators for such purchasers.

"(2) DETERMINATIONS.—If the Board designates employment-based health benefit plans as all or some of the purchasers entitled to be represented in negotiations for a sector, the Board shall establish a procedure for determining whether the 25 percent or 50 percent requirements are met for purposes of subparagraphs (B) and (C) of paragraph (1), based on a weighted designation that considers the number of individuals covered by the health benefits plan of

the purchaser, the total expenditures under such plans, or such other measure as the Boards determines appropriate. In the case of health benefit plans provided pursuant to a collective bargaining agreement, for purposes of the weighted designation, 50 percent of the costs of or individuals covered under such plan shall be assigned to the union and 50 percent to the appropriate employer or employers. If the Board designates other categories of purchasers, a similar procedure shall be utilized.

"(d) CONTINUED APPROVAL AS NEGOTIATORS, LIMITATION.—

"(1) ESTABLISHMENT OF PROCEDURES.—The Board shall establish procedures for the withdrawal of approvals granted to organizations or individuals under subsections (b)(1) or (c)(1).

"(2) EXCLUSIVE NEGOTIATORS.—

"(A) PETITION FOR INITIATION OF PROCEDURES.—The Board may initiate procedures under paragraph (1) to withdraw the approval of an exclusive negotiator under subsection (b)(1)(C) or (c)(1)(C), if not less than 30 percent of the health care providers or purchasers in the appropriate sector file a petition with the Board for such withdrawal.

"(B) VOTE ON WITHDRAWAL.—If the Board determines that a petition received under subparagraph (A) is valid, the Board shall arrange for a vote to take place among the appropriate purchasers or providers to determine whether to withdraw the approval that is the subject of such petition. If in excess of 50 percent of such providers or purchasers vote to withdraw such approval, the Board shall certify that such approval is withdrawn and initiate procedures to select a new negotiator or negotiators.

"(3) LIMITATION AND ELECTION.—

"(A) LIMITATION.—With respect to a sector in which no exclusive negotiator has been approved under subsection (b)(1)(C) or (c)(1)(C), the Board may not grant approvals to organizations and individuals under paragraph (1)(B) of each such subsection, as applicable, in a manner that would result in the approval of individuals and organizations representing in excess of 100 percent of the purchasers or providers.

"(B) ELECTION.—In the event that petitions are received (whether or not approvals

have previously been granted) under subsection (b)(1)(B) or (c)(1)(C), from organizations or individuals cumulatively representing in excess of 100 percent of the purchasers or providers in a sector the Board shall conduct an election among such qualified organizations or individuals to determine which such organizations and individuals will be approved or have their approval continued.

"(4) PERIOD OF DESIGNATION.—No organization or individual shall be a negotiator or an exclusive negotiator for more than a 5-year period without being recertified as a negotiator or exclusive negotiator in the same manner as the original designation was made under this section.

"(5) TIMING.—Any vote or election held under this subsection to determine the negotiators for a particular year, shall be completed prior to June 30 of that year. Votes or elections completed after such date shall apply to the negotiations for the following year.

"REQUIREMENTS FOR RECOMMENDED PAYMENT SYSTEMS AND RATES

"SEC. 1175. (a) HOSPITALS.—

"(1) NEGOTIATED AGREEMENT.—A payment system for hospitals that is recommended in an

agreement negotiated pursuant to section 1176 shall be based on the hospital payment system established under title XVIII of this Act, except that the Board may approve or adopt an alternative payment system.

"(2) ALTERNATIVE PAYMENT SYSTEM.—An alternative payment system approved or adopted under paragraph (1) shall provide for the adjustment of payment rates to reflect the differences in costs between different types of hospitals to the extent that such costs represent appropriate differences in the costs of delivering care efficiently and effectively in different types of hospitals or are necessary to achieve other public policy objectives, as determined by the Board. Such a payment system shall reflect geographic differences in labor and to the extent feasible, other input costs, capital and other needs to maintain adequate access to care and quality of care. To the extent desirable and feasible, the negotiators shall recommend, and the Board shall approve, special treatment for managed care programs.

"(b) PHYSICIANS.—

"(1) NEGOTIATED AGREEMENT.—A payment system for physicians that is recommended in an

agreement negotiated pursuant to section 1176 shall be based on the physician payment system established under title XVIII of this Act, except that the Board may approve or adopt an alternative payment system.

"(2) ALTERNATIVE PAYMENT SYSTEM.—An alternative payment system approved or adopted under paragraph (1) shall reflect geographic differences in practice costs insofar as those differences reflect the cost of economical and efficient provision of quality care, and shall promote an appropriate distribution of primary and specialty care. To the extent desirable and feasible, the negotiators shall recommend, and the Board shall approve, special treatment for managed care programs.

"OUTCOME OF NEGOTIATIONS, AGREEMENTS

"SEC. 1176. (a) AGREEMENT.—If a majority of the negotiators (in the case of multiple negotiators) for the providers and a majority of the negotiators (in the case of multiple negotiators) for the purchasers, for a particular sector, agree to recommend a proposal under this part to the Board, such proposal shall be considered to have been agreed to by the negotiators.

"(b) BINDING NATURE OF AGREEMENTS.—If a negotiated agreement is reached, pursuant to subsection (a), concerning a health services rate structure, or concerning

any other matter that would lead to the achievement of the goals developed by the Board under section 1172, or an alternative goal accepted by the Board under subsection (c), and such agreement, in the judgment of the Board, will lead to the achievement of such goals, the Board shall promulgate regulations implementing such rates and other matters and such rates and other matters shall be binding on providers and purchasers in the sector to which such agreement applies.

"(c) AGREEMENT ON DIFFERENT GOAL.—If the negotiators reach an agreement, pursuant to subsection (a), concerning a goal that is different than a goal that has been developed by the Board under section 1172, the Board shall adopt such agreed upon goal if the Board determines that it would be in the best interest of the general public to adopt such goal. The Board, on a rejection of such alternative agreed upon goal, may request that the negotiators attempt to reach a negotiated agreement concerning the original goal under section 1172, and such other measures to achieve such original goal, and may promulgate regulations recommending rates and other matters to achieve the original goal.

"(d) EFFECT OF NO AGREEMENT.—

"(1) IN GENERAL.—If the negotiators for a particular sector fail to reach a negotiated agree-

ment, pursuant to subsection (a), concerning a goal established under section 1172, the Board shall promulgate regulations recommending advisory rates and other matters necessary to achieve such goals. Such advisory rates and other matters shall not be binding on health care providers and purchasers.

"(2) CONSTRUCTION.—Notwithstanding any other provision of law, health care purchasers may combine for the purpose of agreeing to pay health care providers for services at rates recommended pursuant to paragraph (1).

"(e) TECHNICAL ASSISTANCE.—The Board shall provide technical assistance to negotiators, including estimates of the effect on expenditure goals of alternative proposals and estimates of utilization changes that can be expected under different proposals. The Board may recommend a proposal to achieve expenditure goals for the consideration of the negotiators. The Board may make available professional mediation and conciliation services to the negotiators.

"ENFORCEMENT

"SEC. 1177. (a) IN GENERAL.—A health care provider assessing rates other than those required under regulations promulgated by the Board under this part, or failing to comply in any other manner with such regulations, or a health care purchaser paying rates other than those re-

quired under such regulations, except in the case of an alternative rate or method established under subsections (a)(2) and (b)(2) of section 1175, shall—

"(1) be ineligible for any assistance under this Act; and

"(2) be liable to the United States for a civil penalty for such failure in an amount not to exceed $50,000 in the case of an individual and $500,000 in the case of an organization, as provided for in subsection (b).

"(b) CIVIL ACTIONS.—

"(1) IN GENERAL.—A civil penalty under subsection (a)(2) shall be assessed by the Board on a health care provider or purchaser by an order made on the record after an opportunity for a Board hearing on any disputed issues of material fact and the amount of the penalty. In the course of any investigation or hearing under this paragraph, the Board or its designees may administer oaths and affirmations, examine witnesses, receive evidence, and issue subpoenas requiring the attendance and testimony of witnesses and the production of evidence that relates to the matter under investigation.

"(2) AMOUNT.—In determining the amount of a civil penalty under paragraph (1), the Board shall

take into account the nature, circumstances, extent, and gravity of the act subject to penalty, the ability to pay, the effect on the ability to continue to do business, any history of prior, similar acts, and such other matters as the Board determines appropriate.

"(3) LIMITATION ON ACTIONS.—The Board may not initiate an action under this subsection with respect to any noncompliance described in subsection (a) that occurred before the date of the enactment of this section.

"(c) INJUNCTIVE RELIEF.—The Board shall have the power, upon the initiation of an action regarding noncompliance with a provision of this part, to petition any United States district court, within any district wherein such noncompliance is alleged to have occurred, for appropriate temporary injunctive relief. Upon the filing of any such petition, the court shall cause notice thereof to be served upon such person, and thereupon shall have jurisdiction to grant the Board such temporary injunctive relief as the court determines to be appropriate.

"(d) JUDICIAL REVIEW.—Any health care provider or purchaser that is the subject of an adverse decision under subsection (b)(1) or subsection (c) may obtain a review of such decision by the United States Court of Appeals for the District of Columbia or for the circuit in which

the provider or purchaser resides, by filing in such court (within 60 days following the date the purchaser or provider is notified of the decision of the Board) a petition requesting that the decision be modified or set aside.

"ROLE OF STATES

"SEC. 1178. (a) ALTERNATIVE SYSTEMS, ETC.—A State consortia described in part D of this title may, with the approval of the Board, establish an alternative payment system, rates, and methods for achieving goals developed by the Board under section 1172.

"(b) APPROVAL.—The Board shall approve alternative payment systems, rates, and methods under subsection (a) if Board determines that such alternative systems, rates, or methods would result in a level of health care expenditures in the State that achieves the national goals developed under section 1172, adjusted to the State level. If the Board determines that such national goals would not be achieved through the proposed alternative systems, rates or methods, the rates or other matters that apply to the State under regulations promulgated by the Board shall remain binding in the State. Such Board approval is only necessary where binding payment systems, rates and methods are not promulgated under a negotiated agreement.

"(c) STANDARD FOR DETERMINATION.—In making a determination under subsection (b), the Board shall con-

sider the effect of the alternative systems, rates or methods, with respect to the goals established under section 1172, on the State as a whole rather than on particular health care sectors in the State.

"OTHER GOVERNMENT PROGRAMS

"SEC. 1179. The Board shall promulgate regulations recommending advisory rates and other matters necessary to achieve the goals established under section 1172 for all Federal programs (other than the program under title XVIII of this Act) that reimburse providers on a fee, charge, or cost basis or charge third-party providers on such basis. Such nonbinding rates shall be consistent with the rates promulgated by the Board under sections 1176 and 1178, except that Federal payments resulting from such rates shall be no greater than such payments would have been if determined without regard to this section through the fifth full fiscal year after the date of enactment of this section.

"UNIFORM BILLING AND MANDATORY REPORTING

"SEC. 1180. (a) IN GENERAL.—The Board shall establish a system of uniform billing and reporting, as required under subsection (c), that will enable the Board to determine the progress made in meeting the goals established under section 1172, to provide information for health care providers and purchasers to assist such providers and purchasers in providing and obtaining efficiently

provided quality health care, and to reduce administrative costs of the health care system.

"(b) GENERAL REPORTING AND DATA REQUIREMENTS.—The Board shall—

"(1) develop a computerized system for the collection, analysis, and dissemination of data required to be collected under this part;

"(2) establish one or more uniform claims and billing form as required in subsection (c)(2) to be utilized by all data sources and providers;

"(3) audit information provided by health care providers on a sample basis or in situations where there exists reasonable cause for such an audit; and

"(4) issue public reports concerning health care costs and the effectiveness of the health care provided by health care providers.

"(c) DATA COLLECTION.—

"(1) IN GENERAL.—Data sources shall submit to the Board, on the request of the Board, all data required to be submitted under this part in accordance with the uniform submission formats, coding systems, and other technical specifications established by the Board to assure that such incoming data is substantially valid, consistent, compatible and manageable.

"(2) UNIFORM CLAIMS AND BILLING FORMS.—Data shall be collected by the Board through the use of one or more Federal Uniform Claims and Billing Forms developed by the Board and utilized by providers and purchasers of health care that shall, at a minimum, include—

"(A) a uniform patient identifier;

"(B) the date of birth of the patient;

"(C) the gender of the patient;

"(D) the ZIP Code of the patient;

"(E) the date of admission of the patient for inpatient hospital services;

"(F) the date of discharge of the patient referred to in subparagraph (E);

"(G) the principal and secondary diagnoses of the patient;

"(H) the principal and secondary procedures to be followed in treating the patient;

"(I) a uniform health care facility identifier;

"(J) uniform identifiers of physicians treating the patient;

"(K) for services provided in an inpatient setting, the total charges of the health care facility treating the patient, segregated into major

categories determined appropriate by the Board;

"(L) the amounts of actual payments made to the treating health care facility;

"(M) the amounts of the charges of each physician or professional rendering service to the patient;

"(N) the services provided in an inpatient setting;

"(O) the amounts of actual payments made to each physician or professional rendering service to the patient;

"(P) a uniform identifier of the primary payor;

"(Q) the ZIP Code of the facility where service is rendered to the patient;

"(R) the patient discharge status; and

"(S) such other material as the Board determines necessary or useful to carry out the duties of the Board or to provide adequate information to purchasers of health care to assist such purchasers in appropriately paying for services.

"(3) MEASURE OF SERVICE EFFECTIVENESS.—

"(A) DEVELOPMENT OF METHODOLOGY.—To the extent practical and as rapidly as feasible, the Secretary shall develop and implement a methodology or methodologies that will measure the effectiveness of the health care service provided by health care providers.

"(B) INCLUSION IN UNIFORM BILLING FORM.—To the extent practical and as rapidly as feasible, the Secretary shall include in the uniform claims and billing forms or in other data collection instruments established under subsection (b) data necessary to provide the Secretary with information concerning each service provided by health care providers that is sufficient to enable the Secretary to analyze the quality, cost, and service effectiveness of the provider.

"(4) ADDITIONAL DATA.—The Board may collect additional data, including audited annual financial reports of all hospitals and ambulatory service facilities, medicare cost reports, information on capital expenditures, and any other data that the Board determines necessary to carry out its responsibilities under this part.

"(5) RECOMMENDATIONS.—The Board shall make recommendations to the committees of Congress, the President, and the insurance industry concerning methods to reduce the cost and burden of duplication or excessive reporting requirements imposed on health care providers.

"(d) REPORTS.—

"(1) IN GENERAL.—The Board, not less than once each calendar year, shall for every health care provider for which sufficient data is available, prepare and make available reports that shall, to the extent practicable and scientifically valid, contain data in a form that will provide the most useful information to purchasers of health care services regarding such providers to enable such purchasers to compare providers on the basis of cost and quality.

"(2) AVAILABILITY.—The Secretary shall advertise and make available all reports prepared under paragraph (1) to the general public, including any dissents submitted by health care providers.

"(3) RECOMMENDATIONS.—The Board shall make recommendations to the appropriate committees of Congress, the President, and the insurance industry concerning methods to reduce the cost and

burden of duplicative or excessive reporting requirements imposed on health care providers.

"(e) DEFINITION.—As used in this section, the term 'data sources' means classes of entities and individuals that the Board designates as data sources.

"ANNUAL REPORTS

"SEC. 1181. Not later than June 30 of each year, the Board shall prepare and submit to the President, the appropriate committees of Congress and the general public, a report concerning the success in attaining expenditure, access, and quality goals developed under section 1172, and containing recommendations for additional measures, if any, that the Board determines are necessary to achieve such goals.

"DEFINITIONS

"SEC. 1182. As used in this part:

"(1) HEALTH BENEFIT PLAN.—The term 'health benefit plan' means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(1)) that—

"(A) provides medical care to participants or beneficiaries directly or through insurance, reimbursement, or otherwise; and

"(B) meets the requirements of section 2721 of the Public Health Service Act.

Such term shall include a small business health benefits plan, as defined in section 2713(11) of such Act.

"(2) MANAGED CARE PLAN.—The term 'managed care plan' has the meaning given such term by section 2108(a)(6).

"(3) PROVIDER.—The term 'provider' means a physician, hospital, health maintenance organization, pharmacy, laboratory, or other appropriately licensed provider of health care services or supplies, that has entered into an agreement with a managed care entity to provide such services or supplies to a patient enrolled in a managed care plan.

"(4) PURCHASER.—The term 'purchaser' means an entity that pays for services of providers, including in the case of a health benefit plan provided pursuant to a collective bargaining agreement, the labor union that has negotiated for such plan on behalf of employees shall be considered to be a purchaser.

"EFFECTIVE DATES

"SEC. 1183. The Board shall develop the goals under section 1172 for each calendar year beginning not later than the second full calendar year after the date of the enactment of this part. The Board shall establish the negotiating procedures required under section 1173(a) for

each calendar year beginning not later than the third calendar year after the date of the enactment of this part.".

(c) CONFORMING AMENDMENTS.—

(1) COMPENSATION, LEVEL III.—Section 5314 of title 5, United States Code, is amended by adding at the end thereof the following:

"Members, Federal Health Expenditure Board.".

(2) COMPENSATION, LEVEL IV.—Section 5315 of title 5, United States Code, is amended by adding at the end thereof the following:

"Members, Federal Health Expenditure Board.".

(d) MEDICARE.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

"FEDERAL HEALTH EXPENDITURE BOARD

"SEC. 1893. (a) HOSPITAL SERVICES.—Notwithstanding any other provision of this title, in the second full fiscal year after the date of enactment of this section and annually thereafter, the Federal Health Expenditure Board (hereafter in this section referred to as the 'Board') shall, with due regard to the recommendations of the Prospective Payment Assessment Commission, recommend—

"(1) the update factor for the DRG prospective payment rates provided in section 1886(d);

"(2) the DRG recalibration;

"(3) the update factor for excluded hospitals; and

"(4) such other matters relating to reimbursement under this title as the Board shall elect.

In making such recommendations to the Congress, the Board shall also make recommendations for modifications of the prospective payment system under this title. In recommending the update factor for DRG prospective payment rates and for excluded hospitals, the Board shall seek to maintain parity in increases in payment rates with other purchasers of health care services, and, shall over time, seek to achieve comparability in such rates. Such recommendations shall not result in Federal payments greater than such payments would have been if determined without regard to this section through the fifth full fiscal year after the date of enactment of this section.

"(b) PHYSICIAN SERVICES.—Notwithstanding any other provision of this title, in the second full fiscal year after the date of enactment of this section and annually thereafter, the Board shall, with due regard to the recommendations of the Physician Payment Review Commission, recommend—

"(1) appropriate modifications of the resource based relative value schedule provided for in section 1848;

"(2) volume performance standards provided for in section 1848(f);

"(3) updates in the conversion factor, consistent with the volume performance standards, provided in section 1848(d);

"(4) revisions of the geographical adjustment factors provided in section 1848(e); and

"(5) such other matters relating to reimbursement under this title as the Board shall elect.

In making such recommendations to the Congress, the Board shall also make recommendations for modifications of the physician payment system under this title. In making the recommendations described in paragraphs (1), (2), (3), and (4), the Board shall seek to maintain parity in increases in payment rates with other purchasers of health care services, and shall, over time, seek to achieve comparability in such rates. Such recommendations shall not result in Federal payments greater than such payments would have been if determined without regard to this section through the fifth full fiscal year after the date of enactment of this section.".

Subtitle C—State Purchasing Consortia

SEC. 421. STATE PURCHASING CONSORTIA

(a) PUBLIC HEALTH SERVICE ACT.—Title XXVII of the Public Health Service Act (as added by section 101 and amended by sections 201, 311 and 411) is further amended by adding at the end thereof the following new part:

"PART E—STATE PURCHASING CONSORTIA

"SEC. 2781. STATE PURCHASING CONSORTIA.

"(a) REQUIREMENT.—

"(1) ESTABLISHMENT BY STATE.—Not later than 1 year after the date of enactment of this part, or the first day of the first calendar year beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this part, whichever is later, the State shall establish a State Consortium (hereafter referred to in this section as the 'consortium') which may be a public or nonprofit private entity, or be a member of a Regional Consortium in accordance with subsection (f), that shall carry out the activities described in subsection (d).

"(2) ESTABLISHMENT BY SECRETARY.—If a State fails to establish a State consortium as re-

quired under paragraph (1), the Secretary shall develop and implement a State consortium for such State.

"(b) BOARD OF DIRECTORS AND MEMBERSHIP.—

"(1) BOARD OF DIRECTORS.—

"(A) IN GENERAL.—A consortium shall be managed by a board of directors who shall be appointed and serve in accordance with guidelines and regulations developed by the State.

"(B) MANDATORY FUNCTIONS.—The guidelines and regulations developed under subparagraph (A) shall ensure that, for purposes of carrying out the mandatory functions under subsection (d)(1), the board of directors will be composed of insurers, providers and consumers.

"(C) OPTIONAL FUNCTIONS.—The guidelines and regulations developed under subparagraph (A) shall ensure that, for purposes of carrying out the optional functions under subsection (d)(2), the board of directors will be composed of individuals who represent the balanced interests of all interested parties.

"(2) MEMBERSHIP IN CONSORTIUM.—All providers and purchasers of health insurance and health care in the State, including business, labor, and

consumer organizations, shall be eligible to become members of the consortium in such State.

"(c) APPLICATION AND PLAN, GRANTS AND TECHNICAL ASSISTANCE.—

"(1) APPLICATION AND PLAN.—

"(A) REQUIREMENT.—Prior to the establishment of the State consortium, the State shall prepare and submit to the Secretary for approval, an application in such form and containing such information as the Secretary may require, including the plan described in subparagraph (B).

"(B) PLAN.—As part of the application submitted under subparagraph (A), the State shall prepare a plan that shall outline the form of the State consortium and that shall include a description—

"(i) of the guidelines applicable to the appointment and service of the board of directors of the consortium;

"(ii) of the manner in which the State will solicit membership for the consortium;

"(iii) of the manner in which the consortium will perform the mandatory functions under subsection (d)(1);

"(iv) of the optional functions that the consortium will perform under subsection (d)(2); and

"(v) of any other information that the Secretary determines appropriate.

"(2) GRANTS.—

"(A) IN GENERAL.—The Secretary shall award a grant to each State to assist the State in paying the costs associated with the establishment and initial operation of the State consortium.

"(B) AMOUNTS.—Not less than $150,000 shall be provided to each State under a grant awarded under this subparagraph (A), except that additional amounts may be provided to a State if the Secretary determines, based on an application that is submitted by the State for such amounts, that such amounts are needed to help defray the costs associated with optional functions provided by the consortium under the State plan submitted under paragraph (1)(B).

"(C) PLANNING FUNCTIONS.—Except as provided in subparagraph (B), amounts provided under grants awarded under this paragraph shall be utilized for planning functions only.

"(3) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to States in setting up the State consortia.

"(d) FUNCTIONS OF CONSORTIUM.—

"(1) MANDATORY FUNCTIONS.—The State consortium shall—

"(A) enroll all small share health insurance companies in the State as members of the consortium for insurers, purchasers and providers;

"(B) establish a claim payment fund and procedures for the payment, by the consortium on behalf of its enrollees, of valid claims submitted by providers or enrollees to the consortium, such fund to be capitalized through public and private contributions and assessments made by the consortium on such enrollees to reflect amounts paid from such fund on behalf of each such enrollee;

"(C) develop, in consultation and with the assistance of the Secretary and consistent with the program established under part D, and employ uniform billing and claim form and procedures for providers of health services covered by enrollees, and for individuals submitting claims directly to the consortium;

"(D) further attempt to reduce administrative costs and burdens on enrollees and providers of health services, through—

"(i) the maintenance of a staff to explain claims procedures (that shall be consistent with claims procedures adopted under title XVIII of the Social Security Act) to providers and enrollees and to provide such other services as may assist providers in receiving reimbursement promptly and at the lowest possible cost;

"(ii) establish, to the maximum extent practicable, a paperless processing system to permit providers to submit claims electronically to the consortium;

"(iii) establish, to the maximum extent practicable, the use of 'smart cards' or other electronic methods for immediate verification by providers of an individuals's health insurance coverage;

"(iv) encouraging providers to submit claims directly to the consortium on behalf of enrollees; and

"(v) the conduct of appropriate utilization reviews;

"(E) carry out any other activities determined appropriate by the Secretary; and

"(F) cooperate with the Federal Health Expenditure Board established under part D.

"(2) OPTIONAL FUNCTIONS.—The State consortium may—

"(A) permit insurers with a large share of the market in a State to participate in the consortium;

"(B) convene negotiations with health care providers and purchasers and others, as appropriate, concerning the availability of health care services, coverage and reimbursement levels for such services, and claim submission and payment procedures (activities undertaken as a result of such negotiations shall be exempt from Federal anti-trust laws if such activities are authorized by the State);

"(C) develop procedures for—

"(i) the allocation of capital among health care providers to encourage an adequate and efficient level and distribution of health care resources;

"(ii) encouraging a rational distribution of health care providers; and

"(iii) encouraging the development of managed care;

"(D) the collection and dissemination of data through a Statewide data organization that is accessible to all interested parties in the State in order to facilitate appropriate decisions by consumers and to encourage efficient behavior by providers;

"(E) coordinate with entities responsible for assuring the quality of health care provided within the State; and

"(F) carry out any other activities that are contained within the State plan and approved by the Secretary and that are designed to improve the quality of health care, access to such care, and to control the costs of such care.

"(3) APPLICABILITY OF CONSUMER PROTECTION LAWS.—Notwithstanding any other provision of law, the provisions of the Consumer Product Safety Act and other Federal consumer protection laws shall apply to the functions carried out under paragraph (1).

"(4) MANAGED CARE.—This subsection shall not be construed as limiting the ability of a managed care plan to select providers eligible to perform serv-

ices under the plan, or to establish reasonable procedures to be followed by providers participating in the plan, to assure the provision of cost-effective, quality services.

"(5) SMALL SHARE HEALTH INSURANCE COMPANIES.—As used in this subsection, the term 'small share health insurance companies' shall include entities determined appropriate by the Secretary. In making such determination, the Secretary shall seek to minimize the number of sources reimbursing providers directly in the State but shall permit insurers with a market share that is large enough to sufficiently achieve the economies of scale sought through the consortium, to remain independent of the consortium, to the extent that permitting such separate payment sources would not dilute the purpose of the consortium.

"(e) DATA AND INFORMATION.—A State consortium shall collect or provide for the collection of data and information concerning the operations of the consortium and shall provide such data and information to the Secretary on an annual basis.

"(f) REGIONAL CONSORTIUM.—States may enter into an agreement for the establishment of a regional consortium that shall have jurisdiction over all States that are

parties to such agreement and that shall be subject to the provisions of this section as if such consortium were established by a single State.

"(g) ENFORCEMENT.—A State that fails to comply with the requirements of this section shall be ineligible to receive assistance made available under this Act.

"(h) STUDY.—Not later than 3 years after the date of enactment of this part, the Secretary shall prepare and submit to the appropriate committees of Congress, a report that shall contain the results of a study conducted by the Secretary concerning the State consortia system established under this section, and whether such consortia are effective in containing health care costs, in expanding the availability of access to such care, and in protecting and enhancing the quality of such care.

"(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.".

(b) SOCIAL SECURITY ACT.—Title XI of the Social Security Act (as amended by section 411) is further amended by adding at the end thereof the following new part:

"PART D—STATE PURCHASING CONSORTIA

"STATE PURCHASING CONSORTIA

"SEC. 1191. (a) MEMBERSHIP IN CONSORTIUM.—

"(1) IN GENERAL.—A State may, with the approval of the Secretary, require that the providers operating under the programs conducted under titles XVIII, XIX, and XXI of this Act in the State, participate in the State consortium for purposes of claims processing and for such other purposes as the Secretary may approve, in the least restrictive manner practicable.

"(2) WAIVERS.—With respect to a State requirement under paragraph (1) that providers under titles XVIII, XIX, and XXI of this Act participate in the consortium, the Secretary may waive such requirement on the request of such a provider, if the Secretary determines, on a budget neutral basis, that such waiver is necessary to protect the access of the beneficiaries of such provider to care provided by such provider, and that such waiver will promote the cost effective delivery of services.

"(b) FUNCTIONS OF CONSORTIUM.—

"(1) MANDATORY FUNCTIONS.—The State consortium shall—

"(A) enroll all small share health insurance companies in the State as members of the consortium for insurers, purchasers and providers;

"(B) establish a claim payment fund and procedures for the payment, by the consortium on behalf of it's enrollees, of valid claims submitted by providers or enrollees to the consortium, such fund to be capitalized through public and private contributions and assessments made by the consortium on such enrollees to reflect amounts paid from such fund on behalf of each such enrollee;

"(C) develop, in consultation and with the assistance of the Secretary and consistent with the program established under part C, and employ uniform billing claim forms and procedures for providers of health services covered by enrollees, and for individuals submitting claims directly to the consortium;

"(D) further attempt to reduce administrative costs and burdens on enrollees and providers of health services, through—

"(i) the maintenance of a staff to explain claims procedures (that shall be consistent with claims procedures adopted under title XVIII of this Act) to providers and enrollees and to provide such other services as may assist providers in receiv-

ing reimbursement promptly and at the lowest possible cost;

"(ii) establish, to the maximum extent practicable, a paperless processing system to permit providers to submit claims electronically to the consortium;

"(iii) establish, to the maximum extent practicable, the use of 'smart cards' or other electronic methods for immediate verification by providers of an individuals's health insurance coverage;

"(iv) encouraging providers to submit claims directly to the consortium on behalf of enrollees; and

"(v) the conduct of appropriate utilization reviews;

"(E) carry out any other activities determined appropriate by the Secretary; and

"(F) cooperate with the Federal Health Expenditure Board.

"(2) OPTIONAL FUNCTIONS.—The State consortium may—

"(A) permit insurers with a large share of the market in a State to participate in the consortium;

"(B) convene negotiations with health care providers and purchasers and others, as appropriate, concerning the availability of health care services, coverage and reimbursement levels for such services, and claim submission and payment procedures (activities undertaken as a result of such negotiations shall be exempt from Federal anti-trust laws if such activities are authorized by the State);

"(C) develop procedures for—

"(i) the allocation of capital among health care providers to encourage an adequate and efficient level and distribution of health care resources;

"(ii) encouraging a rational distribution of health care providers; and

"(iii) encouraging the development of managed care;

"(D) the collection and dissemination of data through a Statewide data organization that is accessible to all interested parties in the State in order to facilitate appropriate decisions by consumers and to encourage efficient behavior by providers;

"(E) coordinate with entities responsible for assuring the quality of health care provided within the State; and

"(F) carry out any other activities that are contained within the State plan and approved by the Secretary and that are designed to improve the quality of health care, access to such care, and to control the costs of such care.

"(3) APPLICABILITY OF CONSUMER PROTECTION LAWS.—Notwithstanding any other provision of law, the provisions of the Consumer Product Safety Act and other Federal consumer protection laws shall apply to the functions carried out under paragraph (1).

"(4) MANAGED CARE.—This subsection shall not be construed as limiting the ability of a managed care plan to select providers eligible to perform services under the plan, or to establish reasonable procedures to be followed by providers participating in the plan, to assure the provision of cost-effective, quality services.

"(5) SMALL SHARE HEALTH INSURANCE COMPANIES.—As used in this subsection, the term 'small share health insurance companies' shall include entities determined appropriate by the Secretary. In

making such determination, the Secretary shall seek to minimize the number of sources reimbursing providers directly in the State but shall permit insurers with a market share that is large enough to sufficiently achieve the economies of scale sought through the consortium, to remain independent of the consortium, to the extent that permitting such separate payment sources would not dilute the purpose of the consortium.

"(c) DATA AND INFORMATION.—A State consortium shall collect or provide for the collection of data and information concerning the operations of the consortium and shall provide such data and information to the Secretary on an annual basis.

"(d) REGIONAL CONSORTIUM.—States may enter into an agreement for the establishment of a regional consortium that shall have jurisdiction over all States that are parties to such agreement and that shall be subject to the provisions of this section as if such consortium were established by a single State.

"(e) ENFORCEMENT.—A State that fails to comply with the requirements of this section shall be ineligible to receive payments under section 2109 of this Act.".

Subtitle D—Cost Control Grant Program

SEC. 431. COST CONTROL GRANT PROGRAM.

Part A of title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) is amended by adding at the end thereof the following new section:

"SEC. 905. COST CONTROL GRANT PROGRAM.

"(a) IN GENERAL.—The Administrator may award grants and enter into contracts with States, public entities, insurers, health plan administrators, businesses, labor unions, non-profit organizations, and researchers for the development, demonstration, and evaluation of innovative methods for reducing health care costs.

"(b) APPLICATION.—To be eligible for a grant or contract under subsection (a), an entity of the type described in such subsection shall prepare and submit, to the Administrator, an application at such time, in such form, and containing such information as the Administrator shall require.

"(c) PREFERENCES.—In awarding grants or entering into contracts under subsection (a), the Administrator shall give a preference to entities submitting applications under subsection (b) that propose to implement projects, with assistance provided under this section, with the po-

tential to develop programs that could have a significant impact on overall national health care costs.

"(d) CLEARINGHOUSE.—

"(1) ESTABLISHMENT.—The Administrator shall establish a clearinghouse, and undertake such other activities as may be necessary, to disseminate information concerning successful health care cost control methods and to provide technical assistance in the implementation of such methods.

"(2) OPERATION.—The Administrator may reserve not to exceed 10 percent of the amount appropriated under subsection (g) in each fiscal year for the operation of the clearinghouse, the dissemination of information, and the provision of technical assistance under paragraph (1).

"(e) CONSULTATION.—In developing the procedures for awarding grants under this section, the Secretary shall consult with the Federal Health Expenditure Board established under part D of title XXVII.

"(f) MATCHING REQUIREMENT.—In the case of a grant awarded for the conduct of a demonstration program that will provide a direct benefit to the grantee, the Administrator shall not award such grant unless the grantee agrees to provide additional amounts for such program equal to not less than 25 percent of the amount of

the grant. Such additional amounts may be in cash or in kind.

"(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary in each of the fiscal years 1992 through 1994.".

Subtitle E—Malpractice Reform

SEC. 441. MALPRACTICE REFORM.

Part A of title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) as amended by section 431 is further amended by adding at the end thereof the following new section:

"SEC. 906. MALPRACTICE REFORM.

"(a) IN GENERAL.—The Administrator may award grants to States for the development and implementation of programs for medical malpractice reforms. Programs receiving such grants shall include efforts to develop alternative methods to resolve liability disputes that fairly protect the interests of all parties involved and may include an appropriate role for the use of medical practice guidelines. No grant shall be awarded that is inconsistent with the goal of—

"(1) reducing excessive health care costs;

"(2) reducing unnecessary or ineffective medical care;

"(3) improving access to quality health care;

"(4) ensuring fair and adequate compensation for and review of injuries arising from medical negligence;

"(5) ensuring reasonable insurance rating and premium setting practices; and

"(6) improving patient protections, disciplinary standards for health care professionals, and the effectiveness of State medical boards.

"(b) TYPES OF GRANTS.—A grant awarded under subsection (a) shall be either—

"(1) a planning grant, to assist the grantee in the development of a program under this section that shall be for a period of not to exceed two years; or

"(2) an operational grant, to assist the grantee in operation and evaluation of the new program referred to in paragraph (1), that shall be for a period of not to exceed five years.

"(c) REQUIREMENT.—An operational grant under subsection (b)(2) shall include a requirement that an evaluation, approved by the Administrator as being adequate, is conducted to determine the effectiveness of the program for which the grant is utilized. A final report on the results

of the evaluation shall be prepared and submitted to the Administrator.

"(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.".

SEC. 442. STUDY OF MEDICAL MALPRACTICE.

(a) CONTRACT.—The Secretary shall enter into a contract with the Institute of Medicine, or with a similar independent entity, for the collection and analysis of data and issues, by a group of representatives of interested parties and experts, related to—

(1) ineffective or unnecessary medical testing and practices;

(2) the occurrence of malpractice and malpractice awards (including the number of claims filed and the number of findings of negligence);

(3) the adequacy of existing health care provider licensing and disciplining procedures in preventing malpractice;

(4) the reasonableness of malpractice insurance premiums and rate-setting practices; and

(5) any other issues relevant to the adequacy of current medical practices, of compensation for injuries resulting from medical malpractice, and the impact of legal liability on medical practices.

(b) RECOMMENDATIONS.—Not later than 1 year after the date of enactment of this Act, the Institute or entity referred to in subsection (a) shall make available to the Secretary, the appropriate committees of Congress, the appropriate State officials, and to the general public, a report containing the recommendations of the Institute or entity for any desirable medical malpractice reforms.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

Subtitle F—Reducing the Administrative Cost of Assuring Appropriate Utilization of Health Care Services and Improving the Quality of Health Care Services

SEC. 451. ESTABLISHMENT OF A QUALITY IMPROVEMENT BOARD.

(a) PUBLIC HEALTH SERVICE ACT.—Title XXVII of the Public Health Service Act (as added by section 101 and amended by sections 201, 311, 411, and 421) is further amended by adding at the end thereof the following new part:

"PART F—ESTABLISHMENT OF A QUALITY IMPROVEMENT BOARD

"SEC. 2785. ESTABLISHMENT OF A QUALITY IMPROVEMENT BOARD.

"(a) CONTRACT.—The Secretary shall enter into a contract with an entity in each State (such entity shall hereafter be referred to in this section as the 'quality improvement board') to review the quality of health care provided by health care professionals and institutions in each such State and to establish mechanisms to encourage continuous quality improvement.

"(b) BOARD OF DIRECTORS.—

"(1) REQUIREMENT.—The quality improvement board shall, in accordance with Federal guidelines and regulations and in accordance with the requirements of the contract entered into under subsection (a), be managed by a board of directors.

"(2) MEMBERSHIP.—The board of directors required under paragraph (1) shall consist of 15 members, of whom—

"(A) seven members shall be representatives of health care providers, including individuals of recognized excellence in the development, application, and evaluation of health care services, procedures, and technologies;

"(B) four members shall be representatives of insurers and purchasers of health care services; and

"(C) four members shall be health care service researchers and consumers.

"(3) DUTIES.—The board of directors shall adopt policies for the quality improvement board, approve the budget of the quality improvement board, appoint the executive director of the quality improvement board, and shall assume such other duties as the Secretary may prescribe or the board of directors shall determine to be necessary to the proper functioning of the quality improvement board.

"(c) DUTIES OF THE QUALITY IMPROVEMENT BOARD.—

"(1) GUIDELINES.—

"(A) REQUIREMENT.—The quality improvement board shall adopt guidelines for appropriate medical practice and for recommended measures to be taken by providers to improve the quality of care.

"(B) CONTENTS.—Guidelines adopted under subparagraph (A) shall include those of the type developed under the authority of sec-

tion 912 and such guidelines as the Secretary may specify, and may include additional guidelines developed by professional societies or other appropriately qualified bodies or individuals.

"(2) RECOMMENDED MEASURES.—In cooperation with appropriate professional bodies, associations, and the Joint Commission on Accreditation of Hospitals, the quality improvement board shall recommend measures for continuous quality improvement to be adopted by health care professionals and institutions. Such measures shall include measures specified by the Secretary, appropriate continuing medical education and, for health care institutions, internal quality improvement procedures.

"(3) CERTIFICATION OF PROVIDERS.—The quality improvement board shall periodically review the performance of health care service providers and, based on—

"(A) the conformity of the practice of the provider with the guidelines developed by the board;

"(B) such measures of health care outcomes as may be scientifically valid and adopted by the board;

"(C) adoption by the provider of the measures for continuous quality improvement recommended by the board; and

"(D) such other factors as the board or the Secretary may prescribe; and

may certify a health care provider as an outstanding provider for the purpose of this section.

"(4) LIMITATION ON CERTIFICATION.—A certification under paragraph (3) shall be examined periodically by the quality improvement board to determine if continued certification is appropriate. The quality improvement board may suspend the certification of a provider at any time. At the request of a health plan, insurance company or State agency, the board must reconsider the certification of a provider.

"(5) DATA COLLECTION.—The quality improvement board shall collect and review such data and conduct such inspections and evaluations as are necessary to enable the board to carry out its duties. At the request of the board, insurers shall provide the board with any data collected in the normal course of business as the board determines necessary to perform its duties. The data collected by the Federal Health Expenditure Board under part D and the

data collected by the State consortia under part E shall be made available to the board.

"(d) RESTRICTION ON LIMITATION OF PAYMENT FOR SERVICES PERFORMED BY OUTSTANDING PROVIDERS.—A health benefit plan may not deny payment for any service performed or ordered by a provider certified as outstanding under subsection (c)(3) during the period of such certification for any reason other than noncoverage of the provided service under the plan. The plan may not deny coverage on the basis that the service is not medically necessary. Nothing in this subsection shall be construed to prohibit a plan from paying for services performed or ordered by such provider at its normal reimbursement rates.

"(e) RECERTIFICATION AND SUSPENSION OF CERTIFICATION.—A provider certified as outstanding under subsection (c)(3) shall be recertified periodically by the quality improvement board unless the board acts to suspend such certification. Such suspensions, at the request of the provider shall be reconsidered.

"(f) EXCEPTION FOR MANAGED CARE PLANS.—Nothing in this section shall be construed to limit the ability of a managed care plan to choose providers eligible to perform services under the plan or to establish reasonable procedures to be followed by providers participating in the plan in order to assure cost-effective, quality services.

"(g) PLANNING GRANTS.—To facilitate the establishment of a quality improvement board in each State, the Secretary may award planning grants, in amounts that shall not exceed $200,000 for each State, to private, nonprofit or public entities, for the planning, development and implementation of the board and the programs undertaken by the board.

"(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, such sums as may be necessary to carry out this section.".

(b) SOCIAL SECURITY ACT.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) as amended by sections 411 and 421, is further amended by adding at the end thereof the following new part:

"PART E—ESTABLISHMENT OF A QUALITY IMPROVEMENT BOARD

"ESTABLISHMENT OF A QUALITY IMPROVEMENT BOARD

"SEC. 1195. (a) DUTIES OF THE QUALITY IMPROVEMENT BOARD.—

"(1) GUIDELINES.—

"(A) REQUIREMENT.—The quality improvement board for a State established under section 451(a) of the HealthAmerica Act (hereafter referred to as the 'quality improvement board') shall adopt guidelines for appropriate

medical practice and for recommended measures to be taken by providers to improve the quality of care.

"(B) CONTENTS.—Guidelines adopted under subparagraph (A) shall include such guidelines as the Secretary may specify, and may include additional guidelines developed by professional societies or other appropriately qualified bodies or individuals.

"(2) RECOMMENDED MEASURES.—In cooperation with appropriate professional bodies, associations, and the Joint Commission on Accreditation of Hospitals, the quality improvement board shall recommend measures for continuous quality improvement to be adopted by health care professionals and institutions. Such measures shall include measures specified by the Secretary, appropriate continuing medical education and, for health care institutions, internal quality improvement procedures.

"(3) CERTIFICATION OF PROVIDERS.—The quality improvement board shall periodically review the performance of health care service providers and, based on—

"(A) the conformity of the practice of the provider with the guidelines developed by the board;

"(B) such measures of health care outcomes as may be scientifically valid and adopted by the board;

"(C) adoption by the provider of the measures for continuous quality improvement recommended by the board; and

"(D) such other factors as the board or the Secretary may prescribe; and

may certify a health care provider as an outstanding provider for the purpose of this section.

"(4) LIMITATION ON CERTIFICATION.—A certification under paragraph (3) shall be examined periodically by the quality improvement board to determine if continued certification is appropriate. The quality improvement board may suspend the certification of a provider at any time. At the request of a health plan, insurance company or State agency, the board must reconsider the certification of a provider.

"(5) DATA COLLECTION.—The quality improvement board shall collect and review such data and conduct such inspections and evaluations as are nec-

essary to enable the board to carry out its duties. At the request of the board, insurers shall provide the board with any data collected in the normal course of business as the board determines necessary to perform its duties. The data collected by the Federal Health Expenditure Board under part C and the data collected by the State consortium under part D of title XI shall be made available to the board.

"(b) RESTRICTION ON LIMITATION OF PAYMENT FOR SERVICES PERFORMED BY OUTSTANDING PROVIDERS.—A health benefit plan may not deny payment for any service performed or ordered by a provider certified as outstanding under subsection (a)(3) during the period of such certification for any reason other than noncoverage of the provided service under the plan. The plan may not deny coverage on the basis that the service is not medically necessary. Nothing in this subsection shall be construed to prohibit a plan from paying for services performed or ordered by such provider at its normal reimbursement rates.

"(c) RECERTIFICATION AND SUSPENSION OF CERTIFICATION.—A provider certified as outstanding under subsection (a)(3) shall be recertified periodically by the quality improvement board unless the board acts to suspend such certification. Such suspensions, at the request of a provider, shall be reconsidered.

"(d) EXCEPTION FOR MANAGED CARE PLANS.—Nothing in this section shall be construed to limit the ability of a managed care plan to choose providers eligible to perform services under the plan or to establish reasonable procedures to be followed by providers participating in the plan in order to assure cost-effective, quality services.

"(e) PLANNING GRANTS.—To facilitate the establishment of a quality improvement board in each State, the Secretary may award planning grants, in amounts that shall not exceed $200,000 for each State, to private, nonprofit or public entities, for the planning, development and implementation of the board and the programs undertaken by the board.

"(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, such sums as may be necessary to carry out this section.".

Subtitle G—Use of Practice Guidelines in Federal Health Insurance and Service Programs

SEC. 461. USE OF PRACTICE GUIDELINES IN FEDERAL HEALTH INSURANCE AND SERVICE PROGRAMS.

Guidelines developed under the authority of section 912 of the Public Health Service Act (42 U.S.C. 299b–1) shall, to the extent practical and effective, be utilized

in Federal health insurance programs as utilization review screens and as practice guidelines in Federal programs providing health care services either directly or through grantees.

Subtitle H—National Standards for the Promotion of Managed Care

SEC. 471. NATIONAL STANDARDS FOR THE PROMOTION OF MANAGED CARE.

Title XXVII of the Public Health Service Act (as added by section 101 and amended by sections 201, 311, 411, 421 and 451) is further amended by adding at the end thereof the following new part:

"PART G—NATIONAL STANDARDS FOR THE PROMOTION OF MANAGED CARE

"SEC. 2791. NATIONAL STANDARDS.

"(a) PROHIBITIONS.—No requirement of any State insurance, health care or any other law or regulation shall—

"(1) prohibit a managed care plan from freely selecting the health care providers, or the type of health care providers in a locale, as the participating providers; or

"(2) limit the ability of a managed care entity to negotiate, enter into contracts or establish alternative rates or forms of payment for participating

providers, or to require or provide incentives that promote the use of participating providers.

"(b) UTILIZATION REVIEW SERVICES.—Notwithstanding any State law, an insurer or other person or entity may offer utilization review services in any State if such insurer, person or entity has established—

"(1) a procedure that adequately evaluates the necessity and appropriateness of the proposed or delivered health care services;

"(2) a procedure that permits patients and providers to appeal any adverse decisions by the person or entity performing the utilization review services, as provided for in section 2725;

"(3) a procedure that ensures that the person or entity providing the utilization review services is reasonably accessible (five days each week during normal business hours and, where necessary, at other appropriate times) to patients and providers; and

"(4) a procedure that ensures that all applicable Federal and State laws that are designed to protect the confidentiality of individual medical records are followed.

"SEC. 2792. FAVORABLE TREATMENT OF MANAGED CARE PLANS.

"(a) MANAGED CARE PLAN DEFINED.—

"(1) DEFINED.—As used in this part, the term 'managed care plan' has the same meaning given such term in section 2713(7).

"(2) DETERMINATION OF MANAGED CARE PLANS.—In the case of a health benefit plan that is offered by an entity, that is not a self-insured entity, that is subject to regulation by an applicable regulatory authority (as defined in section 2744(c)), consistent with procedures established by the Secretary in consultation with such authorities, such authorities shall be responsible for certifying for purposes of this part and the Social Security Act whether the health benefit plan is a managed care plan. In the case of self-insured entities, the Secretary shall be responsible for providing such certification.

"(b) CONDITION OF STATE FUNDING.—

"(1) IN GENERAL.—No amounts shall be made available under this Act to a State in any fiscal year (beginning with the first fiscal year beginning after the date of the enactment of this section) unless the State is in compliance with subsection (a).

"(2) DEEMED ELECTION; IMPLIED PREEMPTION.—

"(A) IN GENERAL.—A State is deemed to have elected subsection (a) to be in effect in the State as of the beginning of a fiscal year, unless the chief executive officer of a State indicates in writing that the State will not comply with this section. Such an election shall have the effect of preempting the establishment or enforcement of any State law that is in violation of subsection (a).

"(B) CHANGES.—A State is deemed not to have such an election in effect as of the date the Secretary determines that the State is enforcing any law or regulation in violation of subsection (a).

"(c) LIMITATION ON RESTRICTIONS ON MANAGED CARE PLANS.—In order to comply with the requirements of this subsection, a State may not by law or regulation prohibit or unreasonably limit any of the following:

"(1) A State may not prohibit or limit a managed care plan from including incentives for enrollees to use the services of participating providers.

"(2) A State may not prohibit or limit a managed care plan from limiting coverage of services to those provided by a participating provider.

"(3)(A) Subject to subparagraph (B), a State may not prohibit or limit the negotiation of rates and forms of payments for providers under a managed care plan.

"(B) Subparagraph (A) shall not apply where the amount of payments with respect to a block of services or providers is established under a statewide system applicable to all non-Federal payors with respect to such services or providers.

"(4) A State may not prohibit or limit a managed care plan from limiting the number of participating providers.

"(5) A State may not prohibit or limit a managed care plan from requiring that services be provided (or authorized) by a primary care physician selected by the enrollee from a list of available participating providers.

"(d) ADDITIONAL DEFINITIONS.—In this part, the definitions contained in section 2713 shall also apply.

"SEC. 2793. FAVORABLE TREATMENT OF UTILIZATION REVIEW PROGRAMS.

"(a) PREEMPTION OF STATE LAWS RESTRICTING UTILIZATION REVIEW PROGRAMS THAT MEET FEDERAL STANDARDS.—In the case of a health benefit plan that includes a utilization review program, no State law or reg-

ulation shall prohibit or regulate activities under such program, except insofar as such law or regulation is consistent with the standards established under subsection (b).

"(b) ESTABLISHMENT OF STANDARDS FOR UTILIZATION REVIEW PROGRAMS.—

"(1) IN GENERAL.—The Secretary shall provide, by regulation, for the establishment of Federal standards for utilization review programs of health benefit plans. Such standards shall be designed to assure, within a plan, the cost-effective and medically appropriate use of services.

"(2) CONTENTS OF STANDARDS.—Such standards shall be established with respect to at least each of the following aspects of utilization review programs:

"(A) The qualification of those who may perform utilization review activities.

"(B) The standards to be applied in performing utilization review.

"(C) The timeliness in which utilization review determinations are to be made.

"(D) An appeals process which provides a fair opportunity for individuals adversely affected by a utilization review determination to have such a determination reviewed.

"(E) Protection for the confidentiality of individually-identifiable information used in the process.

"(3) USE OF GUIDELINES.—Such standards shall, to the maximum extent feasible, be consistent with practice guidelines developed by the Agency for Health Care Policy and Research.

"(4) DEADLINE.—Standards shall first be established under this subsection by not later than 2 years after the date of the enactment of this part. The Secretary may revise the standards from time to time as required to assure, within health benefit plans, the cost-effective and medically appropriate use of services.

"(c) UTILIZATION REVIEW PROGRAM DEFINED.—In this section, the term 'utilization review program' means a system of reviewing the medical necessity and appropriateness of patient services (which may include inpatient and outpatient services) using specified guidelines. Such a system may include preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory procedures, and retrospective review.".

Subtitle I—Expansion of Technology Assessment

SEC. 481. EXPANSION OF TECHNOLOGY ASSESSMENT.

Section 904 of the Public Health Service Act (42 U.S.C. 299a-2) is amended by adding at the end thereof the following new subsections:

"(e) EXPANSION OF EFFORTS.—In carrying out section 901(b) through subsection (a), the Administrator shall focus on expanding and applying appropriate assessments of existing health care technologies. Such expansion shall be achieved in part, through an evaluation of health services provided to individuals through publicly and privately funded sources.

"(f) PUBLIC-PRIVATE PARTNERSHIPS.—

"(1) ESTABLISHMENT OF PROGRAM.—The Administrator shall establish a program under which the Administrator shall enter into contracts or cooperative agreements with eligible entities for the establishment of public-private partnerships to undertake technology assessment and related activities in the private sector.

"(2) ELIGIBLE ENTITIES.—Entities eligible to receive a contract or agreement under paragraph (1), shall include academic medical centers, research institutions, or a consortia of appropriate entities es-

tablished for the purposes of conducting technology assessment.

"(3) APPLICATION.—To be eligible to receive a contract or agreement under paragraph (1), an entity shall prepare and submit to the Administrator an application, at such time, in such form, and containing such information as the Administrator may require.".

TITLE V—CONTRIBUTION BY EMPLOYERS NOT PROVIDING PRIVATE HEALTH COVERAGE

SEC. 501. CONTRIBUTION BY EMPLOYERS NOT PROVIDING PRIVATE HEALTH BENEFIT PLANS.

(a) IN GENERAL.—Subtitle C of the Internal Revenue Code of 1986 is amended by adding at the end thereof the following new chapter:

"CHAPTER 26—CONTRIBUTION BY EMPLOYERS NOT PROVIDING PRIVATE HEALTH BENEFIT PLANS

"Sec. 3601. Contribution by employers not providing private health benefit plans.

"SEC. 3601. CONTRIBUTION BY EMPLOYERS NOT PROVIDING PRIVATE HEALTH BENEFIT PLANS.

"(a) CONTRIBUTION.—If an employer to whom part B of title XXVII or section 2701(a) of the Public Health

Service Act applies elects to have this chapter apply, there is hereby imposed on such employer for each payroll period a contribution requirement in the amount determined under subsection (b).

"(b) AMOUNT OF CONTRIBUTION.—

"(1) IN GENERAL.—The amount of the contribution required by subsection (a) for any payroll period shall be equal to the applicable percentage of wages (50 percent of wages in the case of an employer described in section 352 of the HealthAmerica Act) paid during such period to employees with respect to whom the employer is required (without regard to the election under this section) to provide health insurance coverage under part B of title XXVII of the Public Health Service Act.

"(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1)—

"(A) IN GENERAL.—The applicable percentage for any calendar year shall be the percentage established under this paragraph for such calendar year by the Secretary of Health and Human Services at the lowest level consistent with maintaining a fair balance between public and private health insurance coverage for

employees employed by employers not currently offering health insurance coverage.

"(B) FAIR BALANCE.—For purposes of subparagraph (A), the term 'fair balance' means, with respect to a year, a balance calculated based on the estimated cost of a fully implemented health insurance plan in that year, and would, if such plan were fully implemented and in effect, result in a ratio between coverage of such employees under the public health insurance plan under title XXI of the Social Security Act and under a health benefit plan under part B of title II of the Public Health Service Act that is not disproportionate.

"(C) NOT DISPROPORTIONATE.—For purposes of subparagraph (B), the term 'not disproportionate' means a ratio of not greater than 65 percent to 35 percent in comparing coverage under such public health insurance plan to such health benefit plans for a year.

"(3) WAGES.—For purposes of this subsection, the term 'wages' has the meaning given such term by section 3121(a), without regard to any limitation by reference to the contribution and benefit base under section 230 of the Social Security Act.

"(c) PAYROLL PERIOD.—For purposes of this section, the term 'payroll period' has the meaning given such term by section 3401(b).

"(d) ADMINISTRATION.—For purposes of this title, the contribution required by subsection (a) shall be treated in the same manner as the tax imposed by section 3111(a).".

(b) CONFORMING AMENDMENTS.—The table of chapters for subtitle C of the Internal Revenue Code of 1986 is amended by adding at the end thereof the following new item:

"Chapter 26. Contribution in lieu of employer coverage.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payroll periods beginning on or after the effective date of this Act.

TITLE VI—ASSURING PROVISION OF HEALTH BENEFITS TO ALL AMERICANS

SEC. 601. ESTABLISHMENT OF AMERICARE.

(a) IN GENERAL.—The Social Security Act (42 U.S.C. 301 et seq.) is amended by adding at the end thereof the following new title:

"TITLE XXI—AMERICARE

"TABLE OF CONTENTS OF TITLE

"Sec. 2101. State requirements for participation in AmeriCare.
"Sec. 2102. Basic health benefits.
"Sec. 2103. Cost-sharing provisions.

"Sec. 2104. Supplemental payments.
"Sec. 2105. Health care providers.
"Sec. 2106. Quality and cost-effective care measures.
"Sec. 2107. Administration.
"Sec. 2108. Definitions and special rules.
"Sec. 2109. Payments to States.
"Sec. 2110. AmeriCare trust fund.

"STATE REQUIREMENTS FOR PARTICIPATION IN AMERICARE

"SEC. 2101. (a) IN GENERAL.—A State must—

"(1) provide either for the establishment or designation of a single State agency (other than the agency established or designated under section 1902 of this Act) to administer or supervise the administration of AmeriCare;

"(2) provide basic health benefits described in section 2102, subject to cost-sharing provisions under section 2103—

"(A) to any child or pregnant woman who is not otherwise covered under a nongovernmental health insurance policy, plan, or program beginning on the first day of the second full calendar year after the date of the enactment of this title;

"(B) to any employee or family member with respect to whom an employer makes a contribution under title V of the HealthAmerica Act beginning on the first day of the second full

calendar year after the date of the enactment of this title; and

"(C) to any individual not covered under a health benefit plan under title II of such Act, beginning on the first day of the fifth full calendar year after the effective date described in subparagraph (A);

"(3) provide at least monthly supplemental payments for premiums, deductibles, and other cost-sharing charged to individuals and families as provided under section 2104;

"(4) provide a clear, simple explanation of the basic health benefits and supplemental payments available under AmeriCare through public announcements, mailings, and any other suitable means;

"(5) provide enrollment in AmeriCare as described in subsection (b);

"(6) to the extent required by the Secretary, provide basic health benefits or supplemental payments under AmeriCare to individuals who are—

"(A) residents of the State but are absent therefrom,

"(B) temporarily located in the State but are not permanent residents of any State; or

"(C) formerly residents of the State but are currently United States citizens permanently residing in a country which has reciprocity agreements with the United States;

"(7) provide to any individual covered under a health benefit plan under title II of the HealthAmerica Act, or any employer of such individual, the opportunity to purchase (or have purchased for such individual by the individual's employer) AmeriCare benefits described in section 2102(a)(7) at a separate actuarial premium rate determined by the State and subject to such other cost-sharing provisions as the plan under such title II provides for other benefits under such plan;

"(8) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for coverage under AmeriCare is denied or is not acted upon with reasonable promptness, under rules described in section 2107(b);

"(9) meet the requirements of—

"(A) paragraphs (4), (6), (7), (11), (19), (27), (45), (46), (48), and (49) of section 1902(a),

"(B) subsections (b) and (g) of section 1902, and

"(C) section 1907,

in the same manner as they apply to title XIX of this Act;

"(10) meet the requirements of section 2105 and 2106(c);

"(11) provide that AmeriCare shall be in effect in all political subdivisions of the State, and if administered by such subdivisions, be mandatory upon such subdivisions;

"(12) provide for financial participation by the State equal to the non-Federal share of the expenditures under AmeriCare with respect to which payments under section 2109 are authorized by this title;

"(13) meet any other requirements of this title; and

"(14) in order to insure compliance with this title and to receive the Federal share under section 2109, submit to the Secretary a plan that meets the requirements of this subsection and is subject to rules similar to the rules of section 1904.

"(b) ELIGIBILITY FOR BASIC HEALTH BENEFITS.—

"(1) IN GENERAL.—Subject to the provisions of paragraphs (2) and (6) of subsection (a), each individual not otherwise covered under a health benefit

plan under title II of the HealthAmerica Act is entitled to basic health benefits under AmeriCare.

"(2) PERIOD OF COVERAGE.—

"(A) GENERAL RULE.—Upon notification of the approval of an application submitted by any individual (or a guardian or representative of such individual), AmeriCare coverage of the applicant begins on the date of such application.

"(B) FAILURE TO MAKE TIMELY NOTIFICATION.—If the State fails to notify the applicant of the applicant's ineligibility within 1 month of the date of the application, AmeriCare coverage shall apply during the period beginning on the date the individual submitted the application and ending on the date the State notifies such individual of such ineligibility.

"(C) EMPLOYER'S CONTINUATION COVERAGE.—Coverage under AmeriCare shall not apply for services provided during a period of hospitalization that begins prior to the date specified in subparagraph (A) or (B) with respect to an individual whose enrollment in an employer-based health plan terminated during such period of hospitalization.

"(D) GUARANTEED MINIMUM ELIGIBILITY PERIOD.—An individual who is determined in a month to be eligible for benefits under AmeriCare shall remain eligible for coverage for a period of not less than 1 year, unless otherwise covered under a health benefit plan under title II of the HealthAmerica Act.

"(3) APPLICATION FORMS.—Each State plan shall use a standard Federal application which shall be as simple in form as possible and understandable to the average individual and require attachment of such documentation as deemed necessary by the Secretary in order to insure eligibility.

"(4) ENROLLMENT PROCESS.—

"(A) IN GENERAL.—Each State shall provide for the receipt of AmeriCare applications—

"(i) by mail; and

"(ii) at locations broadly available to the general public, including locations that serve large numbers of indigent individuals (as defined and determined by the Secretary).

"(B) EMPLOYER ASSISTANCE.—

"(i) IN GENERAL.—Any employer who contributes under title V of the

HealthAmerica Act in lieu of providing a health benefit plan under title II of such Act shall notify the State of the identities of all employees of that State and shall provide such employees with AmeriCare applications.

"(ii) CHANGE IN STATUS NOTIFICATION.—Any employer shall notify the State of—

"(I) the identities of any employees of that State who become eligible for AmeriCare as the result of changes in employment status; and

"(II) the identities of any individuals (including members of the families of such individuals) who become covered under a health benefit plan under title II of the HealthAmerica Act and who were covered under AmeriCare in such State.

Each employer shall provide employees described in subclause (I) with AmeriCare applications.

"(iii) COLLECTION OF PREMIUMS.—

"(I) IN GENERAL.—Each State may require that employers collect AmeriCare premiums on behalf of the employees of such employer.

"(II) FAILURE TO PAY PREMIUMS.—If a State plan includes the requirement described in subclause (I), the State shall notify the employee and the Secretary of the failure of the employer to make timely premium payments on behalf of the employee and the employee's family members as required under such plan. Such notification shall be provided not less than 30 days prior to any termination of coverage by the State as the result of such nonpayment of premiums.

"(5) ENROLLMENT PERIODS.—

"(A) IN GENERAL.—Except as provided in this paragraph, any individual may enroll in AmeriCare—

"(i) during an annual open enrollment period (of not less than 1 month) established by the Secretary; and

"(ii) during such other periods (including upon loss of coverage under a health benefit plan under title II of the HealthAmerica Act) as the Secretary shall require in regulations.

"(B) FOR UNDER-POVERTY FAMILIES.—In the case of an individual who is determined to be a member of an under-poverty family, the individual may enroll in AmeriCare at any time.

"(C) PHASE-IN PERIODS.—In the case of any individual who first becomes eligible for benefits under AmeriCare in a calendar year described in subsection (a)(2), the period of enrollment shall continue for the entire calendar year.

"(6) AMERICARE CARD.—The State shall issue an AmeriCare card which may be used for purposes of identification and processing of claims under AmeriCare. AmeriCare cards shall identify (as appropriate) if the individual is eligible for special eligibility benefits.

"BASIC HEALTH BENEFITS

"SEC. 2102. (a) GENERAL BENEFITS.—Benefits under this section with respect to all individuals shall include—

"(1) inpatient and outpatient hospital care, except that treatment for a mental disorder is subject to the special limitations described in paragraph (6)(A);

"(2) inpatient and outpatient physician services, except that psychotherapy or counseling for a mental disorder is subject to the special limitations described in paragraph (6)(B);

"(3) diagnostic tests;

"(4) prenatal care and well-baby care provided to children who are 1 year of age or younger;

"(5) preventive services, limited to—

"(A) well child care;

"(B) pap smears; and

"(C) mammograms; and

"(6)(A) inpatient hospital care for a mental disorder for not less than 45 days per year, except that days of partial hospitalization or residential care may be substituted for days of inpatient care according to a ratio established by the Secretary; and

"(B) outpatient psychotherapy and counseling for a mental disorder for not less than 20 visits per year provided by a provider who is acting within the scope of State law and who—

"(i) is a physician; or

"(ii) meets the standards of subsection (e)(2) and is a duly licensed or certified clinical psychologist or a duly licensed or certified clinical social worker, a duly licensed or certified equivalent mental health professional, or a clinic or center providing duly licensed or certified mental health services; and

"(7) items and services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnosis, and treatment for children under the age of 21).

(b) EXCEPTIONS.—Subsection (a) shall not be construed as requiring a plan for AmeriCare to include payment for—

(1) items and services that are not medically necessary as determined under rules similar to rules under title XVIII of this Act;

(2) routine physical examinations or preventive care (other than care and services described in paragraphs (4), (5), and (7) of subsection (a); or

(3) experimental services and procedures as determined under rules similar to rules under title XVIII of this Act.

(c) AMOUNT, SCOPE, AND DURATION OF CERTAIN BENEFITS.—Except as provided in subsection (b),

AmeriCare shall place no limits on the amount, scope, or duration of benefits described in paragraphs (1) through (3) of subsection (a).

(d) AMOUNT, SCOPE, AND DURATION OF PREVENTIVE SERVICES.—AmeriCare may limit the preventive services described in subsection (a)(5) pursuant to regulations of the Secretary specifying the content and periodicity of such care. The Secretary shall develop such regulations after consultation with appropriate medical experts.

(e) MENTAL HEALTH CARE.—

(1) INPATIENT CARE.—Inpatient hospital care described in subsection (a)(6)(A) shall include reimbursement for professional care provided to the individual while the individual is receiving such inpatient care, by a physician or duly licensed or certified clinical psychologist operating within the scope of practice of the physician or psychologist, as determined appropriate under State law. Nothing in this subsection shall be construed to modify hospital practices with regard to scope of practice, admitting privileges, or billing arrangements.

(2) STANDARDS FOR CERTAIN PROVIDERS OF OUTPATIENT CARE.—The Secretary shall establish standards that providers referred to in subsection

(a)(6)(B)(ii) must meet to be eligible for payment under AmeriCare.

"(f) ENHANCED BENEFITS.—Basic health benefits under this section with respect to special eligibility individuals shall include medical assistance, not otherwise described in subsection (a), in the State's plan under title XIX of this Act, other than medical assistance described in paragraphs (4)(A), (7), (14), and (18) of section 1905(a).

"(g) ADDITIONAL BENEFITS.—As part of AmeriCare, a State may provide for the coverage of health benefits in addition to the basic health benefits described in the preceding subsections of this section, on the condition that the State shall not receive any Federal payment for such additional coverage.

"COST-SHARING PROVISIONS

"SEC. 2103. (a) IN GENERAL.—Except as provided in subsection (b), each State that provides AmeriCare shall provide for cost-sharing as follows:

"(1) UNDER-POVERTY FAMILIES.—With respect to an individual who is a member of an under-poverty family, AmeriCare may not impose any premiums, deductibles or other cost-sharing on such individual.

"(2) NEAR-POVERTY FAMILIES.—

"(A) IN GENERAL.—Subject to subparagraph (C), with respect to an individual who is

a member of a near-poverty family that receives benefits under AmeriCare, the amount of the monthly AmeriCare premium for such individual shall be the applicable percentage of the monthly actuarial rate of such State.

"(B) APPLICABLE PERCENTAGE.—For the purposes of this paragraph, the term 'applicable percentage' means 2 percentage points for each 10 percentage point bracket (or any portion thereof) such family's income equals or exceeds the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

"(C) LIMITATION.—The aggregate amount of any AmeriCare premiums imposed on the family of the individual under this paragraph for any calendar year shall not exceed an amount equal to 3 percent of the family income.

"(D) ADDITIONAL COST SHARING LIMITATION.—

"(i) IN GENERAL.—With respect to any individual who is a member of a near-

poverty family that receives benefits under AmeriCare, such individual shall, in addition to the AmeriCare premium described in this paragraph, pay the applicable percentage of any AmeriCare deductible or other cost-sharing.

"(ii) APPLICABLE PERCENTAGE.—For purposes of this subparagraph, the term 'applicable percentage' means 10 percentage points for each 10 percentage point bracket (or any portion thereof) such family's income equals or exceeds 110 percent of such income official poverty line.

"(3) OTHER FAMILIES.—

"(A) IN GENERAL.—Subject to subparagraph (C), with respect to an individual who is a member of a family that receives benefits under AmeriCare and whose income equals or exceeds an income level that is 200 percent of the income official poverty line (as described in paragraph (2)(B)), the amount of the monthly AmeriCare premium for such individual shall be the monthly actuarial rate of such State.

"(B) LIMITATION.—The aggregate amount of any AmeriCare premiums imposed on the

family of the individual under this paragraph for any calendar year shall not exceed an amount equal to—

"(i) in the case of a family whose income equals or exceeds 200 percent of such income official poverty line but is less than 250 percent of such income official poverty line, 3.5 percent of the family income,

"(ii) in the case of a family whose income equals or exceeds 250 percent of such income official poverty line but is less than 325 percent of such income official poverty line, 4 percent of the family income, and

"(ii) in the case of a family whose income equals or exceeds 325 percent of such income official poverty line but is less than 400 percent of such income official poverty line, 5 percent of the family income.

"(C) With respect to any individual who is a member of a family described in this paragraph that receives benefits under AmeriCare, such individual shall, in addition to the

AmeriCare premium described in this paragraph, pay 100 percent of any AmeriCare deductible or other cost-sharing.

"(4) PHASE-IN COVERAGE FOR CHILDREN.—With respect to any family described in this subsection, the children of which are the only individuals eligible for coverage under AmeriCare, the percentages described in paragraphs (2)(C) and (3)(B) shall be reduced by two-thirds.

"(b) MONTHLY AMERICARE PREMIUM FOR EMPLOYED INDIVIDUALS.—

"(1) IN GENERAL.—Except as provided in paragraph (2), a State plan for AmeriCare shall require an individual whose employer makes a contribution under title V of the HealthAmerica Act in lieu of providing a health benefit plan under title II of such Act to pay an AmeriCare premium equal to the lesser of—

"(A) coverage under AmeriCare for such individual for a period of one month; or

"(B) 20 percent of the monthly actuarial rate of such State.

"(2) With respect to any part-time employee who is a member of a family that receives benefits under AmeriCare and whose income equals or ex-

ceeds an income level that is 200 percent of the income official poverty line (as described in subsection (a)(2)(B)) and whose employer makes a contribution under title V of the HealthAmerica Act, the amount of any AmeriCare premium imposed on such employee shall be 50 percent of the amount determined under paragraph (1).

"(c) DEFINITIONS AND SPECIAL RULES.—

"(1) MONTHLY ACTUARIAL RATE DEFINED.—

"(A) IN GENERAL.—For purposes of this section, the term 'monthly actuarial rate' means, with respect to AmeriCare in a plan year, the average monthly per enrollee amount that the State estimates, based on actuarial calculations conducted in conformity with requirements established by the Secretary, for enrollees under AmeriCare during the year, would be necessary to pay for the total benefits required under the State plan for AmeriCare (including administrative costs for the provision of such benefits and an appropriate amount for a contingency margin) during the year.

"(B) SPECIAL RULE.—With respect to any State plan for AmeriCare, for any period ending before the date described in section

2101(a)(2)(C), the monthly actuarial rate shall be calculated as if all eligible children in such State participate in such plan.

"(2) APPLICATION ON BASIS OF FAMILY STATUS.—For purposes of this section, a State plan for AmeriCare may provide for the AmeriCare premium to be applied, and the monthly actuarial rate to be computed—

"(A) separately for individuals who have family members covered under AmeriCare and for individuals who do not have family members covered under the AmeriCare; and

"(B) with respect to individuals with such covered family members, separately—

"(i) for individuals who have a covered spouse and one or more covered children;

"(ii) for individuals who have a covered spouse but no covered children; and

"(iii) for individuals who do not have a covered spouse but have one or more covered children.

"(3) ADJUSTMENT FOR COVERED SPOUSE WITH OTHER COVERAGE.—For purposes of this section, if a State plan for AmeriCare charges an individual for

a share of the AmeriCare premium, the plan shall establish a separate AmeriCare premium category (or categories) for family coverage in the case of a covered spouse who is receiving primary health insurance coverage from another health benefit plan. The AmeriCare premium for such categories shall be established based on actual or projected plan experience or according to a formula established by the Secretary, and shall take into account the reduction in health insurance costs resulting from such coverage.

"(d) AMERICARE DEDUCTIBLE OR OTHER COST-SHARING.—

"(1) IN GENERAL.—For purposes of this title, the term 'AmeriCare deductible or other cost-sharing' means any deductible, copayment, or coinsurance established by the State plan for AmeriCare as determined under paragraphs (2) and (3) of this subsection.

"(2) LIMITATION ON DEDUCTIBLES.—A State plan for AmeriCare shall not provide, for benefits provided in any plan year, for a deductible amount that exceeds—

"(A) with respect to benefits payable for items and services furnished to any individual

with no family member enrolled under AmeriCare, for a plan year beginning in—

"(i) the first calendar year that begins more than 1 year after the effective date of this title, $250; or

"(ii) for a subsequent calendar year, the limitation of deductions specified in clause (i) for the previous calendar year increased by the percentage increase in the consumer price index for all urban consumers (United States city average, as published by the Bureau of Labor Statistics) for the 12-month period ending on September 30 of the preceding calendar year; and

"(B) with respect to benefits payable for items and services furnished to any individual with a family member enrolled under AmeriCare, for a plan year beginning in—

"(i) the first calendar year that begins more than 1 year after the effective date of this title, $250 per family member and $500 per family; or

"(ii) for a subsequent calendar year, the limitation of deductions specified in clause (i) for the previous calendar year in-

creased by the percentage increase in the consumer price index for all urban consumers (United States city average, as published by the Bureau of Labor Statistics) for the 12-month period ending on September 30 of the preceding calendar year.

If the limitation of deductions computed under subparagraph (A)(ii) or (B)(ii) is not a multiple of $10, it shall be rounded to the next highest multiple of $10.

"(3) LIMITATION ON COPAYMENTS AND COINSURANCE.—

"(A) IN GENERAL.—Subject to subparagraphs (B) through (D), a State plan for AmeriCare shall not—

"(i) require the payment of any copayment or coinsurance for an item or service for which coverage is provided under section 2102(g) in an amount that exceeds 20 percent of the cost of the item or service; or

"(ii) require the payment of any copayment or coinsurance for items and services required under section 2102 (other than subsection (g)) to be furnished in a

plan year for an individual after the individual has incurred out-of-pocket expenses under the plan that are equal to the out-of-pocket limit (as defined in subparagraph (E)(ii)).

"(B) EXCEPTION FOR PREFERRED PROVIDERS.—If a State plan for AmeriCare establishes reasonable classifications of participating and nonparticipating providers of items and services, the plan may require payments in excess of the amount permitted under subparagraph (A) in the case of items and services furnished by nonparticipating providers.

"(C) EXCEPTION FOR IMPROPER UTILIZATION.—A State plan for AmeriCare may provide for copayment or coinsurance in excess of the amount permitted under subparagraph (A) for any item or service that an individual obtains without complying with any reasonable procedures established by the plan to ensure the efficient and appropriate utilization of covered services.

"(D) MENTAL HEALTH CARE.—In the case of care provided under section 2102(a)(6)(B), a State plan for AmeriCare shall not require pay-

ment of any copayment or coinsurance for an item or service for which coverage is required by this title in an amount that exceeds 50 percent of the cost of the item or service.

"(E) LIMIT ON OUT-OF-POCKET EXPENSES.—

"(i) OUT-OF-POCKET EXPENSES DEFINED.—For purposes of this paragraph, the term 'out-of-pocket expenses' means, with respect to an individual in a plan year, amounts payable under AmeriCare as deductibles and coinsurance with respect to items and services provided under AmeriCare and furnished in the plan year on behalf of the individual and family covered under AmeriCare.

"(ii) OUT-OF-POCKET LIMIT DEFINED.—For purposes of this paragraph, the term 'out-of-pocket limit' means for a plan year beginning in—

"(I) the first calendar year that begins more than 1 year after the effective date of this title, $3,000; or

"(II) for a subsequent calendar year, the out-of-pocket limit specified

in subclause (I) for the previous calendar year increased by the percentage increase in the consumer price index for all urban consumers (United States city average, as published by the Bureau of Labor Statistics) for the 12-month period ending on September 30 of the preceding calendar year.

If the out-of-pocket limit computed under subclause (II) is not a multiple of $10, it shall be rounded to the next highest multiple of $10.

"SUPPLEMENTAL PAYMENTS

"SEC. 2104. (a) IN GENERAL.—Except as provided in this section, an individual who is enrolled in a health benefit plan under title II of the HealthAmerica Act is not entitled to benefits under AmeriCare.

"(b) ASSISTANCE FOR UNDER-POVERTY FAMILIES.—In the case of an individual described in subsection (a) or an individual whose employer makes a contribution under title V of the HealthAmerica Act in lieu of providing a health benefit plan under title II of such Act, who is a member of an under-poverty family, AmeriCare shall provide for payment of—

"(1) any premiums charged the individual for the applicable category of coverage under the employer's health benefit plan or AmeriCare in which the individual is enrolled, except that AmeriCare is not required to pay for such amount of a premium as exceeds the lowest premium which would be charged the individual for the applicable category of coverage under any health benefit plan offered the individual under title II of the HealthAmerica Act or AmeriCare, as the case may be; and

"(2) deductibles and other cost-sharing imposed on the individual under the employer's health benefit plan or AmeriCare, but only with respect to the basic benefits required under such a plan under such title II or AmeriCare, as the case may be.

"(c) ASSISTANCE FOR NEAR-POVERTY FAMILIES.—

"(1) IN GENERAL.—In the case of an individual described in subsection (a) or an individual whose employer makes a contribution under title V of the HealthAmerica Act in lieu of providing a health benefit plan under title II of such Act, who is a member of a near-poverty family, AmeriCare shall provide for payment of the applicable premium percentage of any premiums charged the individual for the applicable category of coverage under the employer's health

benefit plan or AmeriCare in which the individual is enrolled, except that AmeriCare is not required to pay for such amount of a premium as exceeds the lowest premium which would be charged the individual for the applicable category of coverage under any health benefit plan offered the individual under title II of the HealthAmerica Act or AmeriCare, as the case may be.

"(2) APPLICABLE PREMIUM PERCENTAGE.—For purposes of paragraph (1)(A), the term 'applicable premium percentage' means 20 percent reduced (but not below 2 percent) by 2 percentage points for each 10 percentage point bracket (or portion thereof) such family's income equals or exceeds 110 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

"(d) APPLICATION FOR ASSISTANCE.—The State plan for AmeriCare shall use a standard Federal application which shall be as simple in form as possible and understandable to the average individual and require attachment of such documentation as deemed necessary by the Secretary in order to insure eligibility. Such application

shall be available to any employee as provided in section 2107(b), may by filed at any time, and shall initiate coverage under the rules similar to the rules of subparagraphs (A) and (B) of section 2101(b)(2).

"(e) PAYMENT OF PREMIUMS.—

"(1) IN GENERAL.—The State plan shall provide that upon the initiation of coverage under this section, an individual shall receive advanced payment of supplemental premium payments for the calendar year from AmeriCare, or in the case of an individual enrolled in AmeriCare, a reduction in the annual AmeriCare premium.

"(2) REQUIREMENT FOR FILING OF INCOME STATEMENT.—In the case of a family which is receiving supplemental premium payments (or a reduction in AmeriCare premiums) under this section for any month in a year, a member of the family shall file with the State, by not later than April 15 of the following year, a statement that verifies the family's total family income for the taxable year ending during the previous year. Such a statement shall provide information necessary to determine the family income during the year and the number of family members in the family as of the last day of the year.

"(3) RECONCILIATION OF PREMIUM ASSISTANCE BASED ON ACTUAL INCOME.—Based on and using the income reported in the statement filed under paragraph (2) with respect to a family or individual, the State shall compute the amount of assistance that should have been provided under this section with respect to premiums for the family in the year involved. If the amount of such assistance computed is—

"(A) greater than the amount of premium assistance provided, the State shall provide for payment (directly or through a credit against future premiums owed) to the family or individual involved of an amount equal to the amount of the deficit, or

"(B) less than the amount of assistance provided, the State shall require the family or individual to pay (directly or through an increase in future premiums owed) to the State (to the credit of the program under this title) an amount equal to the amount of the excess payment.

"(4) DISQUALIFICATION FOR FAILURE TO FILE.—In the case of any family that is required to file an information statement under paragraph (2)

in a year and that fails to file such a statement by the deadline specified in such paragraph, no member of the family shall be eligible for assistance under this section after May 1 of such year. The State shall waive the application of this paragraph if the family establishes, to the satisfaction of the State, good cause for the failure to file the statement on a timely basis.

"(5) PENALTIES FOR FALSE INFORMATION.—Any individual that provides false information in a statement under paragraph (2) is subject to a criminal penalty to the same extent as a criminal penalty may be imposed under section 1128B(a) with respect to a person described in clause (ii) of such section.

"(6) NOTICE OF REQUIREMENT.—The State shall provide for written notice, in March of each year, of the requirement of paragraph (2) to each family which received assistance under this section in any month during the preceding year and to which such requirement applies.

"(7) TRANSMITTAL OF INFORMATION.—The Secretary of the Treasury shall transmit annually to the State such information relating to the total income of individuals for the taxable year ending in

the previous year as may be necessary to verify the reconciliation of assistance under this subsection.

"(f) PAYMENT OF OTHER COST-SHARING CLAIMS.—The State plan shall provide that each individual subject to coverage under this section or the health care provider rendering the service shall file claims for the supplemental payment of deductibles and other cost-sharing imposed on such individual under the employer's health benefit plan or Americare, and the State shall make such payments at the option of the individual, to such individual or the health care provider.

"HEALTH CARE PROVIDERS

"SEC. 2105. (a) USE OF MEDICARE PAYMENT RULES.—

"(1) IN GENERAL.—Except as provided in subsections (b) and (c)—

"(A) payment of benefits under the State plan for AmeriCare shall be made in the same amounts and on the same basis as payment may be made with respect to such benefits under title XVIII of this Act, and

"(B) the provisions of sections 1814, 1815, 1833, 1834(c) (other than paragraphs (1)(A)(2)), 1835, 1842, 1848, 1886, 1887 shall apply to payment of benefits (and provision of services and charges thereon) under this title in

the same manner as such provisions apply to benefits, services, and charges under title XVIII of this Act.

"(2) IDENTIFICATION OF COMPARABLE PAYMENT METHODS FOR NEW SERVICES.—In the case of services for which there is not a payment basis established under title XVIII of this Act, the Secretary shall establish payment rules that are similar to the payment rules for similar services under such title.

"(3) ADJUSTMENT OF MEDICARE PAYMENT RATES.—

"(A) IN GENERAL.—For purposes of payment for inpatient hospital services, physicians' services, and other services under this title for which payment rates are established under title XVIII of this Act, the Secretary shall adjust the payment rates otherwise established under such title XVIII to take into account differences between the population served under that title and the population served by the State plan or enrolled under health benefit plans under title II of the HealthAmerica Act and such other appropriate factors (such as the special circumstances of hospitals the inpatients of which are

predominantly children) as the Secretary deems appropriate.

"(B) CONSULTATION.—In making adjustments under subparagraph (A), the Secretary shall consult with the Prospective Payment Assessment Commission with respect to inpatient hospital services and with the Physician Payment Review Commission with respect to physicians' services.

"(b) ALTERNATIVE METHODS.—In issuing regulations to establish national reimbursement levels under this section, a State may provide for alternative payment systems that apply rates and methodologies that are not employed in the Federal guidelines described in subsection (a) if such State meets in the aggregate for all health care providers in such State the requirements for national reimbursement levels described in this section.

"(c) PHASE-IN OF MEDICARE RATES.—In lieu of the rates established under the rules described in subsection (a) or (b), the payment of benefits under the State plan for AmeriCare shall be made in the same amounts and on the same basis as payment may be made with respect to comparable medical assistance under title XIX of this Act, and the provisions of such title shall apply to payment of benefits (and provision of services and charges thereon)

under this title in the same manner as such provisions apply to payment of comparable medical assistance under title XIX of this Act, except as follows:

"(1) With respect to prenatal and child delivery benefits and infant care benefits—

"(A) 50 percent of the rate differential beginning on the first day of the third full calendar year after the date of the enactment of this title.

"(B) 100 percent of the rate differential beginning on the first day of the fourth full calendar year after the date of the enactment of this title.

"(2) With respect to benefits described in section 2102(a)(7) and children outpatient and pediatric hospitalization benefits—

"(A) 50 percent of the rate differential beginning on the first day of the fifth full calendar year after the date of the enactment of this title.

"(B) 100 percent of the rate differential beginning on the first day of the sixth full calendar year after the date of the enactment of this title.

"(3) With respect to all other benefits described in section 2102—

"(A) 50 percent of the rate differential beginning on the first day of the seventh full calendar year after the date of the enactment of this title.

"(B) 100 percent of the rate differential beginning on the first day of the eighth full calendar year after the date of the enactment of this title.

For purposes of this subsection, the term 'rate differential' means with respect to each benefit the difference between the reimbursement rate as determined under subsection (a) or (b) and the reimbursement rate for comparable medical assistance determined under subsection (c).

"(d) NO JUDICIAL OR ADMINISTRATION REVIEW.—There shall be no administrative or judicial review of the payment rates or rules under this section (including adjustments made under this section).

"(e) UNIFORM CLAIMS AND BILLING FORM.—Each State plan shall require the use of any Federal Uniform Claims and Billing Form developed by the Federal Health Expenditure Board under section 1180(b). Additional information may be required by the State plan if approved by the Secretary.

"(f) UNIFORM IDENTIFICATION SYSTEM.—Each State plan shall require each health care provider to use the identification number (if any) such provider uses in furnishing services for which payment is made under title XVIII of this Act or such other identification number specified by the Secretary.

"(g) MULTI-STATE PROVIDERS.—Each State plan shall allow health care providers participating in AmeriCare to participate under any other State plan for AmeriCare.

"QUALITY AND COST-EFFECTIVE CARE MEASURES

"SEC. 2106. (a) APPLICATION OF PEER REVIEW ORGANIZATIONS.—

"(1) IN GENERAL.—The Secretary shall ensure that the quality control and peer review activities described in section 1165 are conducted in the manner prescribed in such section.

"(2) ADDITIONAL CRITERIA.—The Administrator of the Agency for Health Care Policy and Research shall, on an annual basis, and as otherwise determined by the Secretary, advise the Secretary concerning the incorporation of patient outcome measures and practice parameters with respect to care and services furnished under this title in conjunction with the quality control and peer review activities described in paragraph (1) of this subsection.

"(b) ALTERNATIVE DELIVERY AND ADMINISTRATIVE SYSTEMS.—A State may enter into a contract with a private entity or insurer or a State consortium (described under part D of title XI of this Act) to design and implement innovative systems of health care delivery and administrative systems that meet the standards of this title.

"(c) MANAGED CARE.—

"(1) IN GENERAL.—Each State plan shall, as part of AmeriCare, provide for managed care plans in accordance with the requirements of this subsection.

"(2) REQUIREMENTS.—In providing for managed care plans under this subsection, a State shall ensure that—

"(A) managed care plans are, to the extent practicable, selected through a competitive selection process;

"(B) an eligible individual under this title has an option to enroll in any of the managed care plans selected by the State offered by any qualified health care provider (as defined and determined by the Secretary);

"(C) an eligible individual who is receiving benefits under a managed care plan, may, not less often than annually, and without cause, ex-

ercise the option to discontinue receiving benefits under the managed care plan and receive coverage under an alternative plan under AmeriCare;

"(D) any arrangements for incentive payments for physicians under a managed care plan must comply with requirements for the provision of quality care that the Secretary shall prescribe by regulation, taking into account, at a minimum, quality care guidelines under title XVIII of this Act; and

"(E) a managed care plan shall provide for a system of rate assessment and adjustment that minimizes risk selection and segmentation (as defined and determined by the Secretary).

"(3) REGULATIONS.—The Secretary shall, not more than 180 days after the date of the enactment of this title, develop and establish by regulation, standards to ensure the quality of care under managed care plans under AmeriCare.

"(e) COST CONTAINMENT DEMONSTRATION PROJECTS.—

"(1) IN GENERAL.—The Secretary shall establish various demonstration projects to enable the States that submit an approved application, to im-

plement cost management initiatives that promote the effective furnishing of care under this title. Such cost management initiatives shall include:

"(A) Programs for contracting with community-based providers (as defined by the Secretary).

"(B) Financial incentives to encourage the delivery of high quality, cost effective managed care under subsection (d) of this section, including enhanced payment rates to States with a high percentage of individuals enrolled in managed care plans, to the degree such enrollment results in reduced Federal expenditures.

"(C) Case management, including case finding and the coordination of social and support services.

"(D) Financial incentives to encourage outreach programs.

"(E) Financial incentives to encourage the use of cost-effective services.

"(F) Measures to encourage an awareness of the costs associated with medical care, including nominal copayments (as determined by the Secretary) and the advantages of preventive care and other cost-effective types of care.

The Secretary shall require each State that submits an approved application to develop plans for conducting a demonstration project under this paragraph, in accordance with requirements that the Secretary shall establish by regulation.

"(2) ENHANCED COVERAGE DEMONSTRATION PROJECTS.—The Secretary may by waiver provide that a State plan for AmeriCare may include as benefits under such plan payment for all or part of the cost of services described in section 1915(c) (other than paragraph (3) thereof).

"ADMINISTRATION

"SEC. 2107. (a) ADMINISTRATION.—

"(1) IN GENERAL.—Subject to paragraph (3), each State shall provide for administration of this title in the same manner as it provides for administration of the plan established under section 1902(a) of this Act. In the administration of this title, the State agency designated under section 2101(a)(1) may delegate or contract with other public or private entities for the administration of the plan for AmeriCare.

"(2) NOTIFICATION OF AMERICARE; APPLICATION PROCESSING.—Any State that submits an application approved by the Secretary may contract with private entities or a State agency other than

the agency designated under section 2101(a)(1) to provide notification of AmeriCare to the residents of the State and process and review applications as required under section 2101(a)(6), and sections 2101(b) and 2104(d), respectively.

"(3) ELECTION.—A State, with such notice to the Secretary as the Secretary may require, may elect to have this title (insofar as it provides benefits with respect to individuals under section 2101(a)(2)) administered with respect to that State by the Secretary (or by such agent as the Secretary may designate). The Secretary may not accept such an election unless the State provides assurances satisfactory to the Secretary that the State will make payments to the Secretary toward the cost of implementing this title in the same amounts and at the same time as the State would make payments under this title but for the fact of such an election.

"(4) MULTI-STATE PROGRAMS.—Subject to the approval of the Secretary, any State may submit a joint plan for AmeriCare along with 1 or more other States to implement a regional administration of 1 plan for AmeriCare.

"(5) DATA COLLECTION.—Each State shall submit to the Secretary (in such form and manner

as the Secretary determines) for collection and analysis—

"(A) aggregate and per enrollee expenditures for each benefit covered under AmeriCare, including categorization by age, race, sex, and income level; and

"(B) uniform claims collection (by computer) that provide data to assist in the assessment of the amount, type, quality, and location of health care furnished through AmeriCare.

"(b) RIGHT TO REVIEW DENIED CLAIMS.—

"(1) NOTICE.—Each State plan for AmeriCare shall require that the State agency shall provide an individual with written notice concerning the denial of a claim submitted by such individual. Such notice shall include the reasons for such denial.

"(2) PROCESS FOR REVIEW.—Each State plan for AmeriCare shall utilize a fair process for the timely review of claims denied under such plan.

"(3) CLAIM FOR CARE NEEDED FOR LIFE-THREATENING ILLNESS.—In cases in which the failure to provide health care promptly would be life-threatening or result in a risk of permanent disability, the AmeriCare beneficiary shall be entitled to a decision as to whether care will be provided under

AmeriCare not later than 1 day after supplying the State with all requested information. In the event of a denial of coverage for such care, the beneficiary shall be entitled to an expedited review of an appeal of such denial within 5 days.

"(4) APPEALS.—Individuals shall be entitled to appeal the denial of a claim submitted by such individual to the State agency. The Secretary shall promulgate regulations establishing procedures to be utilized for appealing denials of claims under AmeriCare that are similar to the procedures established under title XVIII of this Act for appealing denials of claims under such title XVIII, including the right to a trial de novo.

"(c) ADMINISTRATIVE REGULATIONS.—

"(1) INCOME DETERMINATION.—The Secretary and the States shall develop and promulgate by regulation a system for the certifying of income and the reporting of changes of income by individuals within an appropriate period of time for the purposes of determining the amount of any premiums and copayments under section 2103 and the eligibility for supplemental payments of deductibles and other cost-sharing under section 2104, including the use of the social security identification number in tracking

such changes and verifying the information at least biannually. Such system shall include rules similar to the rules described in paragraphs (2) through (7) of section 2104(e), including a method for making adjustments for any overpayments or underpayments of such premiums, copayments, and supplemental payments.

"(2) NOTICE OF SUPPLEMENTAL PAYMENTS.—

"(A) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, shall, by regulation, require that each employer—

"(i) provide written notification forms to each employee outlining the availability of supplemental payments under AmeriCare in the State in which such employee resides as described in section 2104;

"(ii) coordinate the distribution of standard Federal application forms described in section 2104(d) in conjunction with the provision of written notification under paragraph (1);

"(iii) carry out the requirements of clauses (i) and (ii) without regard to the level of income of any employee.

"(B) CONTENTS OF NOTICE.—In promulgating the regulations described in subparagraph (A), the Secretary shall require the following information to be supplied in the written notification:

"(i) Information relating to the availability of supplemental payments on the basis of family income and size (prepared to coordinate with tax filing units or census information).

"(ii) Information concerning the amount of monthly supplemental payments.

"(c) FAILURE TO PRESCRIBE REGULATIONS.—The failure of the Secretary to prescribe any regulations under this title shall not relieve a State of any responsibility for complying with this title.

"DEFINITIONS AND SPECIAL RULES

"SEC. 2108. (a) DEFINITIONS.—As used in this title:

"(1) CHILD.—The term 'child' means an individual who—

"(A) is under 19 years of age;

"(B) is under 23 years of age and a full-time student; or

"(C) is, regardless of age, unmarried, dependent, and incapable of self-support as a re-

sult of a mental or physical disability that existed prior to the individual reaching 22 years of age.

"(2) EMPLOYEE.—The term 'employee' has the meaning given such term under section 2713(a)(2) of the Public Health Service Act.

"(3) EMPLOYER.—The term 'employer' has the meaning given such term under section 2713(a)(3) of the Public Health Service Act.

"(4) FAMILY.—The term 'family' means an individual, and any spouse or child of an individual. In determining if any individual is a child of another individual, rules similar to the rules of section 152(b)(2) of the Internal Revenue Code of 1986 shall apply.

"(5) HEALTH CARE PROVIDER.—The term 'health care provider' means any entity or person eligible to receive payments under titles XVIII and XIX of this Act.

"(6) MANAGED CARE PLAN.—

"(A) MANAGED CARE PLAN.—The term 'managed care plan' means a health benefit plan (as defined in section 1182(1)—

"(i) in which the insurer—

"(I) utilizes explicit standards for the selection and recertification of participating providers;

"(II) has organizational arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for its health services, which program (aa) stresses health outcomes, and (bb) provides review by physicians and other health professionals of the process followed in the provision of health services; and

"(III) contains significant incentives to use the participating providers and procedures provided for by the plan; and

"(ii) which, if it limits coverage of services to those provided by participating providers or permits deductibles and coinsurance with respect to basic health services provided by persons who are not participating providers which are in excess of those permitted under health benefit plans—

"(I) has a sufficient number and distribution of participating providers to assure that all covered items and services are (aa) available and accessible to each enrollee, within the area served by the plan, with reasonable promptness and in a manner which assures continuity, and (bb) when medically necessary, available and accessible twenty-four hours a day and seven days a week; and

"(II) provides benefits for covered items and services not furnished by participating providers if the items and services are medically necessary and immediately required because of an unforeseen illness, injury, or condition.

"(B) MANAGED CARE ENTITY.—The term 'managed care entity' means an insurer, health maintenance organization, preferred provider organization, dental plan organization, or other entity licensed to do business in a State, that markets managed care plans to groups or individuals or an employer, labor union, or other

State licensed entity that provides managed care plans for its employees or members.

"(C) PARTICIPATING PROVIDER.—The term 'participating provider' means a physician, hospital, health maintenance organization, pharmacy, laboratory, or other appropriately licensed provider of health care services or supplies, that has entered into an agreement with a managed care entity to provide such services or supplies to a patient enrolled in a managed care plan.

"(D) UTILIZATION REVIEW.—The term 'utilization review' means a program for reviewing the necessity and appropriateness of health care services provided or proposed to be provided to a patient.

"(7) MENTAL DISORDER.—The term 'mental disorder' has the same meaning given such term in the International Classification of Diseases, 9th Revision, Clinical Modification.

"(8) NEAR-POVERTY FAMILY.—The term 'near-poverty family' means a family whose income equals or exceeds 100 percent of the income official poverty line (as described in paragraph (1)), but is less than 200 percent of such income official poverty line.

"(9) PART-TIME EMPLOYEE.—The term 'part-time employee' has the meaning given such term under section 2713(a)(2)(G) of the Public Health Service Act.

"(10) SPECIAL ELIGIBILITY INDIVIDUALS.—The term 'special eligibility individual' means an individual who on the date of application for benefits under AmeriCare is—

"(A) a member of an under-poverty family; or

"(B) would have qualified for assistance under title IV of this Act or for medical assistance in the State of the individual's residence under title XIX of this Act (as in effect on the date of the enactment of this title);

"(C) or both.

"(11) STATE.—The term 'State' means the 50 States and the District of Columbia.

"(12) UNDER-POVERTY FAMILY.—The term 'under-poverty family' means a family whose income is less than 100 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation

Act of 1981) applicable to a family of the size involved.

"(b) DETERMINATIONS OF INCOME.—For the purposes of this title—

"(1) IN GENERAL.—The term 'income' means—

"(A) adjusted gross income (as defined in section 62(a) of the Internal Revenue Code of 1986), determined without the application of paragraphs (6) and (7) of such section and without the application of section 162(l) of such Code, plus

"(B) the amount of social security benefits (described in section 86(d) of such Code) which is not includable in gross income under section 86 of such Code.

"(2) FAMILY INCOME.—The term 'family income' means, with respect to an individual, the sum of the income for the individual and all the other family members.

"(3) FAMILY SIZE.—The family size to be applied under this title, with respect to family income, is the number of individuals included in the family for purposes of coverage of basic health benefits under AmeriCare or under a health benefit plan (as the case may be).

"(4) TIMING OF DETERMINATION.—Income shall be determined in accordance with one of the following methods, at the option of the applicant, for coverage under this title:

"(A) Multiplying by a factor of 4 the family income of the applicant for the 3-month period immediately preceding the month in which the application for coverage under this title is made.

"(B) Determining the family income of the applicant for the month in which the application for such coverage is made.

"PAYMENT TO STATES

"SEC. 2109. (a) IN GENERAL.—The Secretary shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1992—

"(1) an amount equal to the Federal insurance assistance percentage of the total amount expended during such quarter for benefits and supplemental payments under the State plan; plus

"(2) an amount equal to the administrative percentage of so much of the sums expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

"(b) FEDERAL INSURANCE ASSISTANCE PERCENTAGE.—

"(1) IN GENERAL.—For purposes of subsection (a)(1), the Federal insurance assistance percentage for any State shall be 100 percent less the State percentage.

"(2) STATE PERCENTAGE.—The State percentage for any State shall be equal to—

"(A) the State percentage determined under section 1905(b), minus

"(B) the applicable percentage of such State percentage.

"(c) ADMINISTRATIVE PERCENTAGE.—For purposes of subsection (a)(2), the administrative percentage for any State shall be—

"(1) 50 percent, plus

"(2) the applicable percentage of 50 percent.

"(d) APPLICABLE PERCENTAGE.—For purposes of this section, the term 'applicable percentage' means in the case of each quarter in the following full calendar years beginning after the date of the enactment of this title, the following percentage:

"Calendar year:	Applicable Percentage:
2nd	20
3rd	20
4th	15
5th	10
6th	5.

"AMERICARE TRUST FUND

"SEC. 2110. (a) CREATION OF TRUST FUND.—There is established in the Treasury of the United States a trust fund to be known as the 'AmeriCare Trust Fund' (hereafter in this section referred to as the 'Fund'), consisting of such gifts and bequests as may be made and such amounts as may be credited to the Fund under this section.

"(b) TRANSFERS TO FUND.—

"(1) IN GENERAL.—There are hereby appropriated to the Fund amounts equivalent to the net revenues received in the Treasury from—

"(A) contributions required by section 3601 of the Internal Revenue Code of 1986,

"(B) contributions made under section 2723(c)(2) of the Public Health Service Act,

"(C) AmeriCare premiums (as defined in section 2104(6)) collected by employers on behalf of employees, and

"(D) penalties collected under section 2732 of the Public Health Service Act.

"(2) TRANSFERS BASED ON ESTIMATES.—The amounts appropriated by subparagraphs (A), (B), and (C) shall be transferred from time to time (not less frequently than monthly) from the general fund

in the Treasury to the Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the amounts, specified in such subparagraphs, paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the amounts specified in such subparagraphs.

"(c) APPROPRIATION OF ADDITIONAL SUMS.—There are hereby authorized to be appropriated to the Fund such additional sums as may be required to make expenditures referred to in subsection (d).

"(d) EXPENDITURES FROM FUND.—

"(1) IN GENERAL.—For the purpose of establishing a public program to provide health insurance coverage to be known as 'AmeriCare', there are authorized and appropriated for each fiscal year from the Fund a sum sufficient to carry out the purpose of this title. The sums made available under this paragraph shall be used for making payments under section 2109 to States that have submitted, and had approved by the Secretary, a State plan for AmeriCare.

"(2) ALLOCATIONS.—Amounts described in subsection (b)(1) shall be allotted to each State

under paragraph (1) on the basis of amounts received in the Fund with respect to employees residing in such State.

"(3) ADDITIONAL FUNDS FOR ADMINISTRATIVE EXPENSES.—Amounts in the Fund shall be available, as provided in appropriation Acts, for the expenses of the Health Care Financing Administration or any other Federal agency designated by the Secretary in administering the provisions of this title.

"(e) INCORPORATION OF TRUST FUND PROVISIONS.—The provisions of subsections (b) through (i) of section 1841, as in effect on the day before the date of the enactment of this title, shall apply to the Fund in the same manner as such provisions apply to the Federal Supplemental Medical Insurance Trust Fund, except that any reference to the Secretary of Health and Human Services or the Administrator of the Health Care Financing Administration shall be deemed a reference to the Secretary of Health and Human Services.".

(b) ADMINISTRATIVE AND JUDICIAL REVIEW OF CERTAIN ADMINISTRATIVE DETERMINATIONS.—Section 1116 of the Social Security Act (42 U.S.C. 1316) is amended—

(1) by striking "or XIX" each place it appears and inserting "XIX, or XXI", and

(2) by striking "or 1904" in subsection (a)(3) and inserting "1904, or 2101(a)(14)".

(c) UTILIZATION AND QUALITY CONTROL PEER REVIEW ORGANIZATIONS.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following new section:

"REVIEW OF AMERICARE UNDER TITLE XXI

"SEC. 1165. (a) REVIEW OF AMERICARE UNDER TITLE XXI.—The Secretary shall provide, by regulation, for reviews of the programs under title XXI of this Act by utilization and quality control peer review organizations to be carried out in a similar manner as provided under this part for review of programs under title XVIII of this Act.

"(b) CLINICAL PRACTICE GUIDELINES.—In providing for the review of programs under title XXI of this Act as described in subsection (a), the Secretary shall, in consultation with recognized experts in the field of utilization and quality control review, ensure that, to the extent practicable, the reviews conducted under this section take into consideration clinical practice guidelines, (including guidelines for clinical practice and other standards developed by the Advisory Council for Health Care Policy, Research, and Evaluation pursuant to section 921 of the Public Health Service Act (42 U.S.C. 299b–1)).".

(d) CALCULATION OF FEDERAL INSURANCE ASSISTANCE PERCENTAGE APPLICABLE TO TITLE XXI.—

(1) IN GENERAL.—The Secretary of Health and Human Services (hereafter in this subsection referred to as the "Secretary"), in consultation with the chief executives of the States, shall develop recommendations for the calculation of a specific Federal insurance assistance percentage applicable to coverage furnished under title XXI of the Social Security Act (as added by this Act). In a recommended formula for the determination of such Federal insurance assistance percentage, the Secretary shall consider factors related to the following:

(A) Levels of employment.

(B) The population of individuals covered under AmeriCare under such title XXI.

(C) Poverty levels.

(D) Economic conditions.

(E) The distribution of urban and rural populations.

(F) Health indicators, such as infant mortality.

(2) EMERGENCY FUND.—The Secretary shall develop recommendations for the creation of an emergency fund to fund certain benefits under title

XXI of the Social Security Act (as added by this Act) in the event a State experiences changes in economic conditions or other conditions that the Secretary determines to necessitate emergency funding.

(3) REPORT.—Upon completion of the recommendations described in paragraphs (1) and (2), the Secretary shall submit a report to the appropriate committees of the Congress that includes such recommendations.

(e) REDUCTION IN PAYMENT FOR HOSPITALS RECEIVING A DISPROPORTIONATE SHARE ADJUSTMENT.—

(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary of Health and Human Services (hereafter in this subsection referred to as the "Secretary") shall for discharges occurring on or after the first day of the second full calendar year after the date of the enactment of this Act provide for a reduction in the payment of the disproportionate share adjustment percentage specified in section 1886(d)(5)(F) of the Social Security Act by ¼ (½, with respect to discharges occurring on or after the first day of the seventh such full calendar year) of what the payments to hospitals under such provision would have been but for the enactment of this subsection.

(2) APPLICATION FOR EXCEPTION.—

(A) IN GENERAL.—The Secretary shall, notwithstanding paragraph (1), provide for payment of the full disproportionate share adjustment percentage specified in section 1886(d)(5)(F) of the Social Security Act in any case in which a hospital applies to the Secretary for an exception from the reduction specified in paragraph (1) and it is determined by the Secretary that such hospital shall receive payments resulting from the enactment of title VI of this Act that are less than 200 percent of the amount of reduction of payments specified in paragraph (1) to such hospital.

(B) DETERMINATION CRITERIA.—In making a determination under subparagraph (A) the Secretary shall consider—

(i) the number of patients served by a hospital that are underinsured or uninsured and the costs to the hospital of providing services to such patients in the first full calendar year after the date of the enactment of this Act; and

(ii) such other relevant factors as the Secretary determines appropriate.

(C) CONSIDERATION OF APPLICATION.—In the case of a hospital that submits an application to the Secretary under this subsection at least 6 months before the first day of the second full calendar year after the date of the enactment of this Act, the Secretary shall make a determination with regard to such application prior to such first day. With respect to all other applications submitted to the Secretary under this subsection the Secretary shall make a determination with respect to such application no later than 6 months after the date of receipt of such application.

(D) APPEAL OF DETERMINATION.—A hospital submitting an application to the Secretary under this subsection may appeal a determination by the Secretary to the Provider Reimbursement Review Board established under section 1878 of the Social Security Act and the provisions of such section shall apply to any such appeal.

(f) COORDINATION WITH TITLE XIX.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by adding at the end the following new section:

"COORDINATION WITH TITLE XXI

"SEC. 1930. (a) The provision of medical assistance under this title shall not apply to any individual eligible for coverage under AmeriCare under title XXI of this Act.

"(b) The Secretary shall, by regulation, provide for appropriate coordination of this title with title XXI of this Act.".

(g) INCREASE IN TITLE XIX CAP FOR TERRITORIES.—Subsection (c) of section 1108 of the Social Security Act (42 U.S.C. 1308) is amended by adding at the end thereof the following new flush sentence:

"Notwithstanding the preceding sentence, for each fiscal year beginning after the date of the enactment of the HealthAmerica Act each amount under subclause (C) of each clause of such sentence shall be increased by the AmeriCare percentage increase for the preceding fiscal year. For purposes of the preceding sentence, the AmeriCare percentage increase equals the percentage increase (if any) in the total Federal program costs of title XXI of this Act over such costs of title XIX of this Act (as determined in the fiscal year preceding the effective date of the HealthAmerica Act) for all States.".

(h) EFFECTIVE DATE.—The amendments made by this title shall take effect on the first day of the second full calendar year beginning after the date of the enact-

ment of this Act, without regard to whether regulations to implement such amendments are promulgated by such day.

TITLE VII—DEVELOPMENT OF HEALTH SERVICE CAPACITY

SEC. 701. GRANTS FOR EXPANSION OF AVAILABILITY OF PRIMARY CARE SERVICES.

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

"Subpart V—Emergency Health Care Grant Programs

"SEC. 340D. GRANTS FOR EXPANSION OF AVAILABILITY OF PRIMARY CARE SERVICES.

"(a) IN GENERAL.—The Secretary shall award grants to eligible entities to expand the availability of comprehensive primary health services (as defined in section 330(b)(1)) in medically underserved areas.

"(b) ELIGIBILITY.—To be eligible to receive a grant under this section an entity shall—

"(1) be—

"(A) a migrant or community health center that receives assistance under section 329 or 330;

"(B) be an entity that meets the requirements of section 329(a) of 330(a) for being a migrant or community health center, though not a recipient of a grant under either of such sections;

"(C) be an entity that does not meet the requirements of section 329(a) or 330(a) for being a migrant or community health center, but that provides assurances satisfactory to the Secretary, including subsequent demonstrable evidence, that such entity will meet the requirements of either such section not later than 2 years after receiving a grant under this section; or

"(D) be an entity that is eligible for a planning grant under sections 329(c) or 330(c); and

"(2) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

"(c) REVIEW OF APPLICATIONS; PRIORITY.—

"(1) REVIEW.—The Secretary shall develop a process and timetable for reviewing applications submitted under subsection (b)(2) to assure that, to the

extent practicable, all amounts appropriated under this section are awarded not later than 180 days after the beginning of each fiscal year.

"(2) PRIORITY.—In awarding grants under this section, the Secretary shall give priority to—

"(A) applicants that will use amounts received under such grant to provide services in areas with the greatest need for such services and in which the demand for such services can be expected to increase after the implementation of the HealthAmerica Act;

"(B) applicants with a demonstrated ability to expand their operations in the most efficient manner;

"(C) applicants that are migrant or community health centers receiving assistance under section 329 or 330, that propose to use amounts received under such grants to expand their operations, including expansion to new sites, to serve high impact areas (as defined in section 329(a)(5)) or medically underserved populations (as defined in section 330(b)(3)), that are not currently being served;

"(D) applicants that do not receive assistance under section 329 or section 330, but that

meet all requirements to receive funds under either of such sections, including, for the purpose of planning the establishment of new centers in areas of high need, entities eligible for planning grants under sections 329(c) and 330(c).

"(3) SECONDARY PRIORITY.—The Secretary shall give secondary priority in awarding grants under this section to applicants that—

"(A) propose to meet the requirements of section 329 or 330 within 2 years after the date on which the application is submitted; and

"(B) are serving or propose to serve such populations or areas that are not currently being served or have a proposal for such service pending.

"(d) USE OF AMOUNTS.—An entity receiving a grant under this section shall use amounts received under such grant to expand the availability of comprehensive primary health services (as defined in section 330(b)(1)) in medically underserved or high impact areas.

"(e) REIMBURSEMENT FROM OTHER SOURCES.—

"(1) IN GENERAL.—An entity receiving a grant under this section shall use any and all reimbursements received from other sources for services provided by such entity to—

"(A) compensate for the unreimbursed costs of providing services to patients;

"(B) expand the amounts and types of services furnished;

"(C) serve additional patients or areas; or

"(D) promote the recruitment, training, or retention of personnel.

"(2) RETURN OF UNUSED AMOUNTS.—Any amounts of the reimbursements referred to in paragraph (1) that are not used for the purposes described in such paragraph shall be returned to the Secretary, either directly or through adjustments in future grants, and shall be used by the Secretary to make additional or expanded grants under this section without regard to appropriations under subsection (h).

"(f) FAILURE TO COMPLY.—

"(1) TERMINATION OF PAYMENTS.—In the case of an entity that receives a grant under this section and fails to comply with the requirements of this section, the Secretary shall, after providing such entity with appropriate notice and an opportunity for a hearing, terminate the payment of amounts under such grant to such entity. The Secretary may termi-

nate grants to entities that fail to demonstrate good faith efforts to meet the requirements of this section.

"(2) ADDITIONAL POWERS OF THE SECRETARY.—In addition to terminating payments under paragraph (1), the Secretary may—

"(A) sell any property acquired by the entity with amounts received under the grant, or transfer such property to another entity receiving such a grant; and

"(B) recoup (to the extent practicable) assistance previously provided to the entity under this section.

"(3) INELIGIBILITY FOR FUTURE GRANTS.—If an entity that is not in compliance with the requirements of this section may be granted a 2-year extension to meet such requirements. If at the end of such 2-year period the entity has failed to comply with such requirements, that entity shall be ineligible for further grants under this section.

"(g) ADMINISTRATION.—Not more than 10 percent of the amounts made available under this section may be used for administrative purposes. The costs of administration include—

"(1) the cost of providing, either directly or by grant or contract to nonprofit private entities that

represent the recipients of grants under this section, for the identification of areas and populations eligible for assistance under this section; and

"(2) the provision of technical assistance to entities for the planning, development and operation of the service delivery systems supported under this section.

"(h) AUTHORIZATION OF APPROPRIATIONS.—

"(1) IN GENERAL.—There are authorized to be appropriated and there are appropriated to carry out this section—

"(A) $58,000,000 for fiscal year 1992;

"(B) $166,000,000 for fiscal year 1993;

"(C) $266,000,000 for fiscal year 1994;

"(D) $350,000,000 for fiscal year 1995; and

"(E) $426,000,000 for fiscal year 1996.

"(2) REPORT.—Not later than September 30, 1995, the Secretary shall prepare and submit to the appropriate committees of Congress a report concerning the need for further migrant and community health center primary care service capacity development and recommendations concerning the appropriate level of support needed for activities to address such capacity development.

"(3) ADDITIONAL AMOUNTS.—Amounts provided under this section shall be in addition to any amounts appropriated under sections 329 and 330.".

TITLE VIII—EFFECTIVE DATE

SEC. 801. EFFECTIVE DATE.

(a) GENERAL RULE.—Except as otherwise provided in this section, titles I and II of this Act shall take effect on January 1 of the second full year that begins after the date of the enactment of this Act.

(b) EXISTING PLANS.—In the case of an employer that, on the date of the enactment of this Act, has in effect a health insurance plan covering the employees of such employer, the amendments made by titles I and II shall not apply to such employer until the date described in subsection (a) or the first day of the second full year after the date of the enactment of this Act, whichever is later.

(c) STATE AND LOCAL GOVERNMENTS.—In the case of an employer whose revenue is raised by a taxing authority, a health insurance plan covering the employees of such employer shall not be required to meet the requirements of part B of title XXVII of the Public Health Service Act until the first day of the third full year after the date of the enactment of this Act. During the period beginning on the effective date prescribed under subsections (a) and (b) and ending on the first day of such third full plan

year, employee participation in such plan shall be voluntary unless otherwise required by the plan.

SEC. 802. POLICY RESPECTING ADDITIONAL BENEFITS.

(a) IN GENERAL.—After the date of the enactment of this Act, no employer shall be required under part B of title XXVII of the Public Health Service Act to provide any health benefit in addition to the benefits required to be provided under section 2721(a) of such Act (as in effect on the date of the enactment of this Act) unless—

(1) such additional health benefit is for a service that the AmeriCare plans (under title XXI of the Social Security Act) are required to cover; and

(2) before the enactment of such requirement, the benefits and costs of requiring the provision of such additional health benefit have been analyzed and considered by Congress.

(b) REPORTS.—

(1) IN GENERAL.—In carrying out subsection (a)(2) with respect to the consideration of a proposed additional health benefit, Congress shall request a report from the Institute of Medicine of the National Academy of Sciences or a public or nonprofit entity with expertise relating to health benefits. Any such report shall—

(A) analyze and summarize such proposed additional health benefit; and

(B) contain an estimate of the economic and health impacts of such proposed additional health benefit.

(2) CONSULTATION.—Any such report shall be prepared in consultation with interested members of the public and with individuals and entities having expertise with respect to such proposed additional health benefit.

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102D CONGRESS
1ST SESSION

S. 700

To amend the Internal Revenue Code of 1986 to impose an excise tax on insurance companies not meeting certain requirements with respect to health insurance provided to small employers.

IN THE SENATE OF THE UNITED STATES

MARCH 20 (legislative day, FEBRUARY 6), 1991

Mr. DURENBERGER (for himself, Mr. MCCAIN, Mr. WALLOP, and Mr. JEFFORDS) introduced the following bill; which was read twice and referred to the Committee on Finance

---

A BILL

To amend the Internal Revenue Code of 1986 to impose an excise tax on insurance companies not meeting certain requirements with respect to health insurance provided to small employers.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the "American Health Security Act of 1991".

SEC. 2. FAILURE TO SATISFY CERTAIN STANDARDS FOR HEALTH INSURANCE PROVIDED TO SMALL EMPLOYERS.

(a) IN GENERAL.—Chapter 47 of the Internal Revenue Code of 1986 (relating to excise taxes on qualified pension, etc. plans) is amended by adding at the end thereof the following new subchapter:

"Subchapter B—Health Insurance Provided to Small Employers

"Sec. 5000A. Failure to satisfy standards for health insurance of small employers.
"Sec. 5000B. General issuance requirements.
"Sec. 5000C. Specific contractual requirements.
"Sec. 5000D. State compliance agreements.
"Sec. 5000E. Definitions and other rules.

"SEC. 5000A. FAILURE TO SATISFY CERTAIN STANDARDS FOR HEALTH INSURANCE OF SMALL EMPLOYERS.

"(a) GENERAL RULE.—In the case of any person issuing applicable accident and health insurance contracts, there is hereby imposed a tax on the failure of such person to meet at any time during any taxable year—

"(1) the general issuance requirements of section 5000B, or

"(2) the specific contractual requirements of section 5000C.

"(b) AMOUNT OF TAX.—

"(1) IN GENERAL.—The amount of tax imposed by subsection (a) by reason of 1 or more failures during a taxable year shall be equal to 20 percent of the gross premiums received during such taxable year with respect to all accident and health insurance contracts issued by the person on whom such tax is imposed.

"(2) GROSS PREMIUMS.—For purposes of paragraph (1), gross premiums shall include any consideration received with respect to any accident and health insurance contract.

"(c) LIMITATION ON TAX.—

"(1) TAX NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No tax shall be imposed by subsection (a) with respect to any failure for which it is established to the satisfaction of the Secretary that the person on whom the tax is imposed did not know, or exercising reasonable diligence would not have known, that such failure existed.

"(2) TAX NOT TO APPLY WHERE FAILURES CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) with respect to any failure if—

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

"(B) such failure is corrected during the 30-day period beginning on the 1st date any of the persons on whom the tax is imposed knew, or exercising reasonable diligence would have known, that such failure existed.

"(3) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a).

"(d) LIABILITY FOR TAX.—The person issuing the applicable accident and health contract with respect to which a failure occurs shall be liable for the tax imposed by subsection (a).

"SEC. 5000B. GENERAL ISSUANCE REQUIREMENTS.

"(a) GENERAL RULE.—The requirements of this section are met if a person meets—

"(1) the mandatory policy requirements of subsection (b), and

"(2) the guaranteed issue requirements of subsection (c).

"(b) MANDATORY POLICY REQUIREMENTS.—

"(1) IN GENERAL.—The requirements of this subsection are met if any person issuing accident

and health contracts to any eligible small employers makes available to such eligible small employers—

"(A) an accident and health contract which provides benefits which are identical to the benefits under the core Medplan described in subsection (d), and

"(B) an accident and health contract which provides benefits which are identical to the benefits under the standard Medplan described in subsection (d).

A person shall not be treated as failing to meet the requirements of this paragraph if the deductible and copayment requirements are less than those in the core or standard Medplan.

"(2) PRICING AND MARKETING REQUIREMENTS.—The requirements of paragraph (1) are not met unless—

"(A) the price at which the contract described in paragraph (1) is made available is not greater than the price for such contract determined on the same basis as prices for other accident and health contracts within the same class of business made available by the person to eligible small employers, and

"(B) such contract is made available to eligible small employers using at least the marketing methods and other sales practices which are used in selling such other contracts.

"(c) GUARANTEED ISSUE.—

"(1) IN GENERAL.—The requirements of this subsection are met if the person offering applicable accident and health insurance contracts to eligible small employers issues such contracts to any eligible small employer seeking to enter into such a contract.

"(2) FINANCIAL CAPACITY EXCEPTION.—Paragraph (1) shall not require any person to issue a contract to the extent that the issuance of such contract would result in such person violating the financial solvency standards (if any) established by the State in which such contract is to be issued.

"(3) EXCEPTIONS FOR CERTAIN EMPLOYERS.—Paragraph (1) shall not apply to a failure to issue a contract to an eligible small employer if—

"(A) such employer is unable to pay the premium for such contract, or

"(B) in the case of an eligible employer with fewer than 15 employees, such employer fails to enroll at least 60 percent of the employ-

er's eligible employees for coverage under such contract.

"(d) MEDPLAN.—For purposes of this section—

"(1) CORE MEDPLAN.—The term 'core Medplan' means an accident and health plan which provides the core benefits described in paragraph (3).

"(2) STANDARD MEDPLAN.—The term 'standard Medplan' means an accident and health plan which provides—

"(A) the core benefits described in paragraph (3), and

"(B) the supplemental benefits described in paragraph (4).

"(3) CORE BENEFITS.—The term 'core benefits' means benefits for any of the following which are determined to be medically necessary:

"(A) Inpatient and outpatient hospital services.

"(B) Inpatient and outpatient surgical services.

"(C) Inpatient and outpatient physicians' services.

"(D) Diagnostic and screening services.

"(E) Prenatal care.

"(F) Ambulance services.

"(G) Durable medical equipment.

Such term does not include a supplemental benefit.

"(4) SUPPLEMENTAL BENEFITS.—The term 'supplemental benefits' means benefits—

"(A) for inpatient or outpatient treatment for a mental disorder, or

"(B) for inpatient and outpatient treatment of a chemical dependency disorder.

"(5) DEDUCTIBLES AND COPAYMENTS.—A plan shall not be treated as providing the benefits described in paragraphs (3) and (4) unless the following requirements are met:

"(A) The plan does not require—

"(i) a deductible amount for any plan year in excess of $500 per individual and $1,000 per family, and

"(ii) a deductible amount for any plan year for prenatal care.

"(B) The plan does not require out-of-pocket expenses for any plan year in excess of $3,000 per individual and $6,000 per family.

"(C) The amount of any copayment required to be paid by an employee for any core benefits does not exceed—

"(i) 20 percent for core benefits described in subparagraphs (A), (B), (C), (D), and (E) of paragraph (2),

"(ii) 50 percent for core benefits described in subparagraphs (F) and (G) of paragraph (2).

"(D) The amount of any copayment required to be paid by an employee for supplemental benefits does not exceed 50 percent.

"(E) The plan provides benefits of not less than 45 days for supplemental benefits which are provided on an inpatient basis and not less than 25 visits for supplemental benefits provided on an outpatient basis.

"SEC. 5000C. SPECIFIC CONTRACTUAL REQUIREMENTS.

"(a) GENERAL RULE.—The requirements of this section are met if, with respect to any applicable accident and health insurance contract, the following requirements are met:

"(1) The coverage requirements of subsection (b).

"(2) The rating requirements of subsection (c).

"(3) The disclosure and recordkeeping requirements of subsection (d).

"(b) COVERAGE REQUIREMENTS.—

"(1) IN GENERAL.—The requirements of this subsection are met with respect to any applicable accident and health contract if, under the terms and operation of the contract, the following requirements are met:

"(A) GUARANTEED ELIGIBILITY.—No eligible employee (and the spouse or any dependent child of the employee eligible for coverage) may be excluded from coverage under the contract.

"(B) LIMITATIONS ON COVERAGE OF PREEXISTING CONDITIONS.—Any limitation under the contract on any preexisting condition—

"(i) may not extend beyond the 6-month period beginning with the date an insured is first covered by the contract, and

"(ii) may only apply to preexisting conditions which manifested themselves, or for which medical care or advice was sought or recommended, during the 3-month period preceding the date an insured is first covered by the contract.

"(C) GUARANTEED RENEWABILITY.—

"(i) IN GENERAL.—The contract must be renewed at the election of the eligible small employer unless the contract is terminated for cause.

"(ii) CAUSE.—For purposes of this subparagraph, the term 'cause'—

"(I) includes nonpayment of premiums, fraud or misrepresentation, noncompliance with plan provisions (including participation requirements), or misuse of network provisions, but

"(II) does not include any reason related to risk characteristics.

"(2) WAITING PERIODS.—Paragraph (1)(A) shall not apply to any period an eligible employee is excluded from coverage under the contract solely by reason of a requirement applicable to all employees that a minimum period of service with the employer is required before the employee is eligible for such coverage.

"(3) DETERMINATION OF PERIODS FOR RULES RELATING TO PREEXISTING CONDITIONS.—For purposes of paragraph (1)(B), the date on which an insured is first covered by a contract shall be the earlier of—

"(A) the date on which coverage under such contract begins, or

"(B) the first day of any continuous period—

"(i) during which the insured was covered under 1 or more other health insurance arrangements, and

"(ii) which does not end more than 120 days before the date employment for the employer begins.

"(4) CESSATION OF SMALL EMPLOYER HEALTH INSURANCE BUSINESS.—

"(A) IN GENERAL.—Except as otherwise provided in this paragraph, a person shall not be treated as failing to meet the requirements of paragraph (1)(C) if such person terminates the class of business which includes the applicable accident and health insurance contract.

"(B) NOTICE REQUIREMENT.—Subparagraph (A) shall apply only if the person gives notice of the decision to terminate at least 90 days before the expiration of the contract.

"(C) 5-YEAR MORATORIUM.—If, within 5 years of the year in which a person terminates a class of business under subparagraph (A),

such person establishes a new class of business which includes contracts within the class of business so terminated, the issuance of such contracts in that year shall be treated as a failure to which this section applies.

"(D) TRANSFERS.—If, upon a failure to renew a contract to which subparagraph (A) applies, a person transfers such contract to another class of business, such transfer must be made without regard to any risk characteristic.

"(c) RATING REQUIREMENTS.—

"(1) IN GENERAL.—The requirements of this subsection are met with respect to any applicable accident and health insurance contract if—

"(A) the premium rate or rates under the contract are within the acceptable premium range, and

"(B) any increase in any premium rate under the renewal contract over the corresponding rate under the contract being renewed does not exceed the applicable annual adjusted increase.

"(2) ACCEPTABLE PREMIUM RANGE.—For purposes of paragraph (1)(A)—

"(A) IN GENERAL.—The acceptable premium range includes premium rates which are not more than 120 percent, or less than 80 percent, of the lowest index rate for all classes of business of the issuer which include applicable accident and health insurance contracts.

"(B) INDEX RATE.—For purposes of subparagraph (A), the term 'index rate' means, with respect to any class of business, 50 percent of the sum of—

"(i) the lowest premium rate, determined under the rating system for the rating period which covers the contract, which may be charged by the person issuing the contract for substantially similar coverage to employers with similar case characteristics (other than risk characteristics) as the employer under the contract to which paragraph (1) is being applied, plus

"(ii) the highest premium rate which may be so charged.

"(C) RANGE MAY BE DETERMINED BY SECRETARY.—In the case of any class of business covering applicable accident and health insurance contracts—

"(i) with respect to which employers who are eligible are not, and have never been, rejected for coverage on the basis of risk characteristics as defined under section 5000C(b)(2)(B),

"(ii) to which business may not be involuntarily transferred from another class of business, and

"(iii) which is currently available for purchase,

the acceptable premium range with respect to such contracts shall be the range (if any) established by the Secretary in accordance with the principles of this subsection.

"(3) APPLICABLE ANNUAL ADJUSTED INCREASE.—

For purposes of paragraph (1)(B)—

"(A) IN GENERAL.—The applicable annual adjusted increase is an amount equal to the sum of—

"(i) the applicable percentage of the premium rate under the contract being renewed, plus

"(ii) any increase in the rate under the renewal contract due to any change in

coverage or to any change of case characteristics (other than risk characteristics).

"(B) APPLICABLE PERCENTAGE.—

"(i) IN GENERAL.—For purposes of subparagraph (A), the applicable percentage is the percentage (if any) by which—

"(I) the premium rate for newly issued contracts for substantially similar coverage for an employer with similar case characteristics (other than risk characteristics) as the employer under the applicable accident and health contract (determined on the 1st day of the rating period applicable to such contracts), exceeds

"(II) such rate on the 1st day of the rating period applicable to the contract being renewed.

"(ii) CASES WHERE NO NEW BUSINESS.—If no new contracts are being issued for a class of business during any rating period, the applicable percentage shall be the percentage (if any) by which the lowest premium rate determined under paragraph (2)(B)(i) with respect to the re-

newal contract exceeds such rate for the contract to be renewed.

"(d) DISCLOSURE AND RECORDKEEPING, ETC. REQUIREMENTS.—The requirements of this subsection are met if—

"(1) DISCLOSURE.—Any person issuing an applicable accident and health insurance contract includes in any sales materials the following:

"(A) The extent to which premium rates are based on risk characteristics and on factors other than risk characteristics.

"(B) The extent to which the person may change the premium rates.

"(C) The class of business within which the contract falls, including a description of the grouping of contracts within a class of business.

"(D) Provisions relating to renewability.

"(2) RECORDKEEPING, ETC.—Any person issuing an applicable accident and health insurance contract—

"(A) maintains at its principal place of business a complete and detailed description of its rating and renewal underwriting practices, and the information on which such practices are based, and

"(B) files with the Secretary each year an opinion of a qualified health actuary, based on a review of appropriate records, that the rating practices of such person for the preceding year are based upon commonly accepted actuarial assumptions and in accordance with the provisions of this section and sound actuarial principles.

For purposes of paragraph (2), the term 'qualified health actuary' means a member of the American Academy of Actuaries who is qualified by reason of prior and continuing education and relevant experience to render the actuarial opinion.

"SEC. 5000D. STATE COMPLIANCE AGREEMENTS.

"(a) AGREEMENTS.—The Secretary may, in his discretion, enter into an agreement with any State—

"(1) to apply the standards set by the laws of such State for applicable accident and health insurance contracts in lieu of the requirements of this subchapter, or

"(2) to provide for the State to make the initial determination as to whether a person is in compliance with the provisions of this subchapter.

"(b) STANDARDS.—An agreement may be entered into under subsection (a)(1) only if—

"(1) the chief executive officer of the State requests such agreement be entered into,

"(2) the Secretary determines that the State standards to be applied under the agreement will apply to substantially all applicable accident and health contracts issued in such State, and

"(3) the Secretary determines that the application of the State standards will carry out the purposes of this subchapter.

"(c) MEDPLAN REQUIREMENT MAY NOT BE WAIVED.—Any agreement entered into under subsection (a)(1) shall not waive the mandatory policy requirement under section 5000B(a)(1) (relating to offering of Medplan).

"(d) TERMINATION.—The Secretary shall terminate any agreement if the Secretary determines that the application of State standards ceases to carry out the purposes of this subchapter.

"SEC. 5000E. DEFINITIONS AND OTHER RULES.

"(a) APPLICABLE ACCIDENT AND HEALTH INSURANCE CONTRACT.—For purposes of this subchapter—

"(1) IN GENERAL.—The term 'applicable accident and health insurance contract' means a contract under which a person authorized under applicable State insurance law provides a health insur-

ance plan or arrangement to an eligible small employer. Such term does not include any self-insured plan of an employer.

"(2) CERTAIN CONTRACTS NOT COVERED.—The term 'applicable accident and health insurance contract' does not include any contract—

"(A) which provides for accident only, dental only, or disability only coverage,

"(B) which provides coverage as a supplement to liability insurance,

"(C) which provides insurance arising out of a workmens' compensation or similar law, or automobile medical-payment insurance, or

"(D) which provides insurance which is required by law to be contained under any self-insured plan of an employer.

"(3) EXCEPTION FOR SMALL ISSUERS.—The term 'applicable accident and health insurance contract' shall not include any contract issued during a taxable year by a person which had less than $1,000,000 in gross premiums from accident and health contracts during the preceding taxable year. For purposes of the preceding sentence, the aggregation rules of section 448(c) shall apply.

"(b) OTHER DEFINITIONS.—For purposes of this subchapter—

"(1) CLASS OF BUSINESS.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'class of business' means, with respect to accident and health insurance provided to eligible small employers, all accident and health insurance provided to such employers.

"(B) ESTABLISHMENT OF GROUPINGS.—An issuer may establish separate classes of business with respect to accident and health insurance provided to eligible small employers but only if such classes are based on 1 or more of the following:

"(i) Business marketed and sold through persons not participating in the marketing and sale of such insurance to other eligible small employers.

"(ii) Business acquired from other insurers as a distinct grouping.

"(iii) Business provided through an association of not less than 20 eligible small employers which was established for purposes other than obtaining insurance.

"(iv) Business related to managed health care arrangements.

"(v) Business within groupings under clauses (i) through (iv) which is based on risk selection or underwriting criteria expected to produce substantial variations in claims costs.

"(vi) Any other business which the Secretary determines needs to be separately grouped to prevent a substantial threat to the solvency of the insurer.

"(C) MANAGED HEALTH CARE ARRANGEMENT.—For purposes of subparagraph (B)(iv), the term 'managed health care arrangement' means an arrangement which integrates the financing and delivery of health care services to covered individuals by employing the following:

"(i) Contracts with selected health care providers to furnish health care services to members.

"(ii) The adoption of explicit standards for the selection and recertification of providers.

"(iii) An explicit, formal program for ongoing quality assurance and utilization review.

"(iv) Significant financial incentives for members to use the providers and procedures associated with the arrangement.

"(2) CHARACTERISTICS.—

"(A) IN GENERAL.—The term 'characteristics' means, with respect to any insurance rating system, the factors used in determining rates.

"(B) RISK CHARACTERISTICS.—The term 'risk characteristics' means factors related to the health risks of individuals, including health status, prior claims experience, the duration since the date of issue of a health insurance plan or arrangement, industry, and occupation.

"(C) GEOGRAPHIC FACTORS.—In applying geographic location as a characteristic, an insurer may not use for purposes of this subchapter areas smaller than Census Bureau designations of metropolitan statistical areas and nonmetropolitan statistical areas.

"(3) ELIGIBLE EMPLOYEE.—The term 'eligible employee' means any employee other than an em-

ployee who works less than 30 hours per week. For purposes of this paragraph, the term 'employee' includes a self-employed individual as defined in section 401(c)(1).

"(4) ELIGIBLE SMALL EMPLOYER.—The term 'eligible small employer' means an employer who normally employed more than 1 but not more than 50 eligible employees on a normal business day. For purposes of the preceding sentence, all employers covered under the same health insurance plan or arrangement covered by a contract shall be treated as 1 employer."

(b) CONFORMING AMENDMENT.—So much of chapter 47 of the Internal Revenue Code of 1986 as precedes section 5000 is amended to read as follows:

"CHAPTER 47—CERTAIN GROUP HEALTH PLANS

"SUBCHAPTER A. Nonconforming group health plans.
"SUBCHAPTER B. Health insurance provided to small employers.

"Subchapter A—Nonconforming Group Health Plans

"Sec. 5000. Certain group health plans."

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to contracts issued, or renewed, after the date of the enactment of this Act.

(2) GUARANTEED ISSUE.—The provisions of section 5000B(c) of the Internal Revenue Code of 1986 shall apply to contracts which are issued, or renewed, after the date which is 18 months after the date of the enactment of this Act.

(3) PREMIUM RANGE.—In the case of any contract in effect on the date of the enactment of this Act, the provisions of section 5000C(c)(1)(A) of such Code shall not apply to the premiums under such contract or any renewal contract for benefits provided during the period beginning on such date and ending on the last day of the 2nd plan year beginning after such date.

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102D CONGRESS
1ST SESSION

H. R. 2121

To amend the Internal Revenue Code of 1986 to impose an excise tax on premiums received on health insurance policies which do not meet certain requirements.

IN THE HOUSE OF REPRESENTATIVES

APRIL 29, 1991

Mr. STARK introduced the following bill; which was referred to the Committee on Ways and Means

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A BILL

To amend the Internal Revenue Code of 1986 to impose an excise tax on premiums received on health insurance policies which do not meet certain requirements.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the "Health Insurance Reform Act of 1991".

SEC. 2. EXCISE TAX ON PREMIUMS RECEIVED ON HEALTH INSURANCE POLICIES WHICH DO NOT MEET CERTAIN REQUIREMENTS.

(a) IN GENERAL.—Chapter 47 of the Internal Revenue Code of 1986 (relating to excise taxes on qualified pension, etc. plans) is amended by adding at the end thereof the following new subchapter:

"Subchapter B—Health Insurance Standards

"Sec. 5000A. Failure to satisfy standards for health insurance.
"Sec. 5000B. General issuance requirements.
"Sec. 5000C. Specific contractual requirements.
"Sec. 5000D. Definitions.

"SEC. 5000A. FAILURE TO SATISFY CERTAIN STANDARDS FOR HEALTH INSURANCE.

"(a) GENERAL RULE.—In the case of any person issuing applicable accident and health insurance contracts, there is hereby imposed a tax on the failure of such person to meet at any time during any taxable year—

"(1) the general issuance requirements of section 5000B, or

"(2) the specific contractual requirements of section 5000C.

The Secretary of Health and Human Services shall determine whether any contract meets the requirements of such sections.

"(b) AMOUNT OF TAX.—

"(1) IN GENERAL.—The amount of tax imposed by subsection (a) by reason of 1 or more failures during a taxable year shall be equal to 100 percent of the gross premiums received during such taxable year with respect to all accident and health insurance contracts issued by the person on whom such tax is imposed.

"(2) GROSS PREMIUMS.—For purposes of paragraph (1), gross premiums shall include any consideration received with respect to any accident and health insurance contract.

"(c) LIMITATION ON TAX.—

"(1) TAX NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No tax shall be imposed by subsection (a) with respect to any failure for which it is established to the satisfaction of the Secretary that the person on whom the tax is imposed did not know, or exercising reasonable diligence would not have known, that such failure existed.

"(2) TAX NOT TO APPLY WHERE FAILURES CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) with respect to any failure if—

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

"(B) such failure is corrected during the 30-day period beginning on the 1st date any of the persons on whom the tax is imposed knew, or exercising reasonable diligence would have known, that such failure existed.

"(3) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a).

"(d) LIABILITY FOR TAX.—The person issuing the applicable accident and health contract with respect to which a failure occurs shall be liable for the tax imposed by subsection (a).

"SEC. 5000B. GENERAL ISSUANCE REQUIREMENTS.

"(a) GENERAL RULE.—The requirements of this section are met if a person meets—

"(1) the mandatory policy requirements of subsection (b), and

"(2) the guaranteed issue requirements of subsection (c).

"(b) MANDATORY POLICY REQUIREMENTS.—

"(1) IN GENERAL.—The requirements of this subsection are met if any person issuing accident

and health contracts to any employer makes available to such employer an accident and health contract which provides benefits which are identical to the core benefits described in subsection (d). A person shall not be treated as failing to meet the requirements of this paragraph if the deductible and copayment requirements are less than those in the core benefits.

"(2) OTHER REQUIREMENTS.—The requirements of paragraph (1) are not met unless—

"(A) the contract provides continuous full-year open enrollment (including conversions),

"(B) the premiums for coverage under the contract are determined on the basis of the average per capita cost of providing coverage to all individuals covered under applicable accident and health insurance contracts issued by the person issuing such contract, and

"(C) individuals leaving the group covered by the contract are offered the option to convert to individual coverage at not more than 150 percent of the usually applicable community rate for the State in which the contract was issued, without any waiting period, without re-

gard to health, and without regard to the size of the group.

"(c) GUARANTEED ISSUE.—

"(1) IN GENERAL.—The requirements of this subsection are met if the person offering applicable accident and health insurance contracts issues such contracts to any employer seeking to enter into such a contract.

"(2) EXCEPTIONS FOR CERTAIN EMPLOYERS.—Paragraph (1) shall not apply to a failure to issue a contract to an eligible employer if such employer is unable to pay the premium for such contract.

"(d) BENEFITS.—For purposes of this section—

"(1) CORE BENEFITS.—The term 'core benefits' means benefits which are the same benefits as are provided under title XVIII of the Social Security Act to individuals entitled to benefits under part A, and enrolled under part B, of such title.

"(2) DEDUCTIBLES AND COPAYMENTS.—A plan shall not be treated as providing the core benefits described in paragraph (1) unless the following requirements are met:

"(A) $500 DEDUCTIBLE PER INDIVIDUAL.—The plan does not require a deductible

amount for any plan year in excess of $500 per individual with respect to such benefits.

"(B) LIMIT ON OUT-OF-POCKET EXPENSES.—The plan does not require out-of-pocket expenses for any plan year in excess of $2,500 per individual for such benefits.

"(C) CHILDREN.—

"(i) NO DEDUCTIBLES OR COINSURANCE.—In the case of children, there shall be no coinsurance, deductibles, or copayments applicable to covered benefits described in clause (ii).

"(ii) ADDITIONAL PREVENTIVE BENEFITS.—Subject to the periodicity schedule established with respect to the services under this clause, for children benefits shall be available under the plan for the following items and services:

"(I) Newborn and well-baby care, including normal newborn care and pediatrician services for high-risk deliveries.

"(II) Well-child care, including routine office visits, routine immunizations (including the vaccine itself),

routine laboratory tests, and preventive dental care.

The Secretary of Health and Human Services, in consultation with the American Academy of Pediatrics, shall establish a schedule of periodicity which reflects the general, appropriate frequency with which services listed in the preceding sentence should be provided to healthy children.

"(iii) CHILD DEFINED.—For purposes of this subparagraph, the term 'child' means an individual who has not attained age 23.

"(D) PREGNANCY-RELATED SERVICES.—

"(i) IN GENERAL.—In the case of a pregnant woman, benefits under the plan shall include entitlement to have payment made for the following, without the application of deductibles, coinsurance, or copayments, subject to the periodicity schedule established with respect to the services under clause (ii):

"(I) Prenatal care, including care for all complications of pregnancy.

"(II) Inpatient labor and delivery services.

"(III) Postnatal care.

"(IV) Postnatal family planning services.

"(ii) PERIODICITY SCHEDULE.—The Secretary of Health and Human Services, in consultation with the American College of Obstetrics and Gynecology, shall establish a schedule of periodicity which reflects the general, appropriate frequency with which services listed in clause (i) should be provided to pregnant women without complications of pregnancy.

"(iii) PREGNANT WOMAN.—For purposes of this subparagraph, the term 'pregnant woman' means a woman who has been certified by a physician (in a manner specified by the Secretary) as being pregnant, until the last day of the month in which the 60-day period (beginning on the date of termination of the pregnancy) ends.

"(3) PREEMPTION.—No provision of State law shall apply that requires the offering, as part of an

applicable accident and health insurance contract that only provides for core benefits, of any services, category of care, or services of any class or type of provider other than core benefits.

"(4) TREATMENT OF MANAGED CARE.—Nothing in this section shall be construed as preventing an applicable accident and health insurance contract from—

"(A) providing benefits through a selected set of providers,

"(B) providing financial incentives for beneficiaries to use particular providers, or

"(C) providing for utilization review and controls over benefits.

"SEC. 5000C. SPECIFIC CONTRACTUAL REQUIREMENTS.

"(a) GENERAL RULE.—The requirements of this section are met if, with respect to any applicable accident and health insurance contract, the coverage requirements of subsection (b) are met.

"(b) COVERAGE REQUIREMENTS.—

"(1) IN GENERAL.—The requirements of this subsection are met with respect to any applicable accident and health contract if, under the terms and operation of the contract, the following requirements are met:

"(A) GUARANTEED ELIGIBILITY.—No eligible employee (and the spouse or any dependent child of the employee eligible for coverage) may be excluded from coverage under the contract.

"(B) LIMITATIONS ON COVERAGE OF PREEXISTING CONDITIONS.—

"(i) Any limitation under the contract on any preexisting condition may not extend beyond the 6-month period beginning with the date an insured is first covered by the contract.

"(ii) The contract offers full coverage for preexisting conditions of high-risk individuals without a price differential within a community, with reasonable waiting periods as determined or approved under State law or regulation, without cancellation of coverage for heavy usage, and without regard to age, income, or employment status of individuals under age 65.

"(C) GUARANTEED RENEWABILITY.—

"(i) IN GENERAL.—The contract must be renewed at the election of the employer unless the contract is terminated for cause.

"(ii) CAUSE.—For purposes of this subparagraph, the term 'cause'—

"(I) includes nonpayment of premiums, fraud or misrepresentation, noncompliance with plan provisions (including participation requirements), or misuse of network provisions, but

"(II) does not include any reason related to risk characteristics.

"(2) WAITING PERIODS.—Paragraph (1)(A) shall not apply to any period an eligible employee is excluded from coverage under the contract solely by reason of a requirement applicable to all employees that a minimum period of service with the employer is required before the employee is eligible for such coverage.

"SEC. 5000D. DEFINITIONS.

"(a) APPLICABLE ACCIDENT AND HEALTH INSURANCE CONTRACT.—For purposes of this subchapter—

"(1) IN GENERAL.—The term 'applicable accident and health insurance contract' means a contract under which a person authorized under applicable State insurance law provides a health insurance plan or arrangement to any group consisting of more than 3 individuals. Such term does not include

any self-insured plan of an employer and does not include a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act).

"(2) CERTAIN CONTRACTS NOT COVERED.—The term 'applicable accident and health insurance contract' does not include any contract—

"(A) which provides for accident only, dental only, or disability only coverage,

"(B) which provides coverage as a supplement to liability insurance,

"(C) which provides insurance arising out of a workmens' compensation or similar law, or automobile medical-payment insurance, or

"(D) which provides insurance which is required by law to be contained under any self-insured plan of an employer.

"(b) ELIGIBLE EMPLOYEE.—For purposes of this subchapter, the term 'eligible employee' means any employee other than an employee who works less than 30 hours per week. For purposes of this paragraph, the term 'employee' includes a self-employed individual as defined in section 401(c)(1)."

(b) CONFORMING AMENDMENT.—So much of chapter 47 of the Internal Revenue Code of 1986 as precedes section 5000 is amended to read as follows:

"CHAPTER 47—CERTAIN GROUP HEALTH PLANS

"SUBCHAPTER A. Nonconforming group health plans.
"SUBCHAPTER B. Health insurance standards.

"Subchapter A—Nonconforming Group Health Plans

"Sec. 5000. Certain group health plans."

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to contracts issued, or renewed, after the date of the enactment of this Act.

(2) GUARANTEED ISSUE.—The provisions of section 5000B(c) of the Internal Revenue Code of 1986 shall apply to contracts which are issued, or renewed, after the date which is 18 months after the date of the enactment of this Act.

SEC. 3. HEALTH REINSURANCE TRUST FUND.

(a) IN GENERAL.—Subchapter A of chapter 98 of the Internal Revenue Code of 1986 (relating to trust fund code) is amended by adding at the end thereof the following new section:

"SEC. 9511. HEALTH REINSURANCE TRUST FUND.

"(a) ESTABLISHMENT.—There is hereby created in the Treasury of the United States a trust fund to be

known as the 'Health Reinsurance Trust Fund', consisting of such amounts as may be appropriated or credited to such Trust Fund as provided in this section or section 9602(b).

"(b) TRANSFERS TO TRUST FUND.—There are hereby appropriated to the Health Reinsurance Trust Fund amounts equivalent to—

"(1) the taxes received in the Treasury under section 5000A (relating to failure to satisfy certain standards for health insurance), and

"(2) the taxes received in the Treasury under section 5000F (relating to health insurance stop-loss excise tax).

"(c) EXPENDITURES FROM TRUST FUND.—

"(1) IN GENERAL.—Amounts in the Health Reinsurance Trust Fund shall be available—

"(A) to provide reimbursement to qualified plans for payments under the plan for core benefits for any individual after the plan has expended $25,000 in any year for such benefits for the individual, and

"(B) for the payment of all expenses of administration incurred by the Department of Health and Human Services in carrying out subparagraph (A).

The Secretary of Health and Human Services shall provide a procedure for qualified plans obtaining benefits under subparagraph (A).

"(2) QUALIFIED PLAN DEFINED.—For purposes of this section—

"(A) IN GENERAL.—The term 'qualified plan' means an accident and health insurance contract that—

"(i) is issued by a person in compliance with section 5000B,

"(ii) meets the specific contractual requirements of section 5000C, and

"(iii) has applied to the Secretary of Health and Human Services, in a form and manner specified by the Secretary, to obtain benefits under this subsection.

"(B) INCLUSION OF SELF-INSURED PLANS AND QUALIFIED HMOS.—The term 'qualified plan' also includes—

"(i) any self-insured plan of an employer, and

"(ii) any qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act),

if the plan or organization provides benefits which include at least the core benefits (as defined in section 5000B(d)) for every individual covered under the plan.".

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

"Sec. 9511. Health Reinsurance Trust Fund."

SEC. 4. HEALTH INSURANCE STOP-LOSS EXCISE TAX.

(a) IN GENERAL.—Chapter 47 of the Internal Revenue Code of 1986 (relating to certain group health plans) is amended by adding at the end thereof the following new subchapter:

"Subchapter C—Health Insurance Stop-Loss Tax

"Sec. 5000F. Imposition of tax.

"SEC. 5000F. IMPOSITION OF TAX.

"(a) GENERAL RULE.—There is hereby imposed on the providing of coverage by any qualified plan (as defined in section 9511(c)(2)) during the calendar year a tax equal to the prescribed amount with respect to each individual who is covered by such plan at any time during such year.

"(b) PRESCRIBED AMOUNT.—For purposes of subsection (a), the prescribed amount for any calendar year is the amount estimated by the Secretary to be minimum amount necessary to generate revenues to the Treasury

under this section which, when added to the revenues to the Treasury under section 5000A, will be equal to the estimated expenditures (as determined by the Secretary of Health and Human Services) of the Health Reinsurance Trust Fund during the following calendar year.

"(c) LIABILITY FOR TAX.—The qualified plan shall pay the tax imposed by this section."

(b) CLERICAL AMENDMENT.—The table of subchapters for such chapter 47 is amended by adding at the end thereof the following new item:

"Subchapter C. Health insurance stop-loss tax."

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to calendar years ending after the date of the enactment of this Act.

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COMPARISON OF SMALL GROUP INSURANCE REFORM PROPOSALS
Prepared by HCFA/OLP -- December 10, 1991

	ROSTENKOWSKI (H.R.3626)	BENTSEN (S.1872)	CHAFEE (S.1936)
Eligibility	2 - 50 employees, plus dependents; includes self-employed	2 - 50 employees, plus dependents; includes self-employed	3 - 49 employees, plus dependents; includes small employer purchasing group
Pooling Incentives	No provision	$10 M grant for each of 15 States	Grants to small employers meeting certain requirements
Employer Requirements	None	None	None
Pre-Existing Conditions	3 month look-back	3 month look-back	3 month look-back
	6 month waiting period; does not apply to newborns	6 month waiting period; does not apply to newborns	6 month waiting period
Availability	If carrier issues a plan to one small firm in an area, it must guarantee to issue that plan, (min. 12-month term) to all small firms in that area, year-round	State options: guarantee issue same plan to all small firms & reinsurance, or no guaranteed issue but mandatory allocation of high risk groups	Guaranteed issue standard plan developed by NAIC and approved by Sec.; or state opts to assure availability by NAIC model or state program approved by Sec.
	Must cover whole group	Must cover whole group	Must cover whole group
	Each insurer may set minimum participation standards, if uniform for employers of same size	Each insurer may set minimum participation standards, if uniform for firms of same size	Insurer may require firm with 15 employees or less to enroll a minimum percentage of eligible employees, if uniformly applied to same size employer
Renewability	Guaranteed renewable for at least 12 month period, except: not pay premium, fraud, not comply with participation, or insurer ceases all small employer health business in state	Guaranteed renewable except: not pay premium, fraud, not comply with participation, or insurer is ceasing all small firm health in state	Guaranteed renewable except: not pay premium, fraud, failure to comply with participation or employer contribution requirements, misuse of provider network, or insurer ceases that class of business
Minimum Benefits	If an insurer offers health insurance to a small employer, it must offer a standard plan consisting of same benefits as Medicare Parts A and B plus unlimited inpatient hospital services for children, pregnancy, and preventive services, cost-sharing requirements specified in bill	Insurers in small firm market must offer both basic and standard plans; basic: inpt. and outpt. hospital, physician, diagnostic, and preventive svcs.; standard: basic plus limited mental health; standard specifies limits on deductibles, co-pays, and out-of-pocket; basic requires limits but lets insurer set them	NAIC to develop model plan 1 year after enactment; Sec. approves (or develops plan) within 18 mos.; plan includes: basic hospital, medical, and surgical services (including preventive), "reasonable" beneficiary cost-sharing

	ROSTENKOWSKI (H.R.3626)	BENTSEN (S.1872)	CHAFEE (S.1936)
State Provider / Service Mandates	Pre-empts mandates only for standard plan offered to small employers	Pre-empts mandates only for standard and basic plans offered to small firms	Pre-empts mandates only for qualified small employer purchasing groups for plans meeting requirements of model plan
State Anti-Managed Care Legislation	No provision	Voluntary Federal certification of managed care/utilization review; if certified, State anti-managed care laws do not apply	Federal advisory committee develops standards for managed care plans; if plan meets standards, State anti-managed care laws are pre-empted
Effects Outside Small Group Market (Relating to Small Group Reform)	None	None for mandates; anti-managed care exception for certified managed care/UR applies to larger firms also	None for mandates; anti-managed care plan pre-emption applies to larger firms also
Initial Premiums in Same Class of Business	Community rating; may vary no more than 25% + or - average rate for age/gender/geography (not smaller than MSA); no variation permitted for health, experience, occupation, industry, and duration of coverage	Maximum of 20% + or - average rate (after 3 years, max. of 15% + or - average) for age/gender/geography; no variation permitted for health, experience, occupation, industry, and duration of coverage	Maximum of 20% + or - average rate for health, experience, occupation, industry, duration of cov., and geographic area; no limits for age/gender
Initial Premiums Between Different Classes	May vary up to 20% for age, gender, geography (not smaller than MSA); no variation for health, experience, occupation, industry, and duration of coverage	Up to 20% for age, gender, geography; no variation for health, experience, occupation, industry, and duration of coverage	Maximum of 20% + or - average rate for health, experience, occupation, industry, duration of cov., and geographic area; no limits for age/gender
Renewal Premiums	Trend plus 5%	Trend plus 5%	Trend, plus 5%, plus increase for changes in coverage or (non-risk) case characteristic
Reinsurance	No explicit provision (appears to be permissible under state authority)	State options: mandatory prospective reinsurance, voluntary prospective reinsurance, or mandatory allocation of high risk groups among insurers	NAIC to develop several models (including funding options) 120 days after enactment; states can choose NAIC model or variation approved by Sec
Enforcement	Standards set by Sec.; state regulatory program approved by Sec., with Sec. and GAO review; insurer registers with Sec. and each state; approved state (or Sec.) certifies insurer plans for small firms; excise tax for non-complying plans	NAIC develops standards by 9/30/92; Sec. approval (or standards by 12/31/92), state regulatory program subject to GAO and Sec. review and Sec. compliance cert.; insurer registers with each state; excise tax for non-complying plans	State may apply to Sec. to enter into an agreement where state will determine compliance of insurers with requirements; insurer may not use existing tax deduction for insurance contracts that do not meet requirements of bill

COMPARISON OF SMALL GROUP INSURANCE REFORM PROPOSALS
Prepared by HCFA/OLP -- December 10, 1991

	NAIC (BC/BS, HIAA)	JOHNSON (H.R. 1565)	DURENBERGER (S. 700)	MITCHELL (S. 1227)	STARK (H.R. 2121)
Eligibility	3 - 25 employees, plus dependents (states may vary numbers)	3 - 25 employees, plus dependents	2 - 50 employees, plus dependents	1 - 99 employees, plus dependents	3 employees or more, plus dependents (no upper limit)
Pooling Incentives	(Considering)	(No provision)	(No provision)	State purchasing consortia; State plan and grants from Sec.	(No Provision)
Employer Requirements	None (if employers offer coverage, insurer can set employee participation and employer contribution standards if state law permits)	After 1 year, employers must offer MEDACCESS plan but need not contribute anything to cost	None (insurers must make MEDPLANs available, but employers do not have to either offer or pay for insurance)	"Play or pay" provisions are triggered after 5 - 6 years for small firms if more than 25% of employees who were uninsured at enactment still are	None
Pre-Existing Conditions	6 month look-back	6 month look-back	3 month look-back	3 month look-back	No look-back specified
	12 month waiting period (Some Blues plans have no limits)	12 month waiting period	6 month waiting period	6 month waiting period (Neither applies to newborns or to anyone 6 years after enactment; employee buy-in during waiting period required)	"Reasonable" waiting period under state law or regulation, but not more than 6 months
Availability	Support guaranteed availability, not necessarily guaranteed issue by all carriers	If offer small group insurance must guarantee to issue MEDACCESS plan	If offer small group insurance must guarantee to issue core and standard MEDPLANs unless would violate state solvency standards	If offer insurance to 1 small firm in a community must offer same plan to all small employers in same community; term of at least 12 months	If offer health insurance to groups of 3 or more individuals, must guarantee to issue a plan with continuous open enrollment and core benefits to all
	Must cover whole group (cannot exclude high cost individuals)	Must cover whole group	Must cover whole group	(No provision)	Must cover whole group
	Each insurer may set own minimum participation standards, with some limits	NAIC to set standards; may include minimum participation if uniformly applied to firms of same size	Insurer may require firm with 15 employees or less to enroll at least 60% of eligible employees	Insurer participation requirements only permitted during first 5 years after enactment	Permits insurer participation requirements
Renewability	Guaranteed renewable except: not pay premium, fraud, not comply with plan or participation, or employer no longer in same business	Guaranteed renewable except: not pay premium, fraud, not comply with plan or participation, misuse provider network, or insurer is ceasing all small firm health business in state	Guaranteed renewable except: not pay premium, fraud, not comply with plan or participation, or misuse network	Guaranteed renewable for at least 12 month term, except: not pay premium, fraud, fail to meet participation requirements (1st 5 years after enactment only)	Guaranteed renewable except: not pay premium, fraud, not comply with plan or participation, or misuse network

	NAIC (BC/BS, HIAA)	JOHNSON (H.R. 1565)	DURENBERGER (S. 700)	MITCHELL (S. 1227)	STARK (H.R. 2121)
Minimum Benefits	Supports concept that all insurers would have to offer both a basic (minimum) plan and a standard plan; insurance industry may design optional prototypes	Insurers in small firm market must offer a MEDACCESS plan: managed care, indemnity, or other, with only basic hospital, medical, surgical, and preventive benefits meeting requirements in bill	Insurers in small firm market must offer both core and standard MEDPLANs; core: prenatal, inpt. and outpt. hospital, surgical, physician, and diagnostic and screening; standard: core plus limited mental and substance abuse; both limit deductibles, co-pays, and out-of-pocket	5 years after enactment, insurers may only issue plans to small firms that include: inpt. and outpt. hospital and physician services (limits days/visits for mental), diagnostic, prenatal and well-baby, pap smears, and mammograms; limits deductibles, co-pays, and out-of-pocket	Insurers' employer group health contracts must provide: same benefits as Medicare Parts A and B, with specified deductibles and out-of-pocket limits; plus prenatal, maternal, newborn and well-child care without any coinsurance or co-pays, and not subject to deductible
State Provider / Service Mandates	Advocates pre-emption of mandates	Pre-empts mandates for small firm plans meeting consumer protection standards in bill	Pre-empts mandates for MEDPLANs but not for other insurance products marketed to small firms	Pre-empts mandates for all health insurance plans meeting bill requirements, for all size firms	Pre-empts mandates for core benefit plans but not for other employer health insurance
State Anti-Managed Care Legislation	No provision	Pre-exempts state restrictions on managed care/utilization review	No provision	Sets national standards for managed care and pre-empts state anti-managed care laws for plans meetings standards unless state opts out of all funding under bill	No provision
Effects Outside Small Group Market (Relating to Small Group Reform)	Unclear	None for mandates; also pre-empts state anti-managed care laws for large firms	None	Also pre-empts mandates for large firm plans meeting bill requirements; also pre-empts anti-managed care laws for large firm plans unless state opts out	Also pre-empts mandates for core plans for large firms
Initial Premiums in Same Class of Business	May vary no more than 25% + or - average rate (HIAA wants 35%)	Maximum of 25% + or - average rate	Maximum of 20% + or - average rate	Maximum of 150% of lowest rate 1st year after enactment; 122% 2nd year; 0% 3rd year +	Core plan: community rating required (average per capita cost of all employer group health by that insurer); no restrictions for other plans
Initial Premiums Between Different Classes	May vary up to 20% for health; plus 15% for industry or occupation; unlimited for geography, age, gender	Up to 20% for health; unlimited for geography, age, gender, and industry/occupation	Up to 20% (total) for, health, and industry occupation; no limits for age, gender, and geography (MSA or NMSA)	Up to 20% total; phases out health and gender after 2 years; phases age down to 110% over 3 years	(No limits specified except for general community rating requirement defined above)
Renewal Premiums	Trend (insurer's lowest new small group rate) plus 15%	Standard to be set by NAIC	Equal to trend	Equal to trend	(No limits specified except for community rating)

	NAIC (BC/BS, HIAA)	JOHNSON (H.R. 1565)	DURENBERGER (S. 700)	MITCHELL (S. 1227)	STARK (H.R. 2121)
Reinsurance	Working on 2 model laws: prospective (voluntary or mandatory), and allocation; (HIAA likes mandatory, not voluntary or allocation; Blues position opposite)	NAIC to develop several models; each state must establish and fund one or more; Secretary of HHS to establish one for each state that fails to do so	(No provision - leave it up to the states to decide whether and how to do)	NAIC to develop models for: voluntary, retrospective, and case management for reinsured individuals and groups; each must include insurer deductibles/co-pay	All insurers must pay per capita federal tax into federal reinsurance trust fund and may request reimbursement above $25,000/person/year
Enforcement	(No provision - expects model laws to be adopted and enforced by states)	Secretary approves state program; in states not approved, 25% federal tax on insurer's premiums from small group health if fail to meet Secretary's standards; federal tax for employer that fails to offer MEDACCESS plan	20% federal tax on insurer on gross premium income from all accident and health policies if fail to meet requirements in bill	Secretary determines violations of state's or Secretary's requirements; 25% federal tax on amounts insurer received during period violation persists - all blocks of business in all communities	100% federal tax on insurer's gross premiums from all accident and health policies if fail to meet requirements (limited exceptions and Secretarial waiver authority)

THE WHITE HOUSE

WASHINGTON

November 15, 1991

MEMORANDUM FOR ROGER B. PORTER

FROM: HANNS KUTTNER
STEPHANIE FOSSAN

SUBJECT: S.1872, Senator Bentsen's Health Care Proposal and H.R.3626, Representative Rostenkowski's Companion Bill.

Both Senator Bentsen and Representative Rostenkowski have broken ranks with their Democratic leadership's commitment to "comprehensive" health care reform in favor of more incremental approaches. This memorandum reviews the details of their proposals. Bentsen proposal, S.1872, "Better Access to Affordable Health Care Act of 1991," introduced on October 24, 1991, has the following goals and means of achieving them:

- To improve health insurance affordability for small employers, it:

  1. Permanently increases deductible health insurance costs (from 25 percent to 100 percent) for self-employed persons.

  2. Sets up grants to states ($150 million per year for the next 3 years) to establish group purchasing programs for small business insurance.

  3. Requires HHS to evaluate impact of these programs on the numbers of uninsured and the price of insurance available to small businesses.

  4. Requires HHS to study feasibility and impact of requiring insurers to pay providers based on Medicare rates.

     [Rostenkowski differs significantly in this regard; he would make these government monopsony prices available to everyone.]

- To reform health insurance for small employers, it:

  1. Sets up standards and requirements prohibiting insurers from excluding workers or their dependents from group coverage or renewal of coverage for factors involving health status, claims experience, industry or occupation and duration of insurance coverage. An insurer may

terminate or refuse to renew a plan only for:

(i) Nonpayment of premiums;
(ii) fraud or misrepresentation; or
(iii) failure to maintain minimum participation rates.

2. Limits the variation of premiums between blocks of business to 20 percent. "Blocks of business" are defined, with some exceptions, as all of the small employers with a health insurance plan issued by the insurer.

3. Limits variation in premium rates within a block of business such that a rate will not exceed an amount that is 1.5 times the base rate for the block in the first three years and 1.35 times the base rate thereafter.

4. Restricts the insurer from transferring employers among blocks of business without the consent of the employer.

5. Requires insurers to fully disclose their rating practices.

6. Limits annual premium increases to the underlying trend in health care costs plus 5 percent, thus precluding insurers from using large price hikes to induce a firm to drop that insurer if an individual in the group becomes very sick.

7. Requires GAO to report to the Congress on the impact of the rating restrictions on the price and availability of insurance to small employers.

8. Allows states to choose among several options for guaranteeing availability of insurance to all small employers in the state.

9. Requires insurers offering coverage to small employers to offer at least two different packages which are defined as "standard benefit packages."

(i) The first standard package includes:

- Inpatient and outpatient hospital care (with limits on treatment for mental disorders);
- Inpatient and outpatient physicians' services (with limits on treatment of mental disorders);
- Diagnostic tests;
- Preventive services limited to:
  -prenatal care
  -well child care

-pap smears
-mammograms
-colorectal services;

- Limiting the portion of premiums that employers can pass on to the employee to a maximum of 20 percent of the total monthly premium (For part-time employees this percentage can reach 50 percent);
- Limiting deductibles to $400 per person or $700 per family (plus the percentage increase in the Consumer Price Index (CPI) for all urban consumers after 1993);
- Limiting copayments and coinsurance for services which are required in the package;
- Limiting out-of-pocket payments to $3000 year (plus the percentage increase in CPI after 1993).

(ii) The second standard package allows more flexibility for dollar thresholds for cost-sharing and includes:

- Inpatient and outpatient hospital care, including emergency services;
- Inpatient and outpatient physicians' services;
- Diagnostic tests;
- Preventive services (same as above);
- Allowing insurer to impose premiums, deductibles, or copayments on employees;
- Insurer must provide limit for out-of-pocket expenses.

10. Levies an excise tax equal to 25 percent on premiums received on health insurance policies for small businesses which do not meet requirements if requirements not met within 30 days.

[This excise tax is the enforcement stick and serves as an alternative to pre-empting state insurance laws.]

- To <u>improve health insurance portability</u>, it:

1. Prohibits all group health insurance and self-insured employer plans from excluding coverage for preexisting conditions for individuals who were covered under policies in their previous jobs. And, for individuals who had not previously been insured, a one-time preexisting condition exclusion could not last for more than six months.

2. Requires insurers not in compliance with requirements to retroactively cover any illegally excluded services and pay a tax penalty of $100 a day for each violation.

- To contain health care costs, it:

  1. Establishes a Health Care Cost Commission to advise the President and Congress on how to contain rising health care costs.

  2. Establishes a voluntary Federal certification program for managed care plans and utilization review programs. Those plans that meet standards would receive special protection from laws that would otherwise restrict their development.

  3. Grants additional funding to outcomes research to identify the most effective treatment patterns.

- To expand Medicare benefits to improve the package of preventative services, it:

  1. Covers colorectal cancer screening, annual mammography screening, influenza immunizations, and well-child care.

Representative Rostenkowski's "Health Insurance Reform and Cost Control Act of 1991," introduced on October 24, 1991, differs from Senator Bentsen's proposal in the following ways:

- Under the heading, "To improve affordability of health insurance for small employers:"

  1. The deductible for self-insured individuals would be phased in, increasing to 50 percent in 1993, to 75 percent in 1994 and then to 100 percent in 1995.

  2. Rostenkowski's bill does not include the grants to states to establish group purchasing programs found in Bentsen's bill.

- Under the heading, "To reform health insurance for small employers:"

  1. The limit on variation of premium rates within a block of business would be 25 percent.

  2. The standard benefit package is different. It would

include:

- The benefits provided in Medicare;
- Unlimited inpatient hospital services for children;
- Pregnancy related services that include:
  -prenatal care
  -inpatient labor and delivery services
  -postnatal care
  -postnatal family planning services;
- A deductible of $250 or $500 plus inflation per family. This does not apply to preventive services;
- No coinsurance allowed for preventive services or for inpatient hospital services for children;
- A limit on cost-sharing of $2500 a year for deductibles and $3000 for coinsurance with respect to covered services;
- Some immunization services.

3. The establishment of a telephone information system to instruct small employment with regard to health insurance.

- Under the heading, "To improve health insurance portability:"

1. An excise tax on insurers for failure to provide for a preexisting condition as an alternative to the tax penalty of $100 a day in Senator Bentsen's bill.

- Under the heading, "To contain health care cost:"

1. Requires development of uniform claims forms and uniform reporting standards by the Secretary and the new Health Care Cost Commission.

2. The establishment of optional provider payment rates by the Secretary by October 1994. After January 1, 1994, the health care provider must accept such rates as payment in full or be subject to a civil money penalty. A provider may still choose to accept payments for services that are less than the rates established by the Secretary.

3. Rostenkowski's bill does not include the additional funding for outcomes research. In other words, all providers would be required to accept Medicare payment rates for all patients.

Neither bill specifies a revenue source to pay for the new spending.

SUBJECT:

102D CONGRESS
1ST SESSION

H. R. 3626

To amend the Social Security Act and the Internal Revenue Code of 1986 to provide for improvements in health insurance coverage through employer health insurance reform, for health care cost containment, for improvements in medicare prevention benefits, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

OCTOBER 24, 1991

Mr. ROSTENKOWSKI introduced the following bill; which was referred jointly to the Committees on Ways and Means and Energy and Commerce

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A BILL

To amend the Social Security Act and the Internal Revenue Code of 1986 to provide for improvements in health insurance coverage through employer health insurance reform, for health care cost containment, for improvements in medicare prevention benefits, and for other purposes.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Health Insurance Reform and Cost Control Act of 1991".

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

Sec. 1. Short title; table of contents.

TITLE I—INCREASE IN DEDUCTION FOR HEALTH INSURANCE FOR SELF-EMPLOYED INDIVIDUALS

Sec. 101. Indefinite extension of deduction for health insurance costs of self-employed individuals.
Sec. 102. Increase in amount of deduction for years after 1992.

TITLE II—IMPROVEMENTS IN HEALTH INSURANCE FOR SMALL EMPLOYERS

SUBTITLE A—STANDARDS AND REQUIREMENTS OF SMALL EMPLOYER HEALTH INSURANCE REFORM

Sec. 201. Standards and requirements of small employer health insurance.

"TITLE XXI—HEALTH INSURANCE STANDARDS

"PART A—SMALL EMPLOYER HEALTH INSURANCE STANDARDS

"Subpart 1—General Standards; Definitions

"Sec. 2101. Standards and requirements of small employer health insurance.
"Sec. 2102. Establishment of standards.
"Sec. 2103. Definitions.

"Subpart 2—Small Employer Health Insurance Reform

"Sec. 2111. General requirements for health insurance plans issued to small employers.
"Sec. 2112. Requirements related to restrictions on rating practices.
"Sec. 2113. Requirements for small employer health insurance benefit package offerings.

SUBTITLE B—TAX PENALTY ON NONCOMPLYING INSURERS

Sec. 211. Excise tax on premiums received on health insurance policies which do not meet certain requirements.

SUBTITLE C—STUDIES AND REPORTS

Sec. 221. GAO study and report on rating requirements for small group health insurance.

TITLE III—IMPROVEMENTS IN PORTABILITY OF PRIVATE HEALTH INSURANCE

Sec. 301. Excise tax imposed on failure to provide for preexisting condition.
Sec. 302. Prohibition of discrimination based on health status for certain services.

"PART B—PROHIBITION OF DISCRIMINATION BASED ON HEALTH STATUS FOR CERTAIN SERVICES

"Sec. 2131. In general.
"Sec. 2132. Treatment of preexisting condition exclusions for all services.
"Sec. 2133. Definitions.

TITLE IV—HEALTH CARE COST CONTAINMENT

Sec. 401. Establishment of National Health Care Cost Commission.
Sec. 402. Establishment of optional provider payment rates.

TITLE V—MEDICARE PREVENTION BENEFITS

Sec. 501. Coverage of colorectal screening.
Sec. 502. Coverage of certain immunizations.
Sec. 503. Coverage of well-child care.
Sec. 504. Annual screening mammography.
Sec. 505. Demonstration projects for coverage of other preventive services.
Sec. 506. OTA study of process for review of medicare coverage of preventive services.

TITLE I—INCREASE IN DEDUCTION FOR HEALTH INSURANCE FOR SELF-EMPLOYED INDIVIDUALS

SEC. 101. INDEFINITE EXTENSION OF DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

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

SEC. 102. INCREASE IN AMOUNT OF DEDUCTION FOR YEARS AFTER 1992.

(a) GENERAL RULE.—Section 162(l) of the Internal Revenue Code of 1986 is amended—

(1) in paragraph (1), by striking "25 percent of" and inserting "the applicable percentage of", and

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

"(C) APPLICABLE PERCENTAGE.—For purposes of paragraph (1)—

"In the case of any taxable year beginning in calendar year:	The applicable percentage is:
1993	50
1994	75
1995 or thereafter	100."

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 1992.

TITLE II—IMPROVEMENTS IN HEALTH INSURANCE FOR SMALL EMPLOYERS

Subtitle A—Standards And Requirements of Small Employer Health Insurance Reform

SEC. 201. STANDARDS AND REQUIREMENTS OF SMALL EMPLOYER HEALTH INSURANCE.

The Social Security Act is amended by adding at the end the following new title:

"TITLE XXI—HEALTH INSURANCE STANDARDS

"PART A—SMALL EMPLOYER HEALTH INSURANCE STANDARDS

"Subpart 1—General Standards; Definitions

"SEC. 2101. STANDARDS AND REQUIREMENTS OF SMALL EMPLOYER HEALTH INSURANCE.

"(a) APPROVAL REQUIRED.—

"(1) IN GENERAL.—No health insurance plan (as defined in section 2103(a)) may be issued on or after the effective date specified in subsection (d) (and no new contract may be offered under such plan with respect to any small employer beginning on or after such effective date) unless the plan has been certified by the Secretary (in accordance with such procedures as the Secretary establishes) or approved by a State regulatory program (approved under subsection (b)) as meeting the standards established under section 2102 by such effective date.

"(2) PLAN DISAPPROVED.—If the Secretary determines that a health insurance plan does not meet the applicable requirements of this part on or after such effective date, no coverage may be provided under the plan to individuals not enrolled as of the date of the determination and the plan may not be continued for plan years beginning after the date of

such determination until the Secretary determines that such plan is in compliance with such requirements.

"(b) CERTIFIED BY STATE APPROVED PROGRAMS.—

"(1) IN GENERAL.—If the Secretary determines that a State has in effect an effective regulatory program for the application of the standards established under section 2102 to health insurance plans, the Secretary may approve such program for purposes of certification of health insurance plans under this part.

"(2) ANNUAL REPORTS.—As a condition for the continued approval of such a regulatory program, the State shall report to the Secretary annually such information as the Secretary may require with respect to the performance of the program. Such information shall include the health insurance plans certified under the program, the compliance of such plans with the standards established under section 2102, and enforcement actions taken to ensure such compliance.

"(3) PERIODIC SECRETARIAL REVIEW OF STATE REGULATORY PROGRAMS.—The Secretary annually shall review State regulatory programs approved under paragraph (1) to determine if they continue to

meet and enforce the standards for approval. If the Secretary initially determines that a State regulatory program no longer meets such standards, the Secretary shall provide the State an opportunity to adopt such a plan of correction that would bring such program into compliance with such standards. If the Secretary makes a final determination that the State regulatory program, fails to meet and enforce such standards after such an opportunity, the Secretary shall disapprove such program and reassume responsibility for certification of all health insurance plans in that State.

"(3) GAO AUDITS.—The Comptroller General shall conduct periodic reviews on a sample of State regulatory programs approved under paragraph (1) to determine their compliance with the requirements of such paragraph. The Comptroller General shall report to the Secretary and Congress on the findings of such reviews.

"(c) EXCISE TAX SANCTIONS.—For application of excise tax in the case of a nonconforming plan, see section 5000A of the Internal Revenue Code of 1986.

"(d) EFFECTIVE DATE.—The effective date specified in this subsection is January 1, 1993.

"SEC. 2102. ESTABLISHMENT OF STANDARDS.

"(a) ESTABLISHMENT OF STANDARDS.—The Secretary shall develop and publish, by not later than October 1, 1992, specific standards to implement the requirements of this part and part B and to be applied under section 5000A of the Internal Revenue Code of 1986.

"(b) MORE STRINGENT STATE STANDARDS PERMITTED.—Except as provided in section 2113(g), a State may implement standards that are more stringent than the standards established under this section to meet the requirements under subpart II of this part.

"(c) TELEPHONE INFORMATION SYSTEM.—The Secretary shall provide for the establishment of a toll-free telephone information and complaint system which provides for—

"(1) a system for the receipt and disposition of consumer complaints or inquiries regarding compliance of health plans with the requirements of this title, and

"(2) information to small employers about insurers that offer health insurance plans that meet the requirements of this title in the area of the employers.

"SEC. 2103. DEFINITIONS.

"(a) HEALTH INSURANCE PLAN.—As used in this title, the term 'health insurance plan' means any hospital

or medical service policy or certificate, hospital or medical service plan contract, health maintenance organization group contract, or a multiple employer welfare arrangement, but does not include—

"(1) a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act); or

"(2) any of the following offered by an insurer—

"(A) accident only, dental only, disability only insurance, or long-term care only insurance,

"(B) coverage issued as a supplement to liability insurance,

"(C) workmen's compensation or similar insurance, or

"(D) automobile medical-payment insurance.

"(b) INSURER AND HEALTH MAINTENANCE ORGANIZATION.—As used in this title:

"(1) INSURER.—The term 'insurer' means any person that offers a health insurance plan to a small employer.

"(2) HEALTH MAINTENANCE ORGANIZATION.—The term 'health maintenance organization' has the

meaning given the term 'eligible organization' in section 1876(b) of the Social Security Act.

"(c) GENERAL DEFINITIONS.—As used in this title:

"(1) APPLICABLE REGULATORY AUTHORITY.—The term 'applicable regulatory authority' means, with respect to a health insurance plan in a State with a regulatory program approved under section 2101(b), the State commissioner or superintendent of insurance or other State authority responsible for regulation of health insurance.

"(2) SMALL EMPLOYER.—The term 'small employer' means, with respect to a calendar year, an employer that normally employs more than 1 but less than 51 eligible employees on a typical business day. For the purposes of this paragraph, the term 'employee' includes a self-employed individual. Section 5000A(b)(3) of the Internal Revenue Code of 1986 shall apply for purposes of the preceding sentence.

"(3) ELIGIBLE EMPLOYEE.—The term 'eligible employee' means, with respect to an employer, an employee who normally performs on a monthly basis at least 17½ hours of service per week for that employer.

"Subpart 2—Small Employer Health Insurance Reform

"SEC. 2111. GENERAL REQUIREMENTS FOR HEALTH INSURANCE PLANS ISSUED TO SMALL EMPLOYERS.

"(a) REGISTRATION.—Each insurer shall register with the Secretary and with any applicable regulatory authority for each State in which it issues or offers a health insurance plan to small employers.

"(b) GUARANTEED ELIGIBILITY.—

"(1) IN GENERAL.—No insurer may exclude from coverage any eligible employee, the spouse or any dependent child of the eligible employee to whom coverage is made available by a small employer.

"(2) WAITING PERIODS.—Paragraph (1) shall not apply to any period an eligible employee is excluded from coverage under the health insurance plan solely by reason of a requirement applicable to all employees that a minimum period of service with the small employer is required before the employee is eligible for such coverage.

"(c) GUARANTEED ISSUE.—

"(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, an insurer that offers a health insurance plan to small employers in a geographic area in a community must offer the same

plan to any other small employer located in the area. Such requirement shall apply on a continuous, year-round basis.

"(2) TREATMENT OF HEALTH MAINTENANCE ORGANIZATIONS.—

"(A) GEOGRAPHIC LIMITATIONS.—A health maintenance organization may deny enrollment to employees (and family members) of a small employer if the employees are located outside the service area of the organization, but only if such denial is applied uniformly without regard to health status or insurability.

"(B) SIZE LIMITS.—A health maintenance organization may apply to the Secretary to cease enrolling new small employer groups in its health insurance plan (or in a geographic area served by the plan) if—

"(i) it ceases to enroll any new employer groups, and

"(ii) it can demonstrate that its financial or administrative capacity to serve previously enrolled groups and individuals (and additional individuals who will be expected to enroll because of affiliation with such previously enrolled groups) will be im-

paired if it is required to enroll new employer groups.

"(3) GROUNDS FOR REFUSAL TO RENEW.—

"(A) IN GENERAL.—An insurer may refuse to renew, or may terminate, a health insurance plan under this part only for—

"(i) nonpayment of premiums,

"(ii) fraud or misrepresentation, or

"(iii) failure to maintain minimum participation rates (consistent with subparagraph (B)).

"(B) MINIMUM PARTICIPATION RATES.—An insurer may require, with respect to a health insurance plan issued to a small employer, that a minimum percentage of eligible employees who do not otherwise have health insurance are enrolled in such plan, so long as such percentage is enforced uniformly for all plans offered to employers of comparable size.

"(d) MINIMUM PLAN PERIOD.—An insurer may not offer to, or issue with respect to, a small employer a health insurance plan with a term of less than 12 months.

"(e) NOTICES AND RENEWAL PERIODS.—

"(1) NOTICE ON EXPIRATION.—An insurer providing health insurance plans to small employers

shall provide for notice, at least 60 days before the date of expiration of the health insurance plan, of the terms for renewal of the plan. Except with respect to rates and administrative changes, the terms of renewal (including benefits) shall be the same as the terms of issuance.

"(2) PERIOD OF RENEWAL.—The period of renewal of each small employer health plan shall be for a period of not less than 12 months.

"(f) GUARANTEED RENEWABILITY.—

"(1) IN GENERAL.—

"(A) GENERAL RULE.—Subject to the succeeding provisions of this subsection, an insurer shall ensure that a health insurance plan issued to a small employer be renewed, at the option of the small employer, unless the plan is terminated for a reason specified in subparagraph (B) or in subsection (c)(3)(A).

"(B) TERMINATION OF SMALL EMPLOYER BUSINESS.—An insurer need not renew a health insurance plan with respect to a small employer if the insurer—

"(i) elects not to renew all of its health insurance plans issued to small employers in a State; and

"(ii) provides notice to the Secretary, any applicable regulatory authority in the State, and to each small employer covered under the plan of such termination at least 180 days before the date of expiration of the plan.

In the case of such a termination, the insurer may not provide for issuance of any health insurance plan to a small employer in the State during the 5-year period beginning on the date of termination of the last plan not so renewed.

"(g) NO DISCRIMINATION BASED ON HEALTH STATUS FOR CERTAIN SERVICES.—A health insurance plan offered to a small employer by an insurer shall meet the requirements of part B (relating to prohibiting discrimination based on health status for certain services).

"SEC. 2112. REQUIREMENTS RELATED TO RESTRICTIONS ON RATING PRACTICES.

"(a) LIMIT ON VARIATION OF REFERENCE PREMIUM RATES BETWEEN BLOCKS OF BUSINESS.—

"(1) IN GENERAL.—The index rate for any block of business of an insurer may not exceed the index rate for any other block of business by more than 20 percent.

"(2) EXCEPTIONS.—Paragraph (1) shall not apply to a block of business if—

"(A) the block is one for which the insurer does not reject, and never has rejected, small employers included within the definition of employers eligible for the block of business or otherwise eligible employees and dependents who enroll on a timely basis, based upon their claims experience, health status, industry, or occupation,

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

"(C) the block of business is currently available for purchase at the time an exception to paragraph (1) is sought by the insurer.

"(b) USE OF COMMUNITY RATING IN PREMIUM RATES WITHIN A BLOCK OF BUSINESS.—

"(1) LIMITING VARIATIONS ON PREMIUM TO AGE AND SEX.—The reference premium rate charged for a health insurance plan offered to small employers within a community (as defined under the plan consistent with paragraph (3)) with similar benefits for a type of family enrollment (described in para-

graph (4)) shall be the same for all small employers in the same block of business in the community.

"(2) AGE AND SEX ADJUSTMENT TO COMMUNITY-RATING.—

"(A) IN GENERAL.—Subject to subparagraph (B), a health insurance plan offered to a small employer may provide for an adjustment to the reference premium rate based on age and gender of covered individuals. Any such adjustment shall be applied consistently to all small employers.

"(B) LIMITATION ON ADJUSTMENT.—The adjustment under subparagraph (A) may not result, with respect to health insurance plans with similar benefits in a community in a block of business, in premium rates that vary from the index rate by more than 25 percent of the index rate.

"(3) SPECIFICATION OF COMMUNITY.—For purposes of paragraph (1), no insurer may use a geographic area that is smaller than a metropolitan statistical area as a community.

"(4) TYPES OF FAMILY ENROLLMENT.—Each health insurance plan offered to a small employer shall permit enrollment of (and shall compute pre-

miums separately for) individuals based on each of the following beneficiary classes:

"(A) 1 adult.

"(B) A married couple without children.

"(C) A married couple with 1 or more children, or 1 adult with 1 or more children.

"(c) LIMIT ON TRANSFER OF EMPLOYERS AMONG BLOCKS OF BUSINESS.—

"(1) An insurer may not transfer a small employer from one block of business to another without the consent of the employer.

"(2) An insurer may not offer to transfer a small employer from one block of business to another unless—

"(A) the offer is made without regard to age, sex, geography, claims experience, health status, industry, occupation or the date on which the policy was issued, and

"(B) the same offer is made to all other small employers in the same block of business.

"(d) LIMITS ON VARIATION IN PREMIUM INCREASES.—The percentage increase in the premium rate charged to a small employer for a new rating period (determined on an annual basis) may not exceed the sum of

the percentage change in the base premium rate plus 5 percentage points.

"(e) DEFINITIONS.—In this section:

"(1) BLOCK OF BUSINESS.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'block of business' means, with respect to an insurer, all of the small employers with a health insurance plan issued by the insurer (as shown on the records of the insurer).

"(B) DISTINCT GROUPS.—A distinct group of small employers with health insurance plans issued by an insurer may be treated as a block of business by such insurer if all of the plans in such group—

"(i) are marketed primarily by direct mail or are not marketed primarily by direct mail,

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

"(iii) are provided through an association with membership of not less than 25 small employers that has been formed for purposes other than obtaining health insurance.

"(2) INDEX RATE.—The term 'index rate' means, with respect to a block of business, 133⅓ percent of the reference premium rate for the block of business.

"(3) REFERENCE PREMIUM RATE.—The term 'reference premium rate' means, for each block of business for each rating period in a community, the lowest premium rate charged or which could have been charged, for the most favorable actuarial class, by the insurer under a rating system for that block of business to small employers in the community for health insurance plans with the same or similar coverage.

"(f) FULL DISCLOSURE OF RATING PRACTICES.—

"(1) IN GENERAL.—At the time an insurer offers a health insurance plan to a small employer, the insurer shall fully disclose to the employer all of the following:

"(A) Rating practices for small employer health insurance plans, including rating practices for different populations and benefit designs.

"(B) The extent to which premium rates for the small employer are established or adjusted based upon the actual or expected vari-

ation in claims costs or health condition of the employees and of such small employer and their dependents.

"(C) The provisions concerning the insurer's right to change premium rates, the extent to which premiums can be modified, and the factors which affect changes in premium rates.

"(2) NOTICE ON EXPIRATION.—An insurer providing health insurance plans to small employers shall provide for notice, at least 60 days before the date of expiration of the health insurance plan, of the terms for renewal of the plan.

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

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

"(2) the rating methods are actuarially sound.

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

"SEC. 2113. REQUIREMENTS FOR SMALL EMPLOYER HEALTH INSURANCE BENEFIT PACKAGE OFFERINGS.

"(a) STANDARD BENEFIT PACKAGES.—If an insurer offers any health insurance plan to small employers in a State, the insurer shall also offer a health insurance plan providing for the standard benefit package defined in subsection (b).

"(b) STANDARD BENEFIT PACKAGE.—

"(1) IN GENERAL.—Except as otherwise provided in this subsection and subsections (c), (d), and (e), a health insurance plan providing for a standard benefit package shall be limited to payment for the same benefits as are provided under title XVIII of individuals entitled to benefits under part A, and enrolled under part B, of such title.

"(2) UNLIMITED INPATIENT HOSPITAL SERVICES FOR CHILDREN.—For children, the standard benefit package also shall include payment for inpatient hospital services without regard to any day limitations under subsections (a)(1) and (b)(1) of section 1812.

"(3) PREGNANCY-RELATED SERVICES.—

"(A) IN GENERAL.—In the case of a pregnant woman (as defined in subparagraph (C), the standard benefit package shall include entitlement to have payment made for the following, subject to the periodicity schedule established with respect to the services under subparagraph (B):

"(i) Prenatal care, including care for all complications of pregnancy.

"(ii) Inpatient labor and delivery services.

"(iii) Postnatal care.

"(iv) Postnatal family planning services.

"(B) PERIODICITY SCHEDULE.—The Secretary, in consultation with the American College of Obstetrics and Gynecology, shall establish a schedule of periodicity which reflects the general, appropriate frequency with which services listed in subparagraph (A) should be provided to pregnant women without complications of pregnancy.

"(C) PREGNANT WOMAN DEFINED.—In this paragraph, the term 'pregnant woman' means a woman during pregnancy and until the

end of the month in which the 60-day period (beginning on the date of termination of the pregnancy) ends.

"(c) DEDUCTIBLE.—

"(1) IN GENERAL.—Except as provided in this subsection, the standard benefit package the deductible described in paragraph (2) shall be applied instead of applying the deductible for inpatient hospital services under the first sentence of section 1813(a)(1) and the deductible under section 1833(b).

"(2) DEDUCTIBLE AMOUNT.—

"(A) IN GENERAL.—For purposes of this subsection, the deductible described in this paragraph is $250.

"(B) FAMILY LIMIT OF $500.—In the case of a family, the deductible under subparagraph (A) shall not apply in a year after members of the family (who are not medicare beneficiaries) have collectively had expended $500 towards such deductible.

"(C) INDEXING OF DOLLAR AMOUNTS OF DEDUCTIBLE.—The dollar amounts specified in subparagraphs (A) and (B) shall each be increased each year (beginning with second year

after the year in which this title is enacted) by a percentage equal to the percentage increase in the contribution and benefit base (determined under section 230) from the year before the year in which this title is enacted to the year before the year involved. Any such increase shall be rounded to the nearest multiple of $5.

"(3) DEDUCTIBLE DOES NOT APPLY TO PREVENTIVE SERVICES.—The deductible established under this subsection does not apply to preventive services provided consistent with any applicable periodicity schedules.

"(d) COINSURANCE.—

"(1) NO COINSURANCE FOR PREVENTIVE SERVICES.—There shall be no coinsurance under the standard benefit package in the case of preventive services provided consistent with any applicable periodicity schedules.

"(2) NO COINSURANCE FOR INPATIENT HOSPITAL SERVICES FOR CHILDREN.—There shall be no coinsurance under the standard benefit package in the case of inpatient hospital services furnished to children.

"(e) LIMITATION ON COST-SHARING.—

"(1) IN GENERAL.—Under the standard benefit package, whenever in a calendar year an individual's or family's expenses for the deductible and coinsurance with respect to required services covered under the standard benefit package and furnished during the year equals $2,500 or $3,000, respectively, payment of benefits under the package for the individual or family for required services furnished during the remainder of the year shall be paid without the application of any coinsurance.

"(2) INDEXING OF DOLLAR AMOUNT OF LIMIT.—The dollar amounts specified in paragraph (1) shall be increased each year (beginning with the second year after the year in which this title is enacted) by a percentage equal to the percentage increase in the contribution and benefit base (determined under section 230) from the year before the year in which this title is enacted to the year before the year involved. Any such increase shall be rounded to the nearest multiple of $5.

"(f) EXCLUSIONS.—

"(1) IN GENERAL.—Except as provided in paragraph (2), section 1862(a) shall apply to expenses incurred for items and services provided under the standard benefit package in the same manner as

such section applies to items and services provided under title XVIII.

"(2) PREVENTIVE SERVICES—In applying paragraph (1), in the case of preventive services provided consistent with the applicable periodicity schedule—

"(A) such services shall be considered to be reasonable and medically necessary, and

"(B) shall not be subject to exclusion through the operation of paragraph (1), (7), or (12) of section 1862(a) (as incorporated under paragraph (1))).

"(3) USE OF SAME NATIONAL COVERAGE DECISION REVIEW PROCESS.—The provisions of section 1869(b)(3) shall apply under the standard benefit package in the same manner as they apply under title XVIII.

"(g) LIMITED PREEMPTION OF STATE MANDATED BENEFITS FOR THE STANDARD BENEFIT PACKAGE.—No State may enforce any law or regulation that requires health insurance plans which—

"(1) are offered to small employers in the State, and

"(2) provide only the standard benefit package,

to include any specified services, category of care, or services of any class or type of provider that is different from the standard benefit package under this section.

"(h) PREVENTIVE SERVICES DEFINED.—In this section, the term 'preventive services' means the following items and services furnished in accordance with any applicable periodicity schedules:

"(1) Pregnancy-related services (described in subsection (b)(3)(A))).

"(2) Well-child care (as defined in section 1861(ll)(1)).

"(3) Screening mammography (as defined in section 1861(jj)).

"(4) Screening pap smear (as defined in section 1861(nn)).

"(5) Colorectal cancer screening services.

"(6) Immunization services described in section 1862(a)(1)(H).

The services referred to in paragraph (5) are screening fecal-occult blood tests and screening flexible sigmoidoscopies provided for the purpose of early detection of colon cancer.".

Subtitle B—Tax Penalty on Noncomplying Insurers

SEC. 211. EXCISE TAX ON PREMIUMS RECEIVED ON HEALTH INSURANCE POLICIES WHICH DO NOT MEET CERTAIN REQUIREMENTS.

(a) IN GENERAL.—Chapter 47 of the Internal Revenue Code of 1986 (relating to taxes on group health plans) is amended by adding at the end thereof the following new section:

"SEC. 5000A. FAILURE TO SATISFY CERTAIN STANDARDS FOR HEALTH INSURANCE.

"(a) GENERAL RULE.—

"(1) TITLE XXI STANDARDS.—

"(A) TAX.—In the case of any person issuing a health insurance plan to a small employer, there is hereby imposed a tax on the failure of such person to meet at any time during any taxable year the applicable requirements of title XXI of the Social Security Act.

"(B) DETERMINATION OF VIOLATIONS.—The Secretary of Health and Human Services shall determine whether any person meets the requirements of such title.

"(2) SMALL EMPLOYER SELF-INSURING FOR HEALTH BENEFITS.—In the case of a small em-

ployer, there is hereby imposed a tax on expenditures for a health plan that is not an insured health plan.

"(b) AMOUNT OF TAX.—

"(1) IN GENERAL.—

"(A) TITLE XXI STANDARDS.—The amount of tax imposed by subsection (a)(1) by reason of 1 or more failures during a taxable year shall be equal to 25 percent of the gross premiums received during such taxable year with respect to all health insurance plans issued to small employers by the person on whom such tax is imposed.

"(B) SMALL EMPLOYER SELF-INSURANCE.—The amount of tax imposed by subsection (a)(2) by reason of 1 or more failures during a taxable year shall be equal to 25 percent of the expenditures under any uninsured health plan during such taxable year.

"(2) GROSS PREMIUMS.—For purposes of paragraph (1), gross premiums shall include any consideration received with respect to any health insurance plan.

"(3) CONTROLLED GROUPS.—For purposes of paragraph (1)—

"(A) CONTROLLED GROUP OF CORPORATIONS.—All corporations which are members of the same controlled group of corporations shall be treated as 1 person. For purposes of the preceding sentence, the term 'controlled group of corporations' has the meaning given to such term by section 1563(a), except that—

"(i) 'more than 50 percent' shall be substituted for 'at least 80 percent' each place it appears in section 1563(a)(1), and

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

"(B) PARTNERSHIPS, PROPRIETORSHIPS, ETC., WHICH ARE UNDER COMMON CONTROL.—Under regulations prescribed by the Secretary, all trades or business (whether or not incorporated) which are under common control shall be treated as 1 person. The regulations prescribed under this subparagraph shall be based on principles similar to the principles which apply in the case of subparagraph (A).

"(c) LIMITATION ON TAX.—

"(1) TAX NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No tax shall be imposed by subsection (a) with respect to any failure for which it is established to the satisfaction of the Secretary that the person on whom the tax is imposed did not know, and exercising reasonable diligence would not have known, that such failure existed.

"(2) TAX NOT TO APPLY WHERE FAILURES CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) with respect to any failure if—

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

"(B) such failure is corrected during the 30-day period beginning on the 1st date any of the persons on whom the tax is imposed knew, or exercising reasonable diligence would have known, that such failure existed.

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

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

"(1) HEALTH INSURANCE PLAN.—The term 'health insurance plan' has the meaning given such term in section 2103 of the Social Security Act.

"(2) SMALL EMPLOYER.—The term 'small employer' means, with respect to a calendar year, an employer that normally employs more than 1 but less than 51 eligible employees on a typical business day. For the purposes of this paragraph, the term 'employee' includes a self-employed individual. Subsection (b)(3) shall also apply for purposes of the preceding sentence.

"(3) ELIGIBLE EMPLOYEE.—The term 'eligible employee' means, with respect to an employer, an employee who normally performs on a monthly basis at least 17½ hours of service per week for that employer."

(b) NONDEDUCTIBILITY OF TAX.—Paragraph (6) of section 275(a) of such Code (relating to nondeductibility of certain taxes) is amended by inserting "47," after "46,".

(c) CLERICAL AMENDMENTS.—The table of sections for such chapter 47 is amended by adding at the end thereof the following new item:

"Sec. 5000A. Failure to satisfy certain standards for health insurance.".

(d) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by subsections (a) and (c) shall take effect on the date of the enactment of this Act.

(2) NONDEDUCTIBILITY OF TAX.—The amendment made by subsection (b) shall apply to taxable years beginning after December 31, 1991.

Subtitle C—Studies and Reports

SEC. 221. GAO STUDY AND REPORT ON RATING REQUIREMENTS FOR SMALL GROUP HEALTH INSURANCE.

The Comptroller General of the United States shall study and report to the Congress by no later than January 1, 1995, on the impact of the standards for rating practices for small group health insurance established under section 2112 of the Social Security Act on the availability and price of insurance offered to small employers. The study shall also include the Comptroller General's recommendations for adjusting the rating standards to eliminate variation in premiums associated with demographic factors.

TITLE III—IMPROVEMENTS IN PORTABILITY OF PRIVATE HEALTH INSURANCE

SEC. 301. EXCISE TAX IMPOSED ON FAILURE TO PROVIDE FOR PREEXISTING CONDITION.

Section 5000A of the Internal Revenue Code of 1986 (relating to taxes on group health plans), as added by section 211(a) of this Act, is amended—

(1) in subsection (a)(1)(A), by inserting "or any group health plan" after "to a small employer";

(2) in subsection (b)(1)(A), by inserting before the period at the end the following: "or (in the case of a violation of a requirement of part B of title XXI of such Act) with respect to all group health plans issued by the person on whom such tax is imposed";

(3) in subsection (b)(2), by inserting "or (in the case of a violation of a requirement of part B of title XXI of such Act) group health plans" after "health insurance plans";

(4) in subsection (d)—

(A) in paragraph (4), by inserting before the period at the end the following: "and means, with respect to a violation of a requirement of part B of title XXI of the Social Secu-

rity Act, an entity offering a group health plan"; and

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

"(5) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning given such term in section 5000(b)(1).".

SEC. 302. PROHIBITION OF DISCRIMINATION BASED ON HEALTH STATUS FOR CERTAIN SERVICES.

(a) IN GENERAL.—Title XXI of the Social Security Act, as added by section 211(a) of this Act, is amended by adding at the end the following new part:

"PART B—PROHIBITION OF DISCRIMINATION BASED ON HEALTH STATUS FOR CERTAIN SERVICES

"SEC. 2131. IN GENERAL.

"Except as provided under section 2132, group health plans may not deny, limit, or condition the coverage under (or benefits of) the plan with respect to standard health services based on the health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability, of an individual.

"SEC. 2132. TREATMENT OF PREEXISTING CONDITION EXCLUSIONS FOR ALL SERVICES.

"(a) IN GENERAL.—Subject to the succeeding provisions of this section, group health plans may exclude cov-

erage with respect to standard health services related to treatment of a preexisting condition, but the period of such exclusion may not exceed 6 months. The exclusion of coverage shall not apply to services furnished to newborns.

"(b) CREDITING OF PREVIOUS COVERAGE.—

"(1) IN GENERAL.—A group health plan shall provide that if an individual under such plan is in a period of continuous coverage (as defined in paragraph (2)(A)) with respect to particular services as of the date of initial coverage under such plan (determined without regard to any waiting period under such plan), any period of exclusion of coverage with respect to a preexisting condition for such services or type of services shall be reduced by 1 month for each month in the period of continuous coverage.

"(2) DEFINITIONS.—As used in this section:

"(A) PERIOD OF CONTINUOUS COVERAGE.—The term 'period of continuous coverage' means, with respect to particular services, the period beginning on the date an individual is enrolled under a health insurance plan, title XVIII or XIX of the Social Security Act, or other health benefit arrangement (including a self-insured plan) which provides substantially

the same or similar benefits with respect to such services and ends on the date the individual is not so enrolled for a continuous period of more than 3 months.

"(B) PREEXISTING CONDITION.—The term 'preexisting condition' means, with respect to coverage under a group health plan, a condition which has been diagnosed or treated during the 3-month period ending on the day before the first date of such coverage.

"SEC. 2133. DEFINITIONS.

"For purposes of this part:

"(1) COVERED INDIVIDUAL.—The term 'covered individual' means—

"(A) an individual who is (or will be) provided coverage under a group health plan by virtue of the performance of services by the individual for 1 or more persons maintaining the plan (including as an employee defined in section 401(c)(1) of the Internal Revenue Code of 1986), and

"(B) the spouse or any dependent child of such individual.

"(2) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning given such term by section 5000(b)(1).

"(3) STANDARD HEALTH SERVICES.—The term 'standard health services' means services for which benefits are available under the standard benefit package under section 2113(b).".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to plan years beginning after December 31, 1992.

TITLE IV—HEALTH CARE COST CONTAINMENT

SEC. 401. ESTABLISHMENT OF NATIONAL HEALTH CARE COST COMMISSION.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—There is hereby established within the Department of Health and Human Services a National Health Care Cost Commission (in this title referred to as the "Commission").

(2) COMPOSITION.—

(A) IN GENERAL.—The Commission shall be composed of 11 members, appointed by the President by and with the advice and consent of the Senate. The President shall first appoint members to the Commission by not later than

6 months after the date of the enactment of this Act.

(B) REPRESENTATION.—The membership of the Commission shall include individuals with national recognition for their expertise in health insurance, health economics, health care provider payment, and related fields. In appointing individuals, the President shall assure representation of consumers of health services, large and small employers, labor organizations, health care providers, and health care insurers.

(b) TERMS.—Members of the Commission shall be appointed to serve for terms of 3 years, except that the terms of the members first appointed shall be staggered so that the terms of no more than 4 members expire in any year. The term of the Chairman shall be coincident with the term of the President. Individuals appointed to fill a vacancy created in the Commission shall be appointed for the remainder of the term.

(c) DUTIES.—

(1) ANNUAL REPORT.—The Commission shall report annually to the President and the Congress on national health care costs. Such report shall be made by June 1 of each year and shall include information on—

(A) increases in public and private health care spending by type of health care service, by geographic region, and by source of payment;

(B) increases in the cost of private health insurance coverage; and

(C) factors contributing to increases in health care costs.

(2) REVIEW OF PAYMENT RATES.—The Commission shall review payment rates established by the Secretary under section 402(b) and make recommendations to the Secretary regarding the appropriateness of such rates.

(d) MISCELLANEOUS.—

(1) AUTHORITY.—The Commission may—

(A) employ and fix compensation of an Executive Director and such other personnel (not to exceed 25) as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

(B) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

(C) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5)); and

(D) make advance, progress, and other payments which relate to the work of the Commission.

(2) COMPENSATION.—While serving on the business of the Commission (including traveltime), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from the member's home and regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of the Commission. Physicians serving as personnel of the Commission may be provided a physician comparability allowance by the Commission in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to the Com-

mission in the same manner as it applies to the Tennessee Valley Authority.

(3) ACCESS TO INFORMATION, ETC.—The Commission shall have access to such relevant information and data as may be available from appropriate Federal agencies and shall assure that its activities, especially the conduct of original research and medical studies, are coordinated with the activities of Federal agencies. The Commission shall be subject to periodic audit by the General Accounting Office.

(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

SEC. 402. ESTABLISHMENT OF OPTIONAL PROVIDER PAYMENT RATES.

(a) ESTABLISHMENT OF RATES.—

(1) IN GENERAL.—The Secretary shall establish, for each class of provider (as defined in subsection (f)) by not later than October 1 before the beginning of each year (beginning with 1994), optional payment rates for hospital, physician, and other health items and services furnished during the year.

(2) REVIEW BEFORE PROMULGATION.—Before promulgating such rates, the Secretary shall provide

the Commission with the opportunity to review the proposed rates and to make recommendations with respect to such rates.

(b) PAYMENT BASIS.—The payment rates established under subsection (a) shall be based on payment rates and methodologies (including payment for inpatient hospital services on the basis of per discharge payments relating to diagnosis-related groups and payment for physicians' services based on a resource-based relative value scale) used under title XVIII of the Social Security Act, with appropriate adjustment to reflect differences in the benefits and populations served. Such methodologies for payment for inpatient and outpatient hospital services shall provide for an adjustment to take into account the costs incurred by hospitals in providing care for which no payment or only partial payment of the applicable payment rate is made.

(c) OPTIONAL APPLICATION OF RATES.—In the case of any purchaser (including a health insurance plan or an individual) that incurs a liability for hospital, physician, or other items and services furnished on or after January 1, 1994, and for which a payment rate is established under subsection (a), if the purchaser—

(1) elects to make payment on the basis of such rate, and

(2) provides (directly, through insurance, or a combination of both) for payment on a timely basis for such items and services of the full amount provided under such rate (or, in the case of physicians' services, a rate charged that does not exceed a maximum rate specified by the Secretary consistent with the rules on limitations on charges for physicians' services under section 1848(g) of the Social Security Act),

the purchaser shall be considered to have discharged any liability for payment for such items and services.

(d) ENFORCEMENT.—If a purchaser indicates to a health care provider (in a manner specified by the Secretary) that the purchaser is electing to make payment on the basis of rates established under subsection (a) and the provider (or another on the provider's behalf) seeks to collect amounts in excess of such rates (or in the case of physicians' services, the maximum rate referred to in subsection (c)(2)), the provider is subject to civil money penalty under section 1128A(a) of such Act in the same manner as a civil money penalty may be imposed under such section for a violation described in paragraph (2) of such section.

(e) CONSTRUCTION.—Nothing in this section shall be construed (1) as preventing a provider from charging or

agreeing to accept payments for items and services at rates less than the rates established under subsection (a), or (2) as preventing a State from establishing uniform payment rates (or maximum charge limits) for one or more items and services.

(f) CLASS OF PROVIDER DEFINED.—In this title, the term "class of provider" means hospitals, physicians, and such other classes of health care providers as the Secretary specifies in regulations.

SEC. 403. UNIFORM CLAIMS FORMS AND UNIFORM REPORTING STANDARDS.

(a) UNIFORM CLAIMS FORMS.—

(1) DEVELOPMENT.—The Secretary, after consultation with the Commission, entities offering group health plans, and health care providers, shall develop uniform claims forms for use by beneficiaries and health care providers in submitting claims under group health plans and the medicare and medicaid programs.

(2) DEADLINE.—Such forms shall be developed so that their acceptance by group health plans and the medicare and medicaid programs may be required for services furnished on or after January 1, 1994.

(b) UNIFORM REPORTING STANDARDS.—

(1) DEVELOPMENT.—In connection with the development of rates under section 402, the Secretary shall develop standards for the uniform reporting by providers of health care services of information (in a form that does not identify individual patients) respecting—

(A) the types and amounts of health services provided, and

(B) the costs of providing such services.

(2) DEADLINE.—Such standards shall be developed so that their use by providers may be required for periods beginning on or after January 1, 1993.

TITLE V—MEDICARE PREVENTION BENEFITS

SEC. 501. COVERAGE OF COLORECTAL SCREENING.

(a) IN GENERAL.—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by inserting after subsection (c) the following new subsection:

"(d) FREQUENCY AND PAYMENT LIMITS FOR SCREENING FECAL-OCCULT BLOOD TESTS AND SCREENING FLEXIBLE SIGMOIDOSCOPIES.—

"(1) SCREENING FECAL-OCCULT BLOOD TESTS.—

"(A) PAYMENT LIMIT.—In establishing fee schedules under section 1833(h) with respect to

screening fecal-occult blood tests provided for the purpose of early detection of colon cancer, except as provided by the Secretary under paragraph (3)(A), the payment amount established for tests performed—

"(i) in 1992 shall not exceed $5; and

"(ii) in a subsequent year, shall not exceed the limit on the payment amount established under this subsection for such tests for the preceding year, adjusted by the applicable adjustment under section 1833(h) for tests performed in such year.

"(B) FREQUENCY LIMIT.—Subject to revision by the Secretary under paragraph (3)(B), no payment may be made under this part for a screening fecal-occult blood test provided to an individual for the purpose of early detection of colon cancer—

"(i) if the individual is under 50 years of age; or

"(ii) if the test is performed within 11 months after a previous screening fecal-occult blood test.

"(2) SCREENING FLEXIBLE SIGMOIDOSCOPIES.—

"(A) PAYMENT AMOUNT.—The Secretary shall establish a payment amount under section 1848 with respect to screening flexible sigmoidoscopies provided for the purpose of early detection of colon cancer that is consistent with payment amounts under such section for similar or related services, except that such payment amount shall be established without regard to subsection (a)(2)(A) of such section.

"(B) FREQUENCY LIMIT.—Subject to revision by the Secretary under paragraph (3)(B), no payment may be made under this part for a screening flexible sigmoidoscopy provided to an individual for the purpose of early detection of colon cancer—

"(i) if the individual is under 50 years of age; or

"(ii) if the procedure is performed within 59 months after a previous screening flexible sigmoidoscopy.

"(3) REDUCTIONS IN PAYMENT LIMIT AND REVISION OF FREQUENCY.—

"(A) REDUCTIONS IN PAYMENT LIMIT.—The Secretary shall review from time to time the appropriateness of the amount of the pay-

ment limit established for screening fecal-occult blood tests under paragraph (1)(A). The Secretary may, with respect to tests performed in a year after 1994, reduce the amount of such limit as it applies nationally or in any area to the amount that the Secretary estimates is required to assure that such tests of an appropriate quality are readily and conveniently available during the year.

"(B) REVISION OF FREQUENCY.—

"(i) REVIEW.—The Secretary, in consultation with the Director of the National Cancer Institute, shall review periodically the appropriate frequency for performing screening fecal-occult blood tests and screening flexible sigmoidoscopies based on age and such other factors as the Secretary believes to be pertinent.

"(ii) REVISION OF FREQUENCY.—The Secretary, taking into consideration the review made under clause (i), may revise from time to time the frequency with which such tests and procedures may be paid for under this subsection, but no such

revision shall apply to tests or procedures performed before January 1, 1995.

"(4) LIMITING CHARGES OF NONPARTICIPATING PHYSICIANS.—

"(A) IN GENERAL.—In the case of a screening flexible sigmoidoscopy provided to an individual for the purpose of early detection of colon cancer for which payment may be made under this part, if a nonparticipating physician provides the procedure to an individual enrolled under this part, the physician may not charge the individual more than the limiting charge (as defined in subparagraph (B), or, if less, as defined in section 1848(g)(2)).

"(B) LIMITING CHARGE DEFINED.—In subparagraph (A), the term 'limiting charge' means, with respect to a procedure performed—

"(i) in 1992, 120 percent of the payment limit established under paragraph (2)(A); or

"(ii) after 1992, 115 percent of such applicable limit.

"(C) ENFORCEMENT.—If a physician or supplier knowing and willfully imposes a charge in violation of subparagraph (A), the Secretary

may apply sanctions against such physician or supplier in accordance with section 1842(j)(2).".

(b) CONFORMING AMENDMENTS.—(1) Paragraphs (1)(D) and (2)(D) of section 1833(a) of such Act (42 U.S.C. 1395l(a)) are each amended by striking "subsection (h)(1)," and inserting "subsection (h)(1) or section 1834(d)(1),".

(2) Section 1833(h)(1)(A) of such Act (42 U.S.C. 1395l(h)(1)(A)) is amended by striking "The Secretary" and inserting "Subject to paragraphs (1) and (3)(A) of section 1834(d), the Secretary".

(3) Clauses (i) and (ii) of section 1848(a)(2)(A) of such Act (42 U.S.C. 1395w–4(a)(2)(A)) are each amended by striking "a service" and inserting "a service (other than a screening flexible sigmoidoscopy provided to an individual for the purpose of early detection of colon cancer)".

(4) Section 1862(a) of such Act (42 U.S.C. 1395y(a)) is amended—

(A) in paragraph (1)—

(i) in subparagraph (E), by striking "and" at the end,

(ii) in subparagraph (F), by striking the semicolon at the end and inserting ", and", and

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

"(G) in the case of screening fecal-occult blood tests and screening flexible sigmoidoscopies provided for the purpose of early detection of colon cancer, which are performed more frequently than is covered under section 1834(d);"; and

(B) in paragraph (7), by striking "paragraph (1)(B) or under paragraph (1)(F)" and inserting "subparagraphs (B), (F), or (G) of paragraph (1)".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to screening fecal-occult blood tests and screening flexible sigmoidoscopies performed on or after January 1, 1992.

SEC. 502. COVERAGE OF CERTAIN IMMUNIZATIONS.

(a) IN GENERAL.—Section 1861(s)(10) of the Social Security Act (42 U.S.C. 1395x(s)(10)) is amended—

(1) in subparagraph (A)—

(A) by striking ", subject to section 4071(b) of the Omnibus Budget Reconciliation Act of 1987,", and

(B) by striking "; and" and inserting a comma;

(2) in subparagraph (B), by striking the semicolon at the end and inserting ", and"; and

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

"(C) tetanus-diphtheria booster and its administration;".

(b) LIMITATION ON FREQUENCY.—Section 1862(a)(1) of such Act (42 U.S.C. 1395y(a)(1)), as amended by section 502(b)(4)(A), is amended—

(1) in subparagraph (F), by striking "and" at the end;

(2) in subparagraph (G), by striking the semicolon at the end and inserting ", and"; and

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

"(H) in the case of an influenza vaccine, which is administered within the 11 months after a previous influenza vaccine, and, in the case of a tetanus-diphtheria booster, which is administered within the 119 months after a previous tetanus-diphtheria booster;".

(c) CONFORMING AMENDMENT.—Section 1862(a)(7) of such Act (42 U.S.C. 1395y(a)(7)), as amended by section 502(b)(4)(B), is amended by striking "or (G)" and inserting "(G), or (H)".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to influenza vaccines and tetanus-diphtheria boosters administered on or after January 1, 1992.

SEC. 503. COVERAGE OF WELL-CHILD CARE.

(a) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(1) by striking "and" at the end of subparagraph (O);

(2) by striking the semicolon at the end of subparagraph (P) and inserting "; and"; and

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

"(Q) well-child services (as defined in subsection (ll)(1)) provided to an individual entitled to benefits under this title who is under 19 years of age;".

(b) SERVICES DEFINED.—Section 1861 of such Act (42 U.S.C. 1395x) is amended—

(1) by redesignating the subsection (jj) added by section 4163(a)(2) of the Omnibus Budget Reconciliation Act of 1990 as subsection (kk); and

(2) by inserting after subsection (kk) (as so redesignated) the following new subsection:

"Well-Child Services

"(ll)(1) The term 'well-child services' means well-child care, including routine office visits, routine immunizations (including the vaccine itself), routine laboratory tests, and preventive dental care, provided in accordance with the periodicity schedule established with respect to the services under paragraph (2).

"(2) The Secretary, in consultation with the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and other entities considered appropriate by the Secretary, shall establish a schedule of periodicity which reflects the appropriate frequency with which the services referred to in paragraph (1) should be provided to healthy children.".

(c) CONFORMING AMENDMENTS.—(1) Section 1862(a)(1) of such Act (42 U.S.C. 1395y(a)(1)), as amended by sections 501(b)(4)(A) and 502(b), is amended—

(A) in subparagraph (G), by striking "and" at the end;

(B) in subparagraph (H), by striking the semicolon at the end and inserting ", and"; and

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

"(I) in the case of well-child services, which are provided more frequently than is provided under the schedule of periodicity established by the Secretary under section 1861(ll)(2) for such services;".

(2) Section 1862(a)(7) of such Act (42 U.S.C. 1395y(a)(7)), as amended by sections 502(b)(4)(B) and 503(c), is amended by striking "or (H)" and inserting "(H), or (I)".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to well-child services provided on or after January 1, 1992.

SEC. 504. ANNUAL SCREENING MAMMOGRAPHY.

(a) ANNUAL SCREENING MAMMOGRAPHY FOR WOMEN OVER AGE 64.—Section 1834(c)(2)(A) of the Social Security Act (42 U.S.C. 1395m(b)(2)(A)) is amended—

(1) in clause (iv), by striking "but under 65 years of age,"; and

(2) by striking clause (v).

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to screening mammography performed on or after January 1, 1992.

SEC. 505. DEMONSTRATION PROJECTS FOR COVERAGE OF OTHER PREVENTIVE SERVICES.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall establish and provide for a series of ongoing demonstration projects under which the Secretary shall provide for coverage of the preventive services described in subsection (c) under the medicare program in order to determine—

(1) the feasibility and desirability of expanding coverage of medical and other health services under the medicare program to include coverage of such services for all individuals enrolled under part B of title XVIII of the Social Security Act; and

(2) appropriate methods for the delivery of those services to medicare beneficiaries.

(b) SITES FOR PROJECT.—The Secretary shall provide for the conduct of the demonstration projects established under subsection (a) at the sites at which the Secretary conducts the demonstration program established under section 9314 of the Consolidated Omnibus Budget Reconciliation Act of 1985 and at such other sites as the Secretary considers appropriate.

(c) SERVICES COVERED UNDER PROJECTS.—The Secretary shall cover the following services under the se-

ries of demonstration projects established under subsection (a):

(1) Glaucoma screening.

(2) Cholesterol screening and cholesterol-reducing drug therapies.

(3) Screening and treatment for osteoporosis, including tests for bone-marrow density and hormone replacement therapy.

(4) Screening services for pregnant women, including ultra-sound and clamydial testing and maternal serum alfa-protein.

(5) One-time comprehensive assessment for individuals beginning at age 65 or 75.

(6) Other services considered appropriate by the Secretary.

(d) REPORTS TO CONGRESS.—Not later than October 1, 1993, and every 2 years thereafter, the Secretary shall submit a report to the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives describing findings made under the demonstration projects conducted pursuant to subsection (a) during the preceding 2-year period and the Secretary's plans for the demonstration projects during the succeeding 2-year period.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated from the Federal Supplementary Medical Insurance Trust Fund for expenses incurred in carrying out the series of demonstration projects established under subsection (a) the following amounts:

(1) $4,000,000 for fiscal year 1993.

(2) $4,000,000 for fiscal year 1994.

(3) $5,000,000 for fiscal year 1995.

(4) $5,000,000 for fiscal year 1996.

(5) $6,000,000 for fiscal year 1997.

SEC. 506. OTA STUDY OF PROCESS FOR REVIEW OF MEDICARE COVERAGE OF PREVENTIVE SERVICES.

(a) STUDY.—The Director of the Office of Technology Assessment (in this section referred to as the "Director") shall, subject to the approval of the Technology Assessment Board, conduct a study to develop a process for the regular review for the consideration of coverage of preventive services under the medicare program, and shall include in such study a consideration of different types of evaluations, the use of demonstration projects to obtain data and experience, and the types of measures, outcomes, and criteria that should be used in making coverage decisions.

(b) REPORT.—Not later than 2 years after the date of the enactment of this title, the Director shall submit a report to the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives on the study conducted under subsection (a).

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pillars of democracy on which our country is founded and that we will uphold the responsibilities we have. We will tell the Almighty that: You really have blessed us and given us benefits nobody else has. But we will share that responsibly.

The Framers knew that the Supreme Court was central to the protection of individuals against the excesses of the majority. They understood that, to protect the independence of the Court, neither the executive nor the legislature—nor the Senate—should have the power to cast the Court in its own image. They therefore made the Senate an equal partner in appointments to the Supreme Court.

If the White House were willing to seek the Senate's advice rather than simply demanding its consent; if nominees would come before the Senate prepared to engage in an honest and forthright discussion of the Constitution and the Bill of Rights; if Senators would ask genuine questions instead of indulging in political speeches—and would treat all witnesses with basic fairness and common decency—the advice and consent process would work fine. Before trying to "fix something that isn't broke," let this body and the White House, working together as the Constitution contemplated, make the system work right.

I have had many times in the Senate when I have disagreed with the President. I have had many times when I have agreed with the President. I feel, as the President of this country, he deserves a great deal of respect, and he deserves a great deal of discretion. In so many things, we give him that. In so many things, Republicans and Democrats alike in this body have joined with President Bush for the good of the country.

But let us not assume that because we follow our constitutional duty—not our constitutional right, our constitutional duty—of advice and consent, somehow this is disloyal to America, disloyal to the President, disloyal to this body. It is what every one of us has sworn to do. Each one of us, when we take our oath of office when we begin our term, we stand in this Chamber, we raise our hand and we swear before Almighty God we will uphold the Constitution of this land.

Upholding it does not mean just reading it. Upholding it means defending it with every fiber of our body. Because if we do not, we do not deserve to be here—none of us do.

We have no greater duty than to preserve our democracy. And that means to preserve the checks and balances of our democracy. And it means, also, to preserve the institution not just of the Senate, not just of the Presidency, but—across the street—of the U.S. Supreme Court; and to be able to say, as Senators, we have done everything possible to have a Court that is there for every man, woman, and child in this country, no matter where they fall on the political spectrum. No matter who they are, rich, poor, connected or not. In America every American can say: If my rights are trampled, I will go to the Supreme Court, if necessary. And it is a Court not already predisposed against me. It is a Court that welcomes me.

So, when we talk about changing the process, let us remember that means changing the Constitution. It is a Constitution that has served us all very well for 200 years. If we have a sense of history and a love of the Constitution, we will be very, very careful when we start walking down that road to change.

Instead, every Senator, every one of us, should ask himself or herself what have we done and what are we doing to uphold the Constitution—not to uphold politics; not to uphold a political poll; not to uphold the political fortunes of one side or the other. But first and foremost, what are we doing every day to uphold the Constitution?

Mr. President, I yield the floor.

Mr. MITCHELL. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. LIEBERMAN). Without objection, it is so ordered.

CIVIL RIGHTS ACT OF 1991

Mr. MITCHELL. Mr. President, I have just come from a meeting with the distinguished Republican leader, Senator DANFORTH, and Senator KENNEDY, regarding the pending civil rights bill.

Senator DOLE and I were informed that negotiations are continuing in an effort to reach agreement on some of the more important and controversial aspects of that bill. As a result of the information provided at the meeting, I have concluded, following consultation with Senator DOLE, that it would be best to permit a brief period of time this afternoon for such discussions to continue.

Under the previous order, at 2:30 p.m., the Senate will turn to the Federal Facilities Compliance Act and measures with respect thereto. That will continue until 3:30 p.m., at which time there will be three rollcall votes.

So as to permit those discussions to continue unimpeded, and not to require the presence of the bill's managers on the floor between now and approximately 4:30 p.m., I ask unanimous consent that the time between now and 2:30 p.m. be for purposes of debate only on the civil rights bill.

The PRESIDING OFFICER. Is there objection?

The Republican leader.

Mr. DOLE. Mr. President, reserving the right to object, and I shall not object, the majority leader has accurately stated the situation. There are discussions going on, and there is some optimism. There has been optimism before, so I will not want to say it will happen. At least, there is an effort being made with representatives of the President and others, who are in discussion as we speak, trying to resolve some of the differences. I hope they can be resolved, but I think in a couple hours we may know.

So I thank the majority leader.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. MITCHELL. Mr. President, I thank my colleagues, and I anticipate that those involved will be advising us sometimes in the next several hours as to what the status of the discussion is that time. I expect to be in a position to make some announcement on how we intend to proceed, either prior to or just following the three votes that are not scheduled to commence at 3:30 p.m.

Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. MITCHELL. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

HEALTH CARE

Mr. MITCHELL. Mr. President, in this period during which the civil rights matter is before us for debate only, I want to take the opportunity to discuss a subject, with which I have been deeply involved and about which I have been very much concerned for a long period of time, to encourage my colleagues and others in policymaking positions to consider, and that is the need for comprehensive reform of our health care system.

Prior to becoming majority leader, I served as chairman of the Senate Health Subcommittee, during which time I conducted a series of hearings regarding the status of the health care system in our society. It was my conclusion then—and this was in a period of 1987 and 1988—that major reform was needed in the American health care system, and my conviction in that regard has been strengthened by what I have learned since then.

I believe, Mr. President, and Members of the Senate, that, at its best, the American health care system delivers the highest quality of health care in the world. The problem is that the system does not operate at its best for all Americans. Right now, there are an estimated 37 million Americans who do not have health care insurance, and that number is rising by an estimated 1 million people a year.

Contrary to what is a widespread belief in our country, most of those people are white and most of them are working or the dependents of persons who are working. So a very large and growing proportion of Americans do not have ready access to health care, because, with the tremendous and con-

tinuing increase in health care costs, lack of health care insurance effectively means lack of access to good health care.

This is a most unfortunate result. I believe that in our democracy it ought to be a fundamental right of every citizen to have access to good and affordable health care—a fundamental right of citizenship in a democracy; not a privilege, not something to be limited to a few, not something to be rationed in accordance with wealth or any other measure of status, but rather something that every single American citizen—man, woman, and child—should have as a basic right.

What do we do about it? Well, first, I believe we must recognize that the problem in the American health care system is not that we need to spend more money. In fact, the problem is just the opposite. We need to spend less money. We are already spending too much money on health care.

The most recent estimate I have seen is that in this year Americans will spend an estimated $670 billion on health care—$670 billion. More than 12 percent of our gross national product. Both figures, the absolute dollars and the percentage of gross national product, by far the highest in the world. No other country spends, either in absolute dollars or in percentage of their gross national product, anything near the amount that is spent in this society.

For that, as I said, we get the best care when the system operates at its best and when care is available and accessible and affordable to Americans.

Therefore, Mr. President, it is my conclusion that our system needs comprehensive reform. This is a problem that affects every American family. The American family which is so well off that it need not fear the devastating financial consequences of an unexpected major illness or injury is very, very rare indeed. Every family either confronts the problem immediately now or is filled with anxiety about what might happen if the problem strikes at them.

Earlier this year I was in Fargo, ND, where I visited a superb institution, a regional children's hospital, one of the finest medical facilities I have been in, and I have been in many, many of them. There I met and talked with the dedicated staff of health care professionals who asked me to tour the facility and to talk with some of the patients and their families.

I met a teenage boy and his parents. His parents operated a small farm near Fargo. As we all know, farming is a seasonal and unpredictable business, and income is neither assured nor regular.

In the previous winter, this young couple, faced with a period in which their income was down, having to cut expenses to the bone, decided to temporarily discontinue their health insurance policy. They expected to resume paying the premiums on the health insurance policy in the spring when they expected income to resume from their farming operations.

Tragically, just a short time before they were going to resume paying the premiums and reinstate their health insurance policy their teenage son was involved in a serious automobile accident. As a consequence the young boy is now seriously injured and possibly permanently paralyzed, and the family faces already-incurred medical bills in the tens of thousands of dollars that far exceed any possibility of the family ever being able to meet these payments.

I also met in the hospital a young, 2½-year-old girl and her young parents. This young girl had been born with a serious infirmity and had never spent a single moment of her life outside of the hospital. The entire 2½ years of her life had been spent inside that hospital incurring medical expense at a rate in excess of $1,500 a day. Her parents also were a young couple who operated a farm in the area. And they now confront bills already in the hundreds of thousands of dollars and which may go far beyond that. Again, completely beyond their income, completely beyond any prospect of their paying all or even a major portion of this bill.

A few weeks after that in my office I met and talked with a young man in his midtwenties who works in a factory, a paper mill in Maine. He told me his story.

He and his wife had a child. The child was born with a serious infirmity, and very extensive and very expensive medical procedures were employed to try to save the child's life. After a period of several months the child died. The mother and father got the bill. It was $350,000. A young man about 25-years-old, who works in a factory. He told me he was lucky because he has a good job with health benefits which will pay $200,000 of that bill. He being more fortunate than most in our society.

Yet even with that fortune he and his wife are confronted with a bill of $150,000. They have worked out an arrangement with the health care providers that they will pay some portion of their income for the rest of their lives. They will never be able to repay the entire bill with interest. But they feel that their infant child was given the best care; they have a moral obligation to try to repay it and they are going to do the best they can. But for the rest of their lives, already burdened by the loss of their child, they will now be burdened by a bill that they can never pay.

If these were isolated cases, if there were only these three, or three other such cases in the country, we in the Senate could all fee enormous sympathy with the parents and the children involved but not feel for national policy on the basis of just a few isolated instances. But every Member of the Senate knows these are not isolated instances. These are tragically typical; these are, tragically, a few of the many examples of which we have all heard—people we have all met, people we have all talked to in our town meetings, in our meetings with our constituents, even in some cases within our own families and friends.

This is not an isolated problem. That is not a problem that affects only a few Americans. This is not a problem that affects Americans only in one region of the country. This is not a problem that affects Americans of only one race. This is not a problem that affects Americans in urban or rural areas. This is a problem that affects Americans everywhere and virtually every American family.

The situation simply cries out for leadership, and for effort, and for meaningful and substantive reform of the current system.

Earlier this year I joined with some Senators in introducing comprehensive legislation. It is much too complicated and lengthy to describe in full detail here. I do intend to make a series of statements on the Senate floor on the subject because I think the matter has not received the attention of the Senate, which I believe it deserves. But the legislation has two principal objectives which are, on their face, conflicting—but both of which require action.

On the one hand the legislation provides universal health care insurance. Every American should be insured against the costs of health care—every American.

Mr. WELLSTONE assumed the Chair.

Mr. MITCHELL. Mr. President, there should not be any exceptions. There should not be anyone who confronts the possibility of not being able to deal with something—either injury, illness, accident, some other physical ailment—to a member of their family because they do not have health insurance. There is not anybody who ought to be denied the good care that every citizen ought to have, and the essential first step in that must be health insurance.

And so the first and fundamental premise of our bill is to provide universal health insurance for all Americans. That is absolutely essential, in my judgment. It is the minimum first step, the threshold, which any legislation must provide to be described as meaningful.

The other problem which is major is, How do we control costs? At first glance, one might say if you increase coverage, if you provide more persons with ready access to care, you inevitably drive up costs and, in fact, if you do have any cost-containment provisions, that is exactly what will happen. We clearly are going to exceed $700 billion next year. We are moving to 13 percent of our gross national product in health care costs.

So if we simply say we are gong to expand health insurance, we are going to give everybody access to care and do nothing else, then we guarantee that costs will rise even faster than they have been rising which, in the past several years, has been more than three times the rate of inflation, generally.

So our measure takes as the second, or really a first and coequal principle, that we must take dramatic action to control costs at the national level. We must bring down the amount of money that our society is spending on health care and we need not sacrifice quality. We need not sacrifice comprehensiveness. We can do so at less cost.

The legislation which we have introduced will, according to one estimate, reduce overall costs by an estimated $80 billion in the first 5 years in which the bill is in operation—$80 billion. That is not enough. And we are now receiving comments on our bill—a lot of criticism and a lot of it constructive criticism, suggestions which we are taking seriously and considering as we hope this legislation moves through the legislative process in an effort to come up with what we think will be the best approach.

The legislation seeks to control costs in a variety of ways. I will just touch briefly on a couple of them.

I want to yield momentarily to my friend from Arkansas who has been a leader in this effort and who has been involved in health care and costs, particularly in the area of prescription drugs, which he may want to address. But the principal area in which we believe reform is necessary in terms of controlling costs is, first, to create authority for States to impose dramatic cost-control requirements.

Our legislation calls for administration of the program at the State level because the health care problems of rural Maine are not the same as the heath care problems of inner-city Los Angeles, and the problems of Arkansas are not the same as New York. The best place to do this is at the State level, and our legislation will authorize the States, will create authority for States to undertake a wide range of cost control measures, including some which have been tried at the State level and including others that have not yet been included at the State level.

For example, we proposed to permit States to create legal entities within those States—for want of a better term, in the legislation it is called a State consortium—to negotiate with providers, to control the amount by which health care costs increase each year.

We also would require comprehensive reform of the small insurance company share of the health care market. One of the problems we have in our society now is that we have thousands of different mechanisms by which payment is made—many different companies operating, each with its own claims department, each with its own claims process, each with its own claims form. When you add on to that the forms under Medicare and Medicaid, our health care community is being drowned in a deluge of paperwork.

There is not any reason why we could not have and should not have within each State one form—one form—and one payment mechanism so as to eliminate all of the duplication, eliminate all of the additional paperwork, and eliminate the administrative cost of a large number of small companies, each with its own claims and other administering staff duplicating that of others. We believe this is absolutely essential to controlling costs. When we are talking about $670 billion a year, a 2 percent saving is a modest estimate of what can be saved by the elimination of duplication in this regard.

So I am very deeply committed to trying to get this reform completed in a way that will enable us to bring costs under control.

As I said, Mr. President, there are a number of other measures in our bill that seek to attain cost containment. I think it is essential both in terms of the substantive approach we are taking, that is, I do not think we can expand coverage and not try to contain cost, but for the political purposes of trying to get a bill passed in the first place, the reality is we could not pass a bill in the Senate and do not think a bill could pass in the House if it had one or the other of these components without both. The conflicting economic interests, the diverse social interests, and a lot of others are such that we are going to have to have, in my judgment, both full insurance coverage and meaningful and very effective cost containment in order to be in a position to get legislation enacted.

Mr. President, as I said, this is a subject which has deeply concerned me for many years with respect for which I have been very deeply involved. I introduced legislation a short time ago. We will be holding hearing around the country in the near future to find out more about the problem and to add to public knowledge and, I hope, interest in the subject. I intend to make a series of statements in the Senate on this subject because of the importance which I attach to it in terms of our agenda.

The agenda of the Senate ought to be the agenda of the American family. The problem now in our country is that many Americans perceive that we are not addressing the issues which are immediate concern to them and their families, and that we are addressing issues that are peripheral to or even unrelated to their daily lives and their daily needs.

If we are to regain the confidence and trust of the American people, if we are to truly merit the title of representatives in a representative democracy, then it seems to me we must begin by addressing those concerns that are central to their lives.

I have traveled all over this country and I have traveled all over my State, and I know everywhere I go the subject of health care is foremost in the minds of our citizens. People bring it up all the time, specific examples. Most Senators, I know, hold town meetings. I know based on my own experience, I would guess that there is hardly a Senator who has not been confronted at a town meeting by some person or family getting up and saying, "Senator, this is what happened to me and my family and my child. Here is the bill I have received. It is ten times what I make in a year, 50 times what I have in my savings. Impossible for me to pay. What are you going to do about it?"

I believe it is time we did something about it, and I hope, through this series of statements which I have begun today and which I hope to make on a regular basis in the coming months, that I can somehow at least bring to the attention of the Senate, focus our attention, the need for action on health care legislation and bring about action in this Congress.

It is my intention, which I have stated publicly, and I repeat here today, that we in the Senate will vote on health care legislation in this Congress. It is not going to happen in this year. It has not progressed to the point through the legislative process that will permit us to act in this first session of this Congress. But I fully expect that we will reach that point next year. I am determined that we will do so.

There are many different views sincerely held and many strong differences of opinion. But as I said when we introduced our bill, we did not offer it as the perfect solution. We did not offer it as the only solution. We did not offer it as necessarily the best solution. We offered it as a serious, thoughtful effort, the product of nearly 2 years of work, to try to bring about a focus on the debate on this subject as a first step toward getting legislative action.

To those who disagree with any aspect of our bill, we invite their constructive comments. We invite their alternative suggestions. We invite their criticism.

But it is not enough to simply say our approach is wrong and offer nothing else. That is not leadership, and we are elected to be leaders in our society. To those who do not like this approach, to those who think this approach fails in one or another way, I invite and encourage their participation. I especially invite and ask them to offer their constructive alternatives. Out of that debate I think we can get a good product and a good result.

Mr. President, I want to yield now to the Senator from Arkansas and commend him for his action and involvement in this area. I know he has a par-

ticular interest in the area of prescription drugs that he may wish to address.

Mr. PRYOR addressed the Chair.

The PRESIDING OFFICER. The Senator from Arkansas is recognized.

Mr. PRYOR. Mr. President, I thank the majority leader for yielding to me. I applaud the majority leader for his statement on health care and some of the aspects that his legislation is going to address.

Mr. President, it has been my privilege the last several years to have as my seat mate on the Senate Finance Committee the very able and, I must say, very committed Senator from Maine, Senator MITCHELL. On many occasions I have seen him take this issue of health care and attempt, in his very commanding way, to at least focus the attention of this country and his colleagues on this issue, and to also attempt to get the attention and the support and the cooperation of this administration in dealing with one of the most critical issues of our times.

One of those issues, Mr. President, one of those great concerns that I see in the overall arena of health care to which we must address ourselves, is one that I have addressed on this floor on many occasions, also in the Senate Special Committee on Aging on several occasions, and recently before the Senate Education and Labor Committee and, of course, on several occasions in the Senate Finance Committee. That issue, Mr. President, is the issue of prescription drugs.

We have had a great deal of discussion in our country in recent years about hospital costs and a way to contain the costs of hospitalization. We have gone to the American Medical Association. We have gone to the doctors and have said you have to contribute to cost containment, and if you are not going to do it voluntarily, we are going to do it by statute; we are going to set the prices that you can charge.

So we have seen hospitals and we have seen doctors attempt through voluntary and statutory activities to limit in some way the tremendous cost increases that we have in medical care today.

Mr. President, there is one aspect of the health care delivery system that has not been cooperative, that in no way has attempted to come forward and say we are going to do our part; we are going to help control costs of prescription drugs in America.

To the contrary, Mr. President, the Pharmaceutical Manufacturers Association and their members that manufacture the prescription drugs we use today for our basic life support, those particular companies today, most of them—not all but most—are gouging the American public at an unprecedented rate.

All we have to do, Mr. President, is look back 10 years to see a general inflation rate of 58 percent. That has been over the last decade. But prescription drug costs, Mr. President, have not risen at 58 percent. They have risen at 152 percent—a 152-percent increase in the cost of prescription drugs in 10 years.

What we see is that in 1980, just 11 short years ago, a bottle of capsules that cost $20, today is, on the average, $58 a bottle. What we see also is a response by the pharmaceutical manufacturers. They come to the Congress year after year and they say, well, we must be able to generate huge profits so that we can plow these profits back into research and development of new drugs.

What the pharmaceutical manufacturers do not tell us, Mr. President—and the distinguished majority leader knows this—is that for all those dollars which they plow into research to find the cure for cancer, Alzheimer's, Parkinson's, and the dreaded diseases of our time, they are getting a tax writeoff. This is a tax writeoff for the pharmaceutical manufacturers.

What they are also not telling us, Mr. President, is that once a drug is sent to the market, they have a 17-year period of patent protection; they are protected from any other manufacturer coming in to compete against them.

We see also, Mr. President, that once they secure a patent from the U.S. Patent Office, that same manufacturer, 9 times out of 10, will move to Puerto Rico their plant, their operations, their manufacturing facilities, and they will manufacture these drugs there to become eligible for billions of dollars in tax credits from the section 936 program of the Internal Revenue Service Code. Mr. President, we are seeing today that pharmaceutical manufacturers are getting a $70,000 tax credit for each employer—whose salaries average approximately $26,000 a year—they hire in Puerto Rico. The manufacturers put them to work so that the industry can have a free ride in Puerto Rico in manufacturing these drugs.

Mr. President, I could go on and talk about what the drug manufacturers are doing to the American public, but I can best summarize it in one human experience. I received a letter just last week from a constituent. This constituent lives on a Social Security check of $936 a month. But this individual who sent me what his income is also sent me all of the bills for a month's period for prescription drugs—over $500 a month out of his $900 a month income on Social Security is being used to pay the costs of the prescription drugs this individual needs just to stay alive.

I think we must address the issue of the fast escalating costs of prescription drugs.

Mr. President, I am very hopeful I can join with the majority leader in his legislation. I hope we will be joined by this administration and the President of the United States to address not only those larger concerns expressed by the majority leader but also the issue of prescription drug costs in our country.

Mr. President, I think the time has expired.

FEDERAL FACILITIES COMPLIANCE ACT

The PRESIDING OFFICER. Under the previous order, the hour of 2:30 p.m. having arrived, the Senate will now resume consideration of S. 596, which the clerk will report.

The bill clerk read as follows:

A bill (S. 596) to provide that Federal facilities meet Federal and State environmental laws and requirements and to clarify that such facilities must comply with such environmental laws and requirements.

The Senate resumed consideration of the bill.

The PRESIDING OFFICER. Under the previous order, the Senator from California [Mr. SEYMOUR], is recognized to offer an amendment.

AMENDMENT NO. 1271

(Purpose: To determine the source of the unauthorized release of confidential information compiled by the FBI with respect to Prof. Anita Hill and Judge Clarence Thomas)

Mr. SEYMOUR. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The bill clerk read as follows:

The Senator from California [Mr. SEYMOUR], for himself, Mr. DOMENICI, Mr. MURKOWSKI, Mr. GRAMM, Mr. COATS, Mr. THURMOND, Mr. SIMPSON, Mr. BROWN, Mr. BOND, Mr. BURNS, Mr. CRAIG, Mr. GRASSLEY, Mr. HATCH, Mr. KASTEN, Mr. MACK, Mr. MCCONNELL, Mr. NICKLES, Mr. JEFFORDS, Mr. SMITH, Mr. SYMMS, Mr. HATFIELD, AND Mr. LUGAR proposes an amendment numbered 1271.

The Federal Bureau of Investigation is hereby requested and authorized to obtain such subpoenas as are necessary to secure the attendance of such witnesses and the production of such correspondence, books, papers, documents, and other sources of information, to take such sworn testimony and to make such expenditures out of any funds appropriated and not otherwise obligated to make an investigation into the matter of releasing of any confidential or secretive information transmitted to the Senate committee on the Judiciary regarding Professor Anita Hill of the University of Oklahoma or Judge Clarence Thomas and to report to the Congress the results of this investigation not later than 30 days after the date of enactment of this Act.

RESOLUTION RELATIVE TO THE APPOINTMENT OF SPECIAL COUNSEL—SENATE RESOLUTION 202

The PRESIDING OFFICER. Under the previous order, the Senate majority leader is recognized.

Mr. MITCHELL. Mr. President, I send a resolution to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:



A POLICY MAKER'S GUIDE TO THE HEALTH CARE CRISIS

PART II: THE HERITAGE CONSUMER CHOICE HEALTH PLAN

By Stuart M. Butler, Ph.D.

The Heritage Foundation

March 5, 1992

A POLICY MAKER'S GUIDE TO THE HEALTH CARE CRISIS PART II: THE HERITAGE CONSUMER CHOICE HEALTH PLAN

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INTRODUCTION

Part I of this *Talking Points* series on health care explained that proposals to reform America's health care system generally are based on one of three approaches. Each approach uses a different mechanism to allocate health care resources and to determine what services a family receives. These three methods are:

1) **The Single-Payer (or "Canadian") Approach.** The government becomes the monopoly provider of health care financing. It fixes a budget for health care and allocates money to hospitals, and it sets physician fees.

2) **The "Play or Pay" Approach.** The government gives employers a choice: either provide at least a specified health insurance plan to employees and their families, or pay a payroll tax to finance a public program for their health benefits, as well as for those Americans not currently insured. The government runs the public program and employers are responsible for financing and managing private insurance.

3) **The Consumer Choice Approach.** Americans are allowed to choose the health care plan they want. Unlike today, where government help to obtain a plan effectively is restricted to employer-sponsored plans, families would receive the same amount of government help wherever they obtained coverage. Further, there would be more help for the sick and the low-paid, less for the healthy and the high-paid. No national budget for health care would be set by the government, and efficient allocation and cost control would be determined by consumer choice and competition among providers.

Many of the key features of a consumer-based system already exist in the Federal Employee Health Benefits Program (FEHBP). This covers congressmen and their staff, agency heads and employees, and judicial branch employees—in all over nine million workers, their dependents, and retirees. Several proposals are versions of a consumer-based system. The Bush Administration's recent health proposal would establish such a system for today's uninsured.

way they can obtain a tax break for health care costs (for the implications of this, see *Talking Points, Part I: The Debate Over Reform*, February 12, 1992).[3]

Under the Heritage plan, the current exclusion for company-provided plans, as well as other minor health tax deductions, would be replaced with a new tax credit available to all non-elderly and non-Medicaid families for the purchase of health insurance and out-of-pocket medical costs. The cost to the Treasury for the credit would exactly equal the cost of current tax breaks. In Washington jargon, this makes the plan "budget neutral."

Q: What does that mean for employees who have a company plan? Would they pay higher taxes?

A: Generally no. It just means families would gain tax relief in a different way. If they had a company-sponsored plan, the cash value of that plan now would appear as a taxable item on their end-of-year W-2 tax form from the employer. But the family then would be able to claim a credit for the cost of employer-sponsored plan and for out-of-pocket costs, such as deductibles. Further, if the family chose a plan from a source other than their employer, the employer would be required to "cash out" their current benefits by adding the value of those benefits to the worker's paycheck. As described below, the Lewin/ICF analysis of the proposal indicates that most families would pay slightly lower total taxes after this switch. And while some families would pay higher taxes, it would be because they had found ways to cut their medical insurance costs and thus gained more (taxable) income for other purposes.

Q: What about families without a company plan?

A: They would receive a credit for buying insurance and out-of-pocket medical care. Today these families normally receive no tax help or any other assistance, unless they go on welfare.

Q: What about the working poor, who pay little or no tax?

A: The new credit would be refundable. This means that if the family's credit exceeded its tax liability, it would receive the difference from the government, in the form of a voucher that could be used only for health care.

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3 Three smaller tax breaks are available for some Americans. The self-employed can deduct 25 percent of the cost of insurance. Americans with high out-of-pocket medical costs can deduct the amount in excess of 7.5 percent of their adjusted gross income if they itemize their tax return. And low-income working Americans can obtain a credit for certain insurance to cover their children, through the earned income tax credit (EITC).

the transition, employers and employees would bargain for compensation packages as they do today.

2) **Introduce a payroll deduction for health insurance and adjust withholdings.** Employers would be required to make a payroll deduction each pay period, at the direction of each employee, and send the amount to the plan of the employee's choice. This would be like the payroll deduction that many employees instruct their employers to make for contributions to a 401(k) or similar savings plan. In the federal employee health system, a worker's agency or congressional office makes a similar payroll deduction to pay for premium costs.

Employers also would be required to adjust the employee's withholdings to reflect their estimated health credit, just as they do now when, say, an employee buys a house and becomes eligible for the mortgage deduction. This means that employees would not have to wait until the end of the year to claim the credit.

Q: What about a low-paid worker who does not have taxes withheld?

A: Actually even the low-paid normally have Social Security taxes withheld. In any case the employer would estimate the refundable credit available to the employee and send this, plus any contribution by the employee, to the employee's chosen plan. The employer would adjust the total withholdings sent to the IRS to reflect refundable credits for any employees.

Q: What about the unemployed?

A: If an individual became unemployed, normally he or she would become eligible for a larger credit, since family income would fall. For the unemployed, the government would send the value of the credit to the individual's plan. In addition, the unemployment check could be adjusted to reflect the contribution, if any, due to the plan by the individual. Further, since the paperwork for this change in the payment method would take time, health plans would not be permitted to drop coverage if a working family became unemployed. When the paperwork is complete, the plan would receive premium payments due during the interval.

ADVANTAGES OF THE HERITAGE PLAN

A consumer-based plan would have profound and beneficial effects on America's health care system. Among the most important:

✓ **Every American family would have access to affordable and adequate health care.**

Under the Heritage plan, all Americans—most important, all Americans now uninsured—would be enrolled in a health plan or covered by a public program (chiefly Medicaid or Medicare programs).

Churches

In many communities the church easily could sponsor a group health plan. This is especially true in the black community, where typically the church already functions as a social and economic development agency. Similarly, the Church of Jesus Christ of Latter Day Saints (that is, the Mormon church) carries out a sophisticated social welfare function for its members. Sponsoring a health plan for members would be a natural development.

Farm bureaus

Some state farm bureaus, such as Virginia's, already have a health plan for farm-based families. But often families receive limited or no tax breaks for joining such plans. With the Heritage proposal as law, farm bureaus and similar organizations would have a natural market niche in rural areas, especially for seasonal or casual workers.

Sickness groups

In some cases, a family might choose a plan offered by an organization of individuals suffering from a particular ailment. Many such organizations exist and give advice on obtaining treatment. Making a plan available to members would be a simple step. These plans, moreover, would structure medical services around the particular needs of the member, say a diabetic. Today, a diabetic typically has to take a standard company-sponsored plan containing items he or she does not use and then pay out-of-pocket for additional specialized services.

✓ Costs would be controlled effectively and efficiently.

The Heritage plan uses the best device ever found to hold down costs without sacrificing quality and efficiency: consumer choice within a competitive market. This works well and simply in the huge Federal Employee Health Benefit System, where cost increases are running at about one-third to one-half less than increases in company-sponsored plans.[6] It also works well in non-company insured markets, such as cosmetic surgery. It also works in every other private sector of the economy.

The Heritage plan would permit it to work in health care. Families would "shop around," comparing the premium prices and benefits of rival plans and making their choice accordingly, just as they do for life insurance, a car or a house, or college education for their children—and as federal workers do for health plans. Premium costs would be reduced by virtue of the tax credit, but families would still save money by choosing the least expensive plan that met their needs. In turn, plan organizers would have to compete aggressively for the family's dollars by developing plans that combined attractive benefits with a

6 See Moffit, *op. cit.*

Table 1

Federal Tax Credit Alternatives

Tax Credit Version #1

- 80 of the cost of premiums up to $275 per family members, plus
- 18 percent of premiums over $275 per member, plus
- 18 percent of umreimbursed medical expenses.

Tax Credit Version #2

Premiums and Unreimbursed Expenses as a Percent of Gross Household Income	Percent Reimbursed Under the Credit
Below 10%	21%
10% - 20%	45%
20% or more	65%

Tax Credit Version #3

- 75 percent of premiums up to $275 per family member, plus
- 14 percent of premiums over $275, plus

Unreimbursed Expenses as a Percent of Gross Household Income	Percent Reimbursed Under the Credit
Below 10%	21%
10% - 20%	45%
20% or more	65%

Note: The credits are refundable.
This structure of credits is budget neutral at the state and federal levels.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model.

lower percentage for inpatient prescription drugs. A prepaid managed health plan (such as a Health Maintenance Organization, or HMO) with at least the same basic coverage would be permitted.

The legally-required basic plan would limit deductibles for a family to no more than $2,000 and total unreimbursed costs (including the deductible) to no more than $5,000, often known as the "stop loss" amount or amount above which there is "catastrophic" protection. A family could choose a plan with a lower deductible or catastrophic protection, but normally that would mean a higher premium. These unreimbursed medical costs would be offset by a credit in each version of the Heritage plan (they are not normally given tax relief today) and so would be less costly to a family than the same amounts included in a company-sponsored plan today.

✓ The employer's responsibility

Table 3 summarizes the responsibility of employers. In essence employers act as bookkeepers for their employees, handling premium payments and tax adjustments on the employee's behalf. One important assumption is made about Social Security (FICA) tax. If employer-provided plans become subject to tax (offset, of course, by the new credit), the value of those benefits also would become subject to the "employer's share" of Social Security tax. Heritage analysts instructed Lewin/ICF to assume in modeling the plan that in con-

Table 3
The Employer's Responsibiliy

Employers have the option of:

- ❒ Continuing to provide health benefits; or
- ❒ Discontinuing the health plan.

For employers who continue to provide benefits:

- ❒ The average amount of the employer's contribution is counted as taxable income to the employee.*
- ❒ Employees may not take cash in lieu of coverage.

For employers who discontinue coverage:

- ❒ Employers must maintain their current level of effort by converting benefits to income.
- ❒ Employers must deduct premiums for workers.

Employers will hold workers harmless for the employer share of increased FICA tax payments due to taxation of benefits.

* Separate employer contribution amounts would be used for persons with single and family coverage.

Third Requirement: Plans could not charge more than 25 percent above or below the average charged for new enrollees with similar characteristics. This means that sick families, who today often find the cost of coverage prohibitive, could not be charged premiums more than 25 percent above those for similar families of average health. If a family switched plans, moreover, the new carrier could not charge them more than 25 percent above the average premium charged for similar families.

✓ Modelling assumptions made by Lewin/ICF

Lewin/ICF had to make certain assumptions about consumer behavior and other features of the basic Heritage plan to "run the numbers." Some of these are crucial; others simply were to ease the process of modelling and could be changed in any final program. These are contained in Tables 5 and 6. Among the most important:

First Assumption: All employers are presumed to discontinue their existing plans and convert their value into additional cash income for employees. This makes the calculations easier and more reliable, but is not crucial to the plan. Some large companies might well continue to provide coverage.

Second Assumption: Healthy families buy a basic plan and pocket the savings, while currently insured Americans in poor or fair health either maintain their existing coverage or upgrade to better coverage. The model assumes all the uninsured buy the basic package, which includes catastrophic protection (although some doubtless would buy more elaborate plans).

Table 5
Key Assumptions

Employers who now offer insurance:

- All will discontinue coverage and convert benefits to wages.
- Firms with over 1,000 workers establish employee premium financed cafeteria plans, which will reduce administrative costs.

Workers now covered by employer insurance:

- Those in poor/fair health will select plans that at least maintain their existing level of coverage.
- Those in good/excellent health will downgrade to the standard package.
- Health services utilization for persons who downgrade coverage will decline based upon price elasticities reported in the literature (a price elasticity of -0.2 was selected).

Persons now covered by non-group insurance:

- Persons who now have coverage in excess of the minuimum standard will maintain that coverage.
- Others will upgrade to the minimum standard.

Currently uninsured persons:

- All will take the minimum standard package.
- Utilization will adjust to levels reported by insured persons with similar charactoeristics.

No change is assumed in the number of persons enrolled in Medicaid.

HOW TOTAL SPENDING WOULD BE AFFECTED

Effect #1: Total U.S. spending on health care would fall immediately by $10.8 billion. Families initially would save $18.8 billion.

Households would pay directly for their own coverage under the Heritage plan, rather than have their employer paying for it as happens today. As a result, total household health payments would, in the first instance, go up substantially. But the cost would be more than offset by two items, as indicated in Table 7: the tax credit (worth a total of $84.9 billion), and the increase in wages due to firms cashing out existing benefits (for a total increase in cash wages of $148.7 billion). This would leave families as a whole ahead by $18.8 billion. Private employers, as well as federal, state and local governments, would save on health costs, but pay their employees more in cash income. The net effect on total health spending, concludes Lewin/ICF, would be a reduction of $10.8 billion.

Q: Would this one-time saving be all the cost reduction under the Heritage plan?

A: No. Lewin/ICF does believe that the pattern of spending after these changes would continue in line with today's trend. However, Heritage analysts believe the new incentives for families to shop around for the best bargain would hold the annual growth of spending significantly below current trends. If the general increase were to be held to the rate in recent years of the consumer-based Federal Employee Health Benefits Program, for instance, American families would save tens of billions of dollars each year in health costs, with bigger savings each year compared with current projections.

Table 7
Change in National Health Spending by Source of Payment
(billions of dollars)

	Subtotals	Change in Spending
Impact on Payors		
Household Payments		$129.9[a]
Premium Payments	$88.2	
Out-of-Pocket Spending	62.7	
Tax Credits	(84.9)	
Eliminate Tax Exclusion	63.9	
Private Employers[b]		(112.4)
Federal Government[b]		(5.1)
State Governments[c]		(23.2)
Net Change in Health Spending		
Changed in Health Spending		(10.8)
Utilization for Newly Insured	8.9	
Utilization for Currently Insured	(21.8)	
Insurer Administrative Costs	2.1	

Note: Figures indicate increase in spending. Reductions in spending are in parenthesis.
a The increases in household health spending will be offset by increased wages of $148.7 billion.
b Reflects elimination of employee coverage. Employer savings in health spending will be offset by increases in wages not shown here.
c Reflects elimination of employee coverage and savings to county hospitals.
Source: Lewin/ICF estimates using the Health Benefits Simulation Model.

Q: Could states introduce their own health credit?

A: Yes. In fact a credit in a state's tax code would be a logical addition to the basic federal plan. Several states, including Maryland and Minnesota, already are considering a state health tax credit.

Q: Could states add funds to the plan to give more help to the low-paid?

A: Yes. In one version of the Heritage proposal, Lewin/ICF was asked to assume that each state would supplement the federal program with a program to cover the expenses of any family that, despite the federal credit, faced out-of-pocket costs of more than 20 percent of its income. In modeling this version, states were given discretion in how they would structure such additional assistance. Taking together the various savings to states and local governments, thanks to the federal credit and tax changes, Lewin/ICF calculated that the new program would cost state and local governments $6.7 billion more than they now spend on health care. In this variant of the plan, the states would not contribute to the cost of the federal credit. Thus for federal budget neutrality, the federal credits would have to be less generous.

Table 9

Sources and Uses of State Funds Under the Tax Credit Program in 1991

(billions of dollars)

Changes in Revenues			Changes in Expenditures		
Elimination of State Income Tax Exclusion[a]		**$8.3**	**Public Hospitals**		**($13.2)**
Premium Taxes[b]			**State and Local Worker Benefits**		
Current Revenues	(1.6)		Health Benefits	(23.8)	
Revenues Under Policy	1.5		Wages	23.8	
		(0.1)	OASDI and HI Taxes	2.0	
					2.0
State Corporate Income Tax Loss		**(0.6)**	**Contribution to Federal Tax Credit**		**18.8**
Net Change in Revenues		**$7.6**	**Net Change in Expenditures**		**$7.6**

Note: Number in parenthesis represent negative amounts.

a The increase in wages under the program will result in an increase in state income tax payments.

b Premium tax revenues decline due to the reduction in the value of health insurance coverage under the tax credit program.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model.

would lose the tax exclusion for any company-provided benefits. Yet, they would also receive extra income, because employers would be required to give them cash instead of benefits and they would receive a new tax credit to replace the tax exclusion. The net effect is that working age households would have a total of $18.8 billion more in their pockets after all these changes. They would also be able to choose their own health plan and keep it if they changed jobs.

Table 11
Change in Household Health Spending Under the Tax Credit Program in 1991
(billions of dollars)

Health Spending		
Premium Payment		$88.2
Employee Contribution in Employer Plans	(45.2)	
Individual Premium Payments	133.4	
Out-of Pocket Expenses		62.7
Tax Credit		(84.9)
Eliminate Tax Expenditures (individual share)		61.4
Federal	53.1	
State	8.3	
Eliminate Health Expense Deduction (over 7.5% AGI)		2.5
Net Change in Health Spending		129.9
Wage Effect		
Increased Wages (offset to change in health spending)		(148.7)
Net Impact on Households		($18.8)

Note: Number in parenthesis represent negative amounts.
Source: Lewin/ICF estimates using the Health Benefits Simulation Model.

Impact 2: A family with an annual income below $50,000 typically would receive higher tax breaks for its health care plan.

Table 12 shows how the value of tax breaks for health coverage would be affected for typical households.[8] Today the typical family earning less than $10,000 gets just $50 a year in tax relief under the tax exclusion system. Under version #1 of the Heritage plan, this family would receive $372 more in (refundable) tax benefits and $684 more under version #2. A family earning over $50,000, but less than $75,000, would lose just $13 in tax breaks under version 1, or just over $1 a month. Families as a whole would receive more federal tax relief under the plan than they do because health cost savings to the states would be added to the funds to finance the new credit.

8 All figures cited here from Tables 12 and 13 are averages for all families within income class.

Table 13
Average Net Impact of Alternative Tax Credit Options on Families by Income (1991)

	All Households	Family Income: less than $10,000	$10,000 - $14,999	$15,000 - $19,999	$20,000 - $29,999	$30,000 - $39,999	$40,000 - $49,999	$50,000 - $74,999	$75,000 - $99,999	$100,000 or more
Household Health Spending Under Current Law	$1,841	$887	$1,223	$1,428	$1,638	$2,106	$1,954	$2,295	$2,400	$3,238
Changes in Health Spending										
Change in Premium Payments[a]	1,214	671	930	991	1,100	1,279	1,312	1,459	1,679	1,854
Change in Out-of-Pocket Payments for Care	692	108	286	367	519	769	990	1,059	1,053	1,176
Elimination of State and Federal Tax Expenditures[b]	745	35	154	283	500	736	875	1,330	1,397	1,492
Wage Effects										
Increased Wages (counted as an offset to health spending)	(1,767)	(162)	(657)	(1,119)	(1,531)	(2,060)	(2,313)	(2,681)	(2,754)	(2,770)
Tax Credits (Federal and State)										
Version #1	(1,052)	(422)	(669)	(810)	(959)	(1,222)	(1,242)	(1,360)	(1,395)	(1,510)
Version #2	(1,052)	(734)	(871)	(978)	(1,045)	(1,258)	(1,168)	(1,141)	(1,082)	(1,178)
Version #3	(1,052)	(526)	(724)	(853)	(966)	(1,245)	(1,234)	(1,289)	(1,298)	(1,408)
Change in After-Tax Health Spending Net of After-Tax Change in Income										
Version #1	(168)	210	44	(288)	(371)	(498)	(378)	(193)	(20)	242
Version #2	(168)	(82)	(158)	(456)	(457)	(534)	(304)	(26)	293	574
Version #3	(168)	126	(11)	(331)	(378)	(521)	(370)	(122)	77	344

Note: Figures in parenthesis represent negative numbers.

a Includes individual premium payments less employee contributions to employer plans eliminated under the tax proposal.

b Includes the additional taxes paid on employer benefits converted to income including: federal income taxes; the employee share of OASDI and HI payroll taxes; and state income taxes.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Case #2: A young single blue-collar worker in excellent health currently works for a major industrial company and earns $21,000. The worker currently has an employer-paid health plan with no deductible worth $3,000 per year.

Under the Heritage plan, the worker switches to a basic plan sponsored by his union. For this plan he pays $850 and he pays out $450 in out-of-pocket costs. The employer adds $3,000 to his paychecks over the year and makes a payroll deduction equal to the premium for his union plan and sends the money to the union.

	Today	Under Heritage Proposal
Tax relief for health	$450	$ 404
Extra cash income		3,000
Taxes on extra income	N/A	450
Net extra taxes paid under Heritage proposal	N/A	46
Change in disposable income after tax changes and health spending under Heritage proposal		+1,654*

The change in disposable income is the additional income received by the family less the extra direct payments for health care and the less the net extra taxes paid.

Case #3: An engineer, aged 50, with a manufacturing company has a non-working spouse, two children, and a typical history of health problems. Currently he earns $45,000 and has a company-paid plan. The company pays the premium of $6,000 and the family pays out the full $600 each year in deductibles and copayments. This year, however, the company has decided to lay off the worker. Although he fortunately has the offer of another job paying the same total compensation of $51,000 ($45,000 + $6,000) with a small engineering firm, that firm says it will not give part of the compensation in the form of health benefits, because it cannot arrange affordable group coverage. So he faces the prospect of being uninsured.

Under the Heritage proposal, he elects to continue his current plan, converted to individual coverage for his family and paid for by himself. The plan will cost the same premium with the same deductibles and copayments.

COMMONLY ASKED QUESTIONS ABOUT THE HERITAGE CONSUMER CHOICE HEALTH PLAN

Q: Are American families capable of choosing health plans?

A: Yes. About 9 million federal workers and federal retirees do so every year under the Federal Employee Health Benefits Program (FEHBP).[9] These workers include mail room clerks, janitors, and messengers, as well as professional economists, congressmen and cabinet secretaries. In the Washington, D.C., area they choose from among over thirty plans. They can make choices because consumer organizations, the local press, their family doctors, employee organizations, and other groups supply them with "user friendly" information on which to base their choices. The same kinds of information would quickly mushroom for 100 million American households choosing health plans as exists today to help these households buy a car, a house, or a mutual fund.

Q: How would costs be controlled?

A: In the same way as they are controlled in the automobile or computer market—by cost-conscious consumers buying a product from among competing suppliers. Critics of consumer-based cost control claim that families cannot question the cost of specialized medical procedures. But this ignores the way consumer choice would work. Most Americans know little about carburetors or steering systems in an automobile. If they bought a car by purchasing all the components individually from different firms the car no doubt would be very expensive, and would not run well. Instead they buy completed cars from among rival assembly firms. In turn these firms bargain for quality and price from component makers.

Essentially the same process would operate in a consumer-based health system —and does so today in the FEHBP. Families would choose among competing plans. The plan organizers, not the families, would bargain with doctors and hospitals to keep costs down. That system of consumer choice and competition has enabled the FEHBP to keep its premium increases well below those of private employer-sponsored plans.

Q: How would the obligation to buy insurance be enforced?

A: In two ways. Taxpayers would have to attach proof of insurance or enrollment in a public program to their tax return or face a fine. In addition, employees would have to furnish their employers with proof of insurance, which would be forwarded to the government. Those unable to show they had

9 See Moffit, *op. cit.*

poor by reducing the tax relief for middle and upper income families. Or if the federal government decided to increase net spending (or tax help) for health, it could make the credit more generous for the lower-paid. States could introduce their own budget neutral credit, or they could add funds to assist the lower-paid.

Q: What about those families on Medicaid?

A: Medicaid would not be affected directly by the proposal. Today a head of household on welfare typically has to give up thousands of dollars in Medicaid health benefits if he or she leaves welfare and takes a job without health benefits. But under the Heritage Plan, many families now on welfare (and Medicaid) would choose to take a job because a refundable credit for health care insurance would be available. This would reduce Medicaid and AFDC costs.

Q: What about those now on Medicare?

A: The basic Heritage plan does not change Medicare. However, it would be quite logical to allow working Americans to keep their health plans when they retire, with the federal government making a financial contribution to these plans in place of today's Medicare cumbersome reimbursement system. This "voucherizing" of Medicare would encourage retirees to shop for the best plan for their needs. The FEHBP operates in much this way for federal retirees.

Q: How does the Heritage plan differ from the Bush Administration's recent health reform proposal?

A: For those now uninsured, both plans are quite similar, except that the Bush plan gives a refundable credit only for the poor, and a deduction for non-poor uninsured families. But it would, like the Heritage plan, cover today's uninsured and enable them to obtain a "portable" plan. The Bush plan, however, would have little or no effect on the costs of company-provided plans, because it makes no changes at all in the tax treatment and so would not encourage employees with company-sponsored plans to seek better value for money.[10] There is also no explicit mechanism in the Bush plan to pay for its new credit and deduction.

Q: Does the Heritage plan have to be introduced all at once?

A: No. It could be phased in gradually. One first step might be to limit the tax exclusion for company-sponsored plans to, say, $4,000 per year for a family, and use the tax revenue to fund a credit for out-of-pocket health expenses ex-

10 See Stuart M. Butler, "What's Right and Wrong with Bush's Health Plan," Heritage Foundation *Executive Memorandum* No. 321, February 7, 1992.

NEWS

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DOCTORS TAKE ON MEDICAL COSTS TO HEAL U.S. HEALTH CARE SYSTEM

The nation's largest medical-specialty society on Monday called for a national cap on health spending, with realistic limits on doctor and hospital fees, to finance a reformed health care system that provides the same benefits to all Americans.

The American College of Physicians (ACP), which represents 77,000 doctors practicing internal medicine, also called for a substantial restructuring of the nation's insurance industry and consolidation of Medicaid, Medicare and other public programs.

The ACP's health care reform proposal, published in the Sept. 15, 1992, issue of *Annals of Internal Medicine*, goes far beyond the incremental reforms backed by most other sectors of organized medicine and contains several unique features that resolve problems with the health care reforms proposed so far.

"This is a plan that can provide a basis for change, especially in this election year with health care high on the political agenda," said Dr. Willis C. Maddrey, President of the American College of Physicians.

The ACP proposal, titled "Universal Insurance for American Health Care," calls for:

- public and private sponsorship of health insurance;

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The ACP's detailed reform plan, released at a news conference at the National Press Club, follows the 1990 publication of an ACP position paper supporting universal access to comprehensive care, which was also a significant departure in policy from much of organized medicine. The proposal released Monday transforms the earlier principle into a working blueprint for change with a strong prescription to contain health care costs."The United States cannot afford, and will not achieve, universal access to care without controlling costs, and costs cannot be controlled without system-wide reform. We must limit total health care spending," the ACP paper reads. "We recognize that these proposals raise politically and procedurally difficult issues....but no plan for reform can succeed without substantial efforts to control spending."

Apart from its commitment to cost control, the College reform agenda is different from others in several important ways. First, it modifies the play-or-pay reform approach by relieving employers of the responsibility for high-cost patients, so that employers will choose to sponsor insurance rather than pay the tax. This answers the criticism that play-or-pay will eventually result in a single-payer system because the cost of employers' premiums could grow higher than the payroll tax.

Second, the ACP proposal consolidates public programs so that all public beneficiaries receive equal care.

Third, it requires uniform benefits for all health plans, so that all publicly sponsored patients receive the same level of care as those having private insurance, yet retains a public-private mix of health coverage.

HOW THE ACP PLAN WORKS

Private and public sponsorship

Under the physicians' plan, employers could offer their own health coverage or pay a tax to enroll their workers in publicly sponsored insurance. To make employer-sponsored insurance affordable, the public system would cover workers over age 60 and people of any age needing high-cost care, along with the unemployed and retirees. Employers would share the cost of private sector insurance with their employees.

The public system would consolidate all current public programs, including Medicaid and Medicare, and offer the same benefits as private plans. Because all employers and individuals would benefit from the public plan, its constituency would be broad enough to ensure its viability. This is not the case with Medicaid -- the federal-state program for low-income people -- which excludes more than half the nation's poor people. Funding for publicly sponsored insurance would come from Medicare, Medicaid and other government health programs; payroll taxes from companies not sponsoring insurance and their employees; income-related premiums from retirees, collected through the tax system; and other tax revenue. A nationwide poll commissioned recently by the ACP showed more than half of all Americans -- 56 percent -- support combining public programs.

The ACP plan would retain private sector insurance to foster a choice of medical practice arrangements, including managed care. However, insurers would have to accept all applicants regardless of pre-existing conditions and calculate premiums based on the health status of the entire community, rather than an individual employer. This would spread the risk and the cost of insurance, making it more affordable to small employers.

The ACP proposal would significantly consolidate the insurance industry, ACP leaders said. Remaining insurers would compete by offering lower premiums or better value, not by avoiding risk or reducing reimbursement to providers.

Cost control

The College proposes to control spending through a national health care budget and management of the price, supply and demand for health care services.

The budget would be developed by a national commission representing all sectors of society and approved by Congress. It would cover public and private spending and account for changing health needs of the population, new technology and general inflation. The plan assumes that the current level of health care spending -- $809 billion in 1992 -- is enough to provide health care to everyone with the elimination of waste such as duplicative efforts of insurance companies in marketing and billing, overuse of expensive procedures and technology, duplicative facilities and equipment and overpriced care.

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Some estimates of waste in health care are as high as $200 billion -- a quarter of all spending. Even a savings of 5 percent would generate $40 billion -- enough to extend coverage to all people under most estimates.

Under the ACP plan, physicians, hospitals and other health care providers would negotiate fees with states, and all insurance plans would pay the same fees. Managed care and other organized delivery systems would negotiate separate budgets with insurers and develop their own compensation packages.

Payments could not exceed the allocation for each state. Payments to providers could be reduced if excesses were not attributable to unanticipated illnesses.

Under the ACP plan, supply would be managed using community targets for the numbers and distribution of physicians and other professionals, hospital beds and capital investments. The targets would create an even balance of generalist and specialty physicians, reducing the system's bias toward the use of costly procedures and specialized care and expanding preventive care. Currently, there are two specialists for every primary care physician. The personnel targets would be achieved through improved reimbursement for generalists, financial and other incentives in graduate medical education and limits on the number of specialty residencies. Capital investment targets would be achieved through a requirement for regulatory approval.

Patient demand would be reduced through patient education on disease prevention and reasonable expectations of medicine and through co-payments, except for low-income patients.

Comprehensive, quality care

While expanding access to care, the ACP plan would also improve the quality of care. Coverage under both the public and private systems would consist of all medically effective and necessary health services based on patient need instead of a pre-determined benefits package. Benefits would be determined by the national health care commission based on medical effectiveness research and judgment of medical value. In addition to improving quality, this approach provides an explicit mechanism to address the question of rationing, which occurs tacitly under the present system.

Quality would also be improved by using a more efficient method of physician oversight -- pattern profiling -- which identifies physicians whose performance deviates significantly from peers. This would replace intrusive and costly case-by-case utilization review.

"Case-by-case review is expensive -- a $7.4 billion industry -- and it has not proven to be cost-effective. It has drawn the profession into a permanent game of phone tag with consultants, whose permission must be granted for doctors to treat their patients," Ball said. "Imagine the Internal Revenue Service auditing every taxpayer. Well, physicians are under constant audit. There is a smarter, better, more cost-effective way to perform quality assurance and contain costs."

--more--

The ACP plan would also improve quality with a more responsive malpractice award system and an increase in health services research to reduce the variations in medical practice using scientific data on the effectiveness of treatments and procedures.

- 30 -

CONTACT: Kathleen Haddad (202) 393-1650 or (800) 633-9400
Susan Anderson (215) 351-2653 or (800) 523-1546

Summary of the American College of Physicians Health Reform Plan

Access

- Employer-sponsored coverage
  - -- Employers either sponsor plan or pay tax to enroll workers in public plan
  - -- Public system covers older workers and people of any age needing high cost care
- Publicly sponsored coverage
  - -- Everyone not enrolled in the employer plan, including:
    - unemployed and those not in job market
    - retirees
    - employees over age 60
    - those in need of more than $50,000 of medical care annually
  - -- Consolidates all current public programs, including Medicare and Medicaid

Financing

- Private sector
  - -- Based on private insurance
  - -- No pre-existing condition clauses allowed
  - -- Community rating
  - -- Employers and employees share cost of private sector insurance, with employers paying at least 50 percent
- Public sector
  - -- Funding from:
    - Payroll taxes from companies not sponsoring insurance and their employees
    - Income-related premiums from retirees, collected through tax system

- Funds now paying for Medicare, Medicaid, and other government health programs

- Increased alcohol and cigarette taxes

Cost Containment

· National health care budget recommended by national health care commission to Congress

· Price

-- Individual practitioners, managed care organizations, hospitals, and other providers negotiate fees with all payers in a state

-- Fees based on system like RBRVS

-- All fees within a sub-state region are uniform

-- (Fee) x (Expected utilization) must not be greater than state's budget allocation for year

-- If greater than state's allocation, adjustments made

· Supply

-- Communities set targets for health resources including supply and distribution of physicians and other professionals, hospital beds, and capital investments

-- Targets linked to payment system

-- Mix of physicians changed from 65% specialist/35% generalist to more even balance through improved reimbursement for generalists and through financial and other incentives in graduate medical education (GME), including:

- Weighting payments for GME to favor generalists

- Reduced-interest or interest-free loans to residents training to be generalists

- Other regulatory approaches affecting number of residency slots for specialists

- Demand

  -- To reduce demand:

     - Patient education on disease prevention and reasonable expectations of medicine

     - Co-payments, except for low-income patients

     - Payment reform to reduce incentives to perform unnecessary procedures

Quality of Care

- All health plans provide same set of medically effective and necessary health services, as determined by national health care commission

- Quality also improved by:

  -- Practice profiling to identify physicians performing below acceptable standards of care

  -- More responsive malpractice award system

  -- Increasing health services research

  -- Improving supply and geographic distribution of primary care physicians

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary
Office of the Assistant Secretary
for Planning and Evaluation
(Program Systems)

ASPE FAX

TO

Name : Stephanie Fossum FAX PHONE NUMBER: 456-7739
Organization : W/H-Office of Policy
Phone : 456-6563

MESSAGE

Here is what is available at this time - F493 + F494 expiring authorities. F495 will not be available for quite some time. Hope this helps.

FROM

The following 9 pages were sent by:

ANDREW ROCK (202) 690-7150

FAX: (202)-690-6518

Rm 447-D
200 Independence Ave., SW
Washington, DC 20201

ADMINISTRATION FOR CHILDREN AND FAMILIES
LEGISLATION EXPIRING ON 9/30/93

LAW	SECTION	PROGRAM	RECOMMENDATION
Child Abuse Prevention and Treatment Act	107a(e)	Authorizes appropriations for emergency grants for child abuse prevention services for children of substance abusers.	Reauthorized by Child Abuse, Domestic Violence, Adoption and Family Services Act of 1992 (P.L. 102-295), through FY 1995.
Comprehensive Child Development Centers Act of 1988	670T(a)	Authorizes appropriations to eligible local entities for provision of a broad array of services to children beginning at birth through school age, and to their families.	Reauthorized by Augustus F. Hawkins Human Resources Reauthorization Act (P.L. 101-501), through FY 1994.
Developmental Disabilities Assistance and Bill of Rights Act	130	Authorizes appropriations for state developmental disabilities grant programs.	Seek reauthorization.
	143	Authorizes appropriations for allotments to states for State Protection and Advocacy Systems.	Seek reauthorization.
	154	Authorizes appropriations for grants to university affiliated programs and satellite centers and grants for feasability studies.	Seek reauthorization.
	163	Authorizes appropriations for projects of national significance.	Seek reauthorization.
Stewart B. McKinney Homeless Assistance Act	753(b)	Authorizes appropriations for the establishment of the Emergency Community Services Homeless Grant program.	Do not seek reauthorization
	779	Authorizes appropriations for grants to Family Support Centers.	Do not seek reauthorization.

ACF
~~SSA~~

EXPIRE
9/30/94

Low-Income Home Energy Assistance Act of 1981 (title XXVI of P.L. 99-35

Sec. 2603(b): Authorize appropriations

Augustus F.Hawkins Human Services Reauthorization Act of 1990

Sec. 934(a)(1): Authorize appropriations for ADYCF Coordination; Supportive Services

Sec. 960(a): Authorizes appropriations for grants for the establishment of National Center for Family Resources and Support Program.

Child Development Associate Scholarship Assistance Act of 1985

Sec. 606: Authorize appropriations for grants to States receiving a grant under title XX of the SSA for scholarships for CDA credential candidates.

Community Services Block Grant Act

Sec. 627(b): Authorizes appropriations

Sec. 681A: Appropriations authorizations for community food and nutrition programs.

Head Start Act

Sec. 639: Authorizes appropriations

State Dependent Care Development Act

Sec. 670A: Authorizes appropriations for grants to States for planning and development of dependent care programs.

HEALTH CARE FINANCING ADMINISTRATION
LEGISLATION EXPIRING ON 9/30/93

LAW	SECTION	PROGRAM	RECOMMENDATION
Consolidated Omnibus Budget Reconciliation Act of 1985	9215	Extends grant for Medicare municipal health service demonstration projects.	Do not seek reauthorization.
Omnibus Reconciliation Act of 1989	6508(f)	Authorizes appropriations for demonstration projects on health insurance for medically uninsurable children.	Do not seek reauthorization.

HCFA

EXPIRE

Title XI of the Social Security Act

Sec. 1142(i): Appropriations authorization for program of research on outcomes of health care services and procedures. 9/30/94

PUBLIC HEALTH SERVICE
LEGISLATION EXPIRING ON 9/30/93

LAW	SECTION	PROGRAM	RECOMMENDATION
Anti-Drug Abuse Act of 1988	3521(g)	Authorizes appropriations for community youth activity programs.	Do not seek reauthorization.
	3522	Authorizes appropriations for evaluation of drug abuse education and prevention efforts.	Replaced by various authorizations under the ADAMHA Reorganization Act (P.L. 102-321).
Disadvantaged Minority Health Improvement Act of 1990	10(f)	Authorizes appropriations for grants for health services for Pacific Islanders.	Do not seek reauthorization.
Indian Health Care Improvement Act	718(d)(1)	Makes grants for demonstration projects for tribal management of health care services.	Do not seek reauthorization.
Omnibus Budget Reconciliation Act of 1989	6509(b)	Authorizes appropriations for Maternal and Child Health Handbooks.	Do not seek reauthorization.
Public Health Service Act, title III	306(o)	Authorize appropriations for statistical and epidemiological activities under the National Center for Health Statistics.	Seek reauthorization.
	338(j)(1)	Authorizes appropriations for grants to states for operation of Offices of Rural Health.	Do not seek reauthorization.
	340(p)(1)	Authorizes appropriations for health care and preventive health services in or near public housing.	Seek reauthorization.
	340(s)(8)	Authorizes appropriations for grants regarding outreach and primary health services for homeless children.	Included in Health Care for the Homless.
	37R(c)	Authorizes appropriations for organ procurement organizations.	Seek reauthorization.
	370(j)	Authorizes appropriations for grants for the establishment of a bone-marrow registry	Seek reauthorization.
	394	Authorizes appropriations to conduct and provide assistance for injury research and to provide assistance to states and localities for injury control.	Seek reauthorization.
	399A(e)	Authorizes appropriations for demonstration projects with regard to	Do not seek reauthorization.

PUBLIC HEALTH SERVICE
LEGISLATION EXPIRING ON 9/30/93

LAW	SECTION	PROGRAM	RECOMMENDATION
Public Health Service Act,	399A(e)	Alzheimer's Disease.	
Public Health Service Act, title V	513(b)	Authorize appropriations for alcohol and drug abuse treatment for homeless individuals.	Included in ADAMHA Reorganization Act (P.L. 102-321), new PHS Act section 506, through FY 1994.
	520(A)(e)(1)	Authorize appropriations for the establishment of a grant program for demonstration projects for mental health services.	Included in ADAMHA Reorganization Act (P.L. 102-321), new PHS Act section 116, through FY 1994.
Public Health Service Act, title VII	740(c)(c)(1)	Authorize appropriations for grants for Federal capital contribition to certain student loan funds for purposes regarding disadvantaged individuals.	Do not seek reauthorization.
	760(g)(1)	Authorizes appropriations for grants for scholarships for individuals from disadvantaged backgrounds to health professions schools.	Do not seek reauthorization.
	761(h)	Authorizes appropriations for loan repayment program regarding on faculties of certain health professions schools.	Do not seek reauthorization.
	782(h)(1)	Authorizes appropriations for grants for programs of excellence in health profession education for minorities.	Do not seek reauthorization.
Public Health Service Act, title XII	1232(a)	Authorizes appropriations for trauma care systems research, training, evaluations, and demonstration projects, and other activities.	Do not seek reauthorization. Note: ADAMHA Reorganization Act (P.L. 102-321) adds new Part D to this section, authorizing appropriations for Trauma Care Centers operating in areas severely affected by drug-related violence, through FY 1994.
Public Health Service Act, title XV	1509(a)	Authorizes appropriations for grants to states for prevention and control of	Seek reauthorization.

PUBLIC HEALTH SERVICE
LEGISLATION EXPIRING ON 9/30/93

LAW	SECTION	PROGRAM	RECOMMENDATION
Public Health Service Act,	1509(a)	breast and cervical cancer.	
Public Health Service Act, title XVII	1707(f)(1)	Authorizes appropriations for the Office of Minority Health.	Seek reauthorization.
Stewart B. McKinney Homeless Assistance Act	612(a)	Authorizes appropriations for community mental health services demonstrations projects for homeless individuals who are chronically mentally ill.	Included in ADAMHA Reorganization Act (P.L. 102-321), new PHS Act section 520A, through FY 1994.
Vaccine and Immunization Amendments of 1990	2(b)(2)	Authorizes appropriations for demonstration projects for vaccine and immunization outreach programs.	Do not seek reauthorization.

HEALTH

Expires 9/30/94

Title III of the PHS Act

Sec. 329(h)(1)(A)(2)(A): Authorizes appropriations for grants and contracts for migrant health centers.

Sec.330(g)(1)(A)(2)(A): Authorizes appropriations for community health centers

Sec.340(q)(1): Authorizes appropriations for health care for the homeless.

Sec. 399(D)(p)(1): Authorizes appropriations for grants for services for children of substance abusers.

Sec. 399(r): Authorize appropriations for projects to improve maternal, infant, and child health

Title IV of the PHS Act

Sec 464(H)(d)(1): Authorize appropriations for the National Institute on Alcohol Abuse and Alcoholism

Sec. 464L(d)(1): Authorize appropriations for the National Institute on Drug Abuse

Sec. 464P(e): Authorize appropriations for a Medication Development Program.

Sec. 464R(f)(1): Authorize appropriations for the National Institute of Mental Health

Title V of the PHS Act

Sec. 501(m): Authorizes appropriations for grants for cooperative agreement and contracts under the Substance Abuse and Mental Health Administration

Sec. 506(e): Authorize appropriations for grants for the benefit of homeless individuals.

Sec. 508(r): Authorize appropriations for residential treatment programs for pregnant and postpartum women

Sec. 510(e): Authorize appropriations for demonstration projects of national significance.

Sec. 512(d): Authorize appropriations for training in provisions of treatment services

Sec. 516(c): Authorize appropriations for community programs.

Sec. 517(h): Authorize appropriations for prevention, treatment, and rehabilitation model projects for high risk youth.

Sec. 561(f)(1): Authorizes appropriations for comprehensive community mental health services for children with serious emotional disturbances.

Sec. 535(a): Appropriation authorization for grants to States for assistance regarding transition from hopelessness.

Title XII of the PHS Act

Sec. 1245: Authorize appropriations for trauma -centers operating in areas severely affected by drug-related violence.

Title XIX of the PHS Act

Sec. 1920(a): Authorize appropriations for block grants for community mental health services

Sec. 1935(a): Authorize appropriations for block grants for prevention and treatment of substance abuse.

Anti-Drug Abuse Act of 1988

Sec. 3505: Authorizes appropriation for grants to prevent adolescents from joining youth gangs and participating in drug-related activities.

Sec. 3513: Authorizes appropriations for grants to public and private nonprofit agencies, organizations and institutions to carry our research demo and services for runaway and homeless youth.