1-29-92

ACTION NOW HEALTH REFORM ACT*

Summary

TITLE I - IMPROVED ACCESS TO AFFORDABLE HEALTH INSURANCE

Subtitle A - Health Deduction Fairness

- Permanent increase in the tax deduction for health insurance cost for self-employed individuals from 25% to 100%.

Subtitle B - Increased Insurance Affordability and Availability for Employees of Small Employers

- Requires states to implement reforms in small group insurance market (businesses with 2 to 35 employees) in accordance with standards developed by the National Association of Insurance Commissioners (NAIC). [*previous draft covered businesses with 3 to 25 employees*]

- Requires all insurers in small group market to offer a core benefits plan and enroll all who apply for coverage.

- Requires insurers to conform to consumer protection rules regarding:

    - limits on medical underwriting
    - limits on premium rates and annual rate increases

- Requires states to establish either a re-insurance mechanism or an appropriate alternative system (e.g. allocation of high risk enrollees to insurers) for sharing of high risk enrollees among insurers. [*previous draft did not include allocation alternative*]

- Preempts state mandates for insurance plans sold in the small group market.

- Limits pre-existing condition requirements as a basis for renewal of enrollees in the small employer health insurance market (assured portability of coverage).

• Ins reform: Bentsen, NAIC, Johnson/Chandler

• If states pass these legislation, what's it in our best interest to do?

opposition research: all payer systems; employment effects of pay or play NI/Rand? (3/23?)

*[***Indicates a change from the previous DRAFT BILL***]

Subtitle C - Improved Small Employer Purchasing Power of Affordable Health Insurance

- Provides incentives to small employers (i.e., employers with 100 or fewer employees), including the self-employed, to form groups to purchase health insurance. Incentives include exemption from state health benefit mandates. [*drops from the previous draft the preemption of state premium taxes*]

Subtitle D - Clarification of Rules Applicable to Multiple Employer Welfare Arrangements (MEWAs)

- Provides exemptions for MEWAs and clarifies the definition under ERISA to preserve the use of the multiple employer and self-funded concept in providing more affordable health care coverage for both large and small businesses.

- Strengthens the concept of corporate ERISA protected plans to include health care coverage for franchise networks.

[*Subtitle D not included in previous draft*]

TITLE II - HEALTH CARE COST CONTAINMENT

Subtitle A - Malpractice Reform

- Requires states to implement tort reforms (unless more stringent tort laws are applicable in a state):

  - A cap on noneconomic damages
  - Periodic payment of awards
  - Limits on attorneys' fees
  - Narrowed statute of limitations
  - Imposes costs and fees on plaintiffs for frivolous actions

  [*Penalties for frivolous actions not included in previous draft*]

- Provides grants to states for the implementation and evaluation of alternative dispute resolution systems.

Subtitle B - Expansion of Medical Practice Guidelines

- Increases the authorization of appropriations for the Agency for Health Care Policy and research (AHCPR) to develop and more broadly disseminate medical practice guidelines ($45 million over 3 years).

- Authorizes a study of the use of practice guidelines to reduce medical malpractice costs.

- Grants immunity from medical liability for physicians following Peer Review Organization medical practice guidelines.
[*Previous draft did not include grant of immunity from medical liability*]

Subtitle C - Removing Restrictions on Managed Care

- Preempts state laws restricting the development of managed care programs (e.g., states could not restrict the ability of an insurer to negotiate reimbursement rates or contract selectively with providers).

Subtitle D - Paperwork Simplification

- Requires hospitals to maintain a common set of clinical patient data in electronic form and transmit it to the Secretary of Health and Human Services or Medicare Peer Review Organization.

- Directs Secretary to re-evaluate Medicare's Peer Review Organization program and report to Congress recommendations to improve the program and increase its usefulness.

- Provides grants to qualified entities to research and demonstrate the application of comprehensive information systems to monitor and improve patient care.

TITLE III - HEALTH CARE SAFETY NET

Subtitle A - Community Health Access

- Provides federal grants to expand Community and Migrant Health Centers (CMHCs) to increase access to primary care services for indigent and low income Americans.

- Brings employees of CMHCs under the Federal Tort Claims Act to reduce medical liability expense of CMHCs.

Subtitle B - Rural Health Care Initiatives

- Expands health professions training programs to encourage more physicians and other health professionals to locate in rural and underserved areas.

- Provides grants to states for the creation or enhancement of systems for the air transport of rural victims of medical emergencies.

- Provides grants to states to conduct demonstrations linking rural health care facilities to urban facilities via telecommunications equipment.

Subtitle C - State Flexibility

- Increases the flexibility of states to manage various aspects of their Medicaid programs:

  - HCFA could not issue "disallowances" under any Medicaid requirement until a final regulation is published.

  - In lieu of compliance with the extensive nursing home quality standards in OBRA '87, states could implement their own quality standards if approved by the Secretary of HHS.

TITLE IV - PREVENTIVE CARE

- Adds new preventive benefits to Medicare, including annual screening for breast cancer, screening for colorectal cancer, tetanus-diptheria immunizations, and outpatient diabetes education.

TITLE V - LONG TERM CARE INITIATIVES

- Provides tax incentives for individuals and employers to promote the purchase of those private long-term care policies certified by the Secretary of HHS.

- Excludes from gross income:

    (1) amounts withdrawn from individual retirement plans for qualified long term care insurance;

    (2) amounts on the surrender of cancellation of any life insurance policy which are used to pay premiums for qualified long term care insurance.

[Exclusions not included in previous draft]

Comparison of Legislative Proposals Submitted
by the House Republicans and by the Administration

Issue	Administration Proposal	House Republicans (H.R. 5325)
Access		
Deductibility of health insurance premiums for the self-employed	Would phase-in increase in deductible amount from 25% to 100% (25% until 12/31/93; 50% between 1/1/94 and 12/31/95; 100% after 12/31/95).	Would increase deductible amount from 25% to 100% as of 1/1/93
Emergency medical services operating in rural areas		Would establish Office of Emergency Medical Services to provide technical assistance to state EMS programs Would provide incentives for improving state EMS program through matching grant program Would provide federal grants to states for demonstrations of telecommunications links between rural and urban health care facilities
Air transport systems for emergency health care services in rural areas		Would provide federal grants to states for development or improvement of rural air transport systems for medical emergencies
Extension of special treatment in payments for rural Medicare dependent hospitals		Would extend adjustment included in OBRA '89 providing small rural Medicare dependent hospitals with an additional hospital payment to offset unique financial risk from treating a high percentage of Medicare patients under prospective payment system

Issue	Administration Proposal	House Republicans (H.R. 5325)
Community health services extension		Would increases current authorization for Community and Migrant Health Centers (C/MHCs) to expand access to primary care services. Authorized to the following levels: FY 1993 $100 million FY 1994 $200 million FY 1995 $300 million FY 1996 $400 million FY 1997 $500 million Would reduce cost of medical liability expenses for C/MHCs by covering their health care professionals under the Federal Tort Claims Act Would authorize demonstration grants to communities for improve the delivery and coordination of health care services
Small Employer Market Reform		
Establishment of an Office of Private Health Care Coverage		Establishes an Office of Private Health Care Coverage to be headed by a Director appointed by the Secretary of HHS.
Size of firm	2-50 employees	2-35 employees
Eligible employee	Works at least 30 hours per week on a monthly basis	Same
Implementation	State implementation with Federal backup. HHS would establish regulations with advice from NAIC.	Similar, but gives responsibility for developing regulations to NAIC, subject to limited review by HHS.

Issue	Administration Proposal	House Republicans (H.R. 5325)
Increased availability of health insurance for small employers	Any insurer offering a health insurance plan to any small employer in a State would be required to: make that plan available to every small employer in the State; make available to every small employer a basic insurance plan (when required); and not cancel or refuse to renew any small employer health insurance plan.	Would require insurers to make available health coverage to small employers for at least a "MedAccess" plan. Insurers must offer either a basic plan or a standard plan. May offer other plans that would not be subject to the availability requirements. Each MedAccess plan: must accept every small employer in the State that applies for coverage; must accept every eligible individual; and may not place any restriction on the eligibility of an individual to enroll so long as the individual is eligible.
Guaranteed eligibility of employees of small employers	Would apply to all small group coverage. Would require each health insurance plan offered to any small employer in a State to accept for enrollment every eligible employee (or family member). Criteria related to health status or claims experience could not be used to determine eligibility for, benefits under, or terms of such health insurance for individual employees.	Would apply to MedAccess plans only. Would require that no exclusions on coverage be placed on small employer group applicants for MedAccess plans based on previous claims experience or the health status of any member of the group
Basic health insurance plan for small employers	No Federal benefit package defined. State could define a basic benefit plan, with approval from Secretary of HHS, that would be required to be offered to all small employers in a state by insurers offering any health insurance plans to any small employers in the State.	MedAccess plan designed to provide benefits typical of the benefits offered in the small employer health coverage market, or to provide only benefits for essential preventive and medical services and has an average actuarial value that does not exceed 60% of the average actuarial value of the benefits typical of the benefits offered in the small employer health coverage market. Includes two uniform benefit levels: a basic plan with essential medical and preventive benefits, and a standard plan more comparable to coverage generally now available

Issue	Administration Proposal	House Republicans (H.R. 5325)
Interim requirements for risk pooling and premium rates for small employer health insurance	Requires all insurers offering health insurance plans to small employers to participate in an interim risk pooling mechanism. Interim risk pooling mechanisms could be either a reinsurance program or an assigned risk program.	Requires each State to establish and fund one or more reinsurance or allocation of risk mechanisms.
Limits on premium rates for small employer health insurance	Base premium rate: With respect to health insurance plans with the same or similar coverage offered in a rating period to a group of small employers within the same block of business whose insured populations had similar demographic characteristics, the lowest per capita premium rate which could be charged to any employer in the group. For any rating period, no base premium rate for any small employer block of business could exceed the equivalent rate of any other block of the insurer by more than 20%. The highest premium rate for a specific health insurance plan that an insurer could charge any small employer in a block of business for a rating period could not exceed the corresponding base premium rate by more than 50% prior to 1/1/97 and 35 percent afterward. Annual percentage increases in the premium rate charged to a small employer would be limited to the sum of the percentage change in the base premium rate plus 5%.	Base premium rate: For each class of business for each rating period, the lowest premium rate charged or which could have been charged under a rating system for that class of business by the small employer carrier to small employers with similar demographic or other objective characteristics. Index rate: Arithmetic average of applicable base premium rate and corresponding highest premium rate for the class. For any rating period, no index rate for any small employer block of business could exceed the index rate of any other block of the insurer by more than 20%. Premium rates charged during a rating period to small employers with similar demographic or other objective characteristics for the same or similar coverage shall not vary from the index rate by more than 25% of the index rate. **Allows premiums to vary up to 67%.** Annual percentage increases in the premium rate charged to a small employer would be limited to the percentage change in the premium rate charged under the plan for a newly covered employer within the same class of business rate 15%.

Issue	Administration Proposal	House Republicans (H.R. 5325)
Application of rating factors for small employer insurance	An insurer would be required to apply rating factors consistently to all small employers, and a geographic area smaller than the smaller of a county or the first three digits of a postal zip code could not be used as a rating factor.	
State health risk pooling system	All insurers covering small employers in a State would participate in the system. An insurer would pay into the pool for below average risk individuals and would receive funds from the pool for above average risk individuals. Secretary of HHS would be permitted to fund health risk pooling demonstrations in as many as four States. Five-year phase-in of health risk pooling as full program starting in 1997 with 100% replacement of premium limits.	Would authorize research on impact of legislation and to conduct demonstrations. Would require development of methods for measuring the relative health risks of eligible individuals. Would require development of a model for equitably distributing health risks among carriers in small employer health care coverage market. Carriers with below average risk would contribute to a common fund. Carriers with higher than average risk would receive transfers from a common fund.
Prohibition of denial of coverage based on health status	Would prohibit insurer from refusing to offer or renew, canceling, or conditioning the coverage under any employment-basis health insurance plan on the basis of the health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability, of one or more individuals.	Would provide assurance of continuity of coverage and a requirement for health plan renewability Would require that all employer-provided benefit plans meet consumer protection standard regarding current health status restrictions.

Issue	Administration Proposal	House Republicans (H.R. 5325)
Exclusions based on pre-existing conditions	Would limit pre-existing condition restrictions: would permit limitation or exclusion only, for not more than 6 months from the date of application, with respect to a condition diagnosed or treated within 3 months preceding that date. Pregnancy, or child under one year of age, not subject to exception. Individual who had lost prior health insurance would be treated as if no break in coverage had occurred, if the period from the loss of coverage to the date of application for new coverage did not exceed 180 days, if involuntary loss of insurance, or 60 days, in any other case.	Would limit pre-existing condition restrictions: would permit limitation or exclusion only, for not more than 6 months from the date of application, with respect to a condition diagnosed or treated within 3 months preceding that date. Would eliminate pregnancy as a preexisting condition, and provides coverage for newborns at birth. Continuous coverage would be required for pre-existing condition exclusion to be in effect. Break in coverage could not exceed 60 days in general or 6 months if individual loses coverage due to termination of employment.
Purchasing Groups		
Organization	Employers would be allowed to form groups for the purpose of purchasing health coverage. Must include small employers but may also include other members.	Small employers with more than 100 employees, including the self-employed, could form groups employees for the purpose of purchasing health coverage.
Minimum size	No specific size requirement, but must demonstrate to the Secretary that the group has (or will have) significant market share.	Groups would have to have a least 100 employers in the group in each State in which the association operates.
Incentives for formation	Would preempt all state regulation except those related to small employer market reform and assessment for insurance solvency funds. (Protects against state premium taxes.)	Would preempt state mandated benefit laws. (But, these laws are also preempted for "basic" and "standard" coverage sold to small businesses. Does not preempt premium taxes. Much weaker incentive than the Administration's proposal.)

Issue	Administration Proposal	House Republicans (H.R. 5325)
Medical malpractice liability reform		
Implementation of general reforms	Would provide incentives to States to implement these reforms. Possible to withhold all Federal domestic discretionary appropriations, with certain exceptions, if not implemented.	Would preempt state laws, but keep litigation in state courts by denying Federal question of jurisdiction.
Cap on non-economic damages	Non-economic damages would be limited to maximum of $250,000 in any health care liability action (with inflation index).	Would cap noneconomic damages at $250,000 without indexing.
Punitive damages		Punitive damages would be handled separately. Could not exceed twice the total of the damages awarded to the plaintiff and members of the plaintiff's family. Directs that punitive damages awarded by courts be paid to states to assist in funding their efforts to reduce medical malpractice.
Statue of limitations		Would establish statue of limitations at 2 years from the date of the alleged injury (in no event to exceed 4 years). For minors, same 2-year period, but in no event after the date on which the minor attains 10 years of age.
Installment payments of damages	Health care providers could not be required to pay future damages awarded as a single, lump-sum payment.	Would allow for structured periodic payment of compensatory awards if more than $100,000 for expenses to be incurred in the future.
Offsets for economic damages paid by collateral source	Total amount of damages received by a plaintiff would be reduced by any other payment that has been made or that will be made to compensate for an injury. (Prevents double recovery.)	Similar to Administration's proposal
Cap on attorneys' fees		Would limit attorneys's fees when paid on contingency basis: 25% of first $150,000 awarded and 15% of any additional amounts.

Issue	Administration Proposal	House Republicans (H.R. 5325)
Joint and several liability	Would eliminate joint and several liability for non-economic damages.	Would eliminated joint and several liability for economic and non-economic damages.
Standard for negligence		Conduct at time of providing health care services that are the subject of the action must be found to be "not reasonable".
Use of guidelines for defense		Allows practice guidelines to be used as an affirmative defense in malpractice actions. Secretary must sanction the use of the guideline for purposes of an affirmative defense to medical malpractice liability actions brought during the year. Secretary will review, not less frequently than annually, the guidelines and standards developed by AHCPR and will sanction those guidelines the Secretary considers appropriate. States may petition to have guidelines developed by the States sanctioned by the Secretary.
Guideline development	States would be required to cooperate, through appropriate health authority, with Federal research efforts with respect to patient outcomes, clinical effectiveness, and clinical practice guidelines.	Would increase authorization of appropriations for the development and dissemination of medical practice guidelines by $10 million in FY 1993, $20 million in FY 1994 and FY 1995. Would authorize a study of the usefulness of medical practice guidelines in reducing incidence and costs of medical liability dispute resolutions

Issue		Administration Proposal	House Republicans (H.R. 5325)
Alternative dispute resolution		Alternative dispute resolution (ADR) mechanisms encouraged. Each state must establish at least one ADR mechanism. Mechanism for non-binding arbitration could be established by each State for dealing with civil action against the health care provider.	Would require all medical liability disputes to be considered by a dispute resolution process prior to entering the court system. Mandatory and binding. To pursue after an ADR decision, would have to show specific evidence of error and burden of proof on appellant.
	Scope	Would apply to CHAMPUS, CHAMPVA, Medicare, Medicaid, FEHB, as result of participation in an "employee benefit plan," or as result of participation in MEWA as defined by ERISA. Also provides for ADR for disputes where health care costs are reimbursable pursuant to any law providing for HINs.	Would apply to all medical malpractice litigation
	Incentives to accept decision	If a plaintiff rejects determination of arbitration and fails to obtain a final judgment that is at least 10% greater than the determination shall pay the defendant's reasonable costs and reasonable attorney's fees incurred after the rejection of the determination (same if defendant rejects determination)	Party that loses an appeal of an ADR decision must pay attorneys' fees for opposing party.
State medical boards		State Medical Boards would be required to provide information on actions and use of continuing medical education. Physicians disciplined by the State Medical Board would have to take continuing education courses.	Would grant immunity to individuals assisting state medical societies under contract to licensing boards. Would authorize research and education on causes of medical malpractice.

Issue	Administration Proposal	House Republicans (H.R. 5325)
MediSave Accounts		
General		Would allow employers to offer as a health plan option MediSave accounts. Contributions to the accounts would be tax deductible, and would be limited to base year health expenditures or a statistical median determined by the Secretary of HHS. Recipients would have to purchase health coverage, and would make IRS approved health expenditures and long term care purchases from the account tax free. Any account balances would roll over year to year and accrue to the recipient. Any MediSave account funds removed for non-medical expenditures would be treated as recipient taxable income. Interest earned on contributions would be taxable.
Contribution limit		Employers that provided health benefits for 3 years prior to setting up a MSA could contribute up to the lower of the employer's base-year health insurance contribution indexed by the CPI-U or the 70th percentile of employer contributions nationwide. Other rules would apply for other employers.
Employer and employee option		MSAs could be set up at employer option; employees could choose between MSA and traditional insurance if offered. Alternative plans would have to have an equivalent actuarial value.

Issue	Administration Proposal	House Republicans (H.R. 5325)
Medicaid Reform		
Medicaid administrative incentives		Would allow states to provide coverage to Medicaid recipients through alternative delivery systems such as primary care case management, health maintenance organizations, and preferred provider organizations. Would provide no new funding to expand coverage. Would extend period for which states must re-apply for certain Medicaid waivers. Would enable states to locally determine certain quality standards for nursing homes.
Cost Containment		
Prohibits self-referral by doctors who own clinical laboratories		Would be applicable to all payers. Would prohibit certain physician referrals to facilities in which that physician holds an ownership or investment interest. (Certain referrals would be allowed where patient access may be adversely affected by these prohibitions). Would prohibit such physician referrals for physical therapy services, clinical laboratory services, radiology and diagnostic imaging services, radiation therapy services, and furnishing of durable medical equipment.

Issue	Administration Proposal	House Republicans (H.R. 5325)
Medicare payments changes		Would change the schedule for the annual Medicare hospital update from fiscal year to calendar year. Would reduce current Medicare payment methodologies for clinical diagnostic laboratory tests .
Preemption of state mandates	Would eliminate State laws requiring any services, category of care, or services of any class or type of provider.	Would preempt certain state laws relating to health insurance. Would eliminate state health plan benefits and service mandates for plans meeting consumer protection standards.
Preemption of state anti-managed care laws	Would preempt any provision of State law that restricts the flexibility of any private entity to negotiate the amount or terms of payment to a provider, prohibits or limits restrictions by an insurer on the location, number, type, or professional qualifications of participating providers, prohibits or limits provisions on incentives for consumers to use participating providers, or prohibits, limits, or establishes requirements for utilization review. The Secretary of HHS would be authorized to preempt any other restriction on utilization review found to be inconsistent with this bill.	Would preempt state laws that restrict the development of managed care programs. The preemption would sunset five years after enactment.

Issue	Administration Proposal	House Republicans (H.R. 5325)
Consumer and Comparative Value Information		
Comparative value information programs for health care purchasing	States would be required to develop and carry out a health care value information program. Information on the average prices of common health care services would be available within 1 year and information related to the value of each health insurance plan available in the State would be provided within 4 years. Federal agencies would make comparative value information available. Information relevant to health services research would be made available to researchers. All Medicare claims records, including records that identify individual physicians or other individuals that furnish items or services under Medicare would be available. The Secretary would develop model systems for gathering health care cost, quality, and outcomes data. HHS would be backup to the States, with fees to cover costs.	Would require states to make available to consumers information on the comparative value of medical services similar to Administration's proposal. Comparative quality and outcomes information would be provided within 6 years after enactment.

Issue	Administration Proposal	House Republicans (H.R. 5325)
Administrative Savings		
Storage and transmission of medical and health insurance information and priority of payment	Would prohibit States from requiring medical or health insurance information be kept in written, rather than electronic, form. Secretary would promulgate requirements concerning health insurance information privacy and confidentiality. Secretary would determine whether problems relating to standards for the electronic receipt and transmission of health insurance information cause significant administrative costs. If so, Secretary would promulgate standards. Secretary would determine whether problems relating to receipt and transmission of health insurance eligibility verification cause significant administrative costs. If so, Secretary would promulgate standards. Secretary would determine whether proportion of health insurance claims and payment information received and transmitted by paper would continue to cause significant administrative costs. If so, Secretary would require a specified proportion of such information to be received and transmitted electronically. Secretary would promulgate requirements concerning the form and content of basic claim forms under health insurance plans.	Would override state laws that prevent the sole use of electronically transmitted claims and other medical records for payment purposes. Would provide protection for individual privacy regarding claims and medical records. Would require Secretary of HHS to develop a standard claims form set for electronic transmission of health coverage information and billing data. Would require Secretary of HHS of adopt standards for data elements for use in paper and electronic claims processing under health benefits plans, as well as for use in utilization review and management of care (including data fields, formats, and medical nomenclature, and including plan benefit and insurance information). Would require hospitals, physicians, and carriers to conform to the uniform claims reporting standards. Enforcement would apply to providers and insurers.

Issue	Administration Proposal	House Republicans (H.R. 5325)
	Secretary would determine whether variety of information requested by health insurers causes administrative costs disproportionate to benefits derived from that information. If so, Secretary would publish recommendations concerning what additional information should be allowed to be requested. Secretary would promulgate rules for determining the priority of payment when two health insurance policies cover the same individual. Secretary would determine whether difficulties relating to transfer of information among health insurers that cover the same individual cause significant mistaken payments or administrative costs. If so, Secretary would promulgate requirements for transfer of information. Enforcement would apply only to insurer.	
Use of magnetized health benefit cards for Medicare and Medicaid		Would require Secretary of HHS to set standards for use of magnetized Medicare cards and issue them to beneficiaries. $25 million would be authorized for Medicare.
Coordination of benefits	HHS could require by 1996 that insurers exchange information listing all individuals entitled to benefits.	Would require Secretary of HHS to design a clearinghouse for primary and secondary payor information for the working aged and other Medicare beneficiaries who may have employer-provided coverage.
Identification numbers	Would require health insurers to use social security number for their beneficiaries and Medicare unique identifiers for hospitals, physicians, and others who furnish items and services by 1994.	Would require use of Social Security number as the identifier for all medical claims

Issue	Administration Proposal	House Republicans (H.R. 5325)
Medical data requirements	Secretary would promulgate requirements for hospitals and other health care entities concerning electronic medical data (specified set of data, specific set of data elements to be used, and standards for transmission of data) by 1995. Would require hospitals that participate in Medicare to maintain electronic patient care information system and transmit data electronically for PRO review by 1996.	Would require all hospitals to put in place an electronic patient care information system by 1/1/96, which meets standards set by Secretary of HHS. Insurers would be prohibited from requiring providers to submit medical data other than that specified by HHS.
Pilot grants	Secretary would be authorized to make grants to at least two, but not more than five, community organizations, or coalitions of health care providers, insurers, and purchasers, to establish communication links between information systems of health insures and of health care providers. Secretary would be authorized to make grants to at least two, but not more than five, public or private nonprofit entities for development of regional or community based clinical information systems. Secretary would be authorized to make grants public or private nonprofit entities for development and testing of electronic medical data set for physicians and other health care providers.	Secretary would be required to provide grants to demonstrate the application of comprehensive information systems in continuously monitoring patient care and improving patient care. Authorized to appropriate from Federal Hospital Insurance Trust Fund $10 million for each fiscal year beginning with FY 1994 and ending with FY 1998. Similar nature of research as Administration's proposal.
Antitrust Exemptions		
Antitrust exemptions for hospitals		Would grant exemptions from certain anti-trust laws if a community-developed regional health care system can demonstrate greater efficiencies, expanded access, reduced costs, and elimination of excess capacity, medical technology and capital investment by hospitals and other providers.

Issue	Administration Proposal	House Republicans (H.R. 5325)
Antitrust exemption for disciplinary activities for medical societies		Would provide exemption from Federal and state antitrust laws for medical societies that establish and enforce professional standards.

ISSUE	ADMINISTRATION PROPOSAL	HOUSE REPUBLICAN (H.R. 5325)
ACCESS		
Tax Credits for the Uninsured	Provides tax credits of $1250/$2500/$3750 for individuals/couples/families with incomes below poverty with phase-down to 150% of poverty.	None provided.
Deduction of Premiums for Self-Employed	Phases-in 100% deduction by '96. (25% in '93, 50% in '94/'95, 100% in '96)	100% deductible in '93.
Community Health Centers	No new funding provided.	Increases authorization by $100 m in '93, $500 m by '97
Rural Health Care	No specific provisions, but tax credit and self-employed deduction would help.	Establishes program to improve emergency care and air transport in rural areas. Also extends favorable rules for Medicare-dependent small rural hospitals.
SMALL EMPLOYER MARKET REFORM	Applies to employers with up to 50 workers.	Applies to employers with up to 35 workers.
Implementation	State implementation with Federal backup; HHS establishes regulations with advice from NAIC.	Similar, but gives responsibility for developing regulations to NAIC, subject to limited review by HHS.
Required Benefit Plans	None required.	Must offer basic and standard plans; may offer other plans.
Guaranteed Issue and Renewability	Applies to all small group coverage. Insurer may not refuse to provide or renew coverage based on health risk.	Only applies to basic and standard MedAccess plans
Premium Variation Between Demographic Categories	Insurers may vary premiums without limit by age, sex, geography.	Same.
Premium Variation Based on Health Risk	Insurers may vary premiums within demographic categories by only 50% to reflect differences in risk.	Same except that premiums can vary up to 67%.
Limit on Relative Premium Increases for Groups with Deteriorating Health Status	Insurer cannot increase premium for group with worsening health risk by more than 5% a year relative to the premiums for low-risk groups.	Similar, but group with deteriorating risk can face a relative premium increase of up to 15%.
Reinsurance and Assigned Risk	Requires that state implement either system.	Similar.
Health Risk Pooling	5-year phase-in of health risk pooling as full program starting in 1997 replacing premium limits.	Authorizes HHS to study health risk pooling and to develop recommendations for use.
PURCHASING GROUPS		
Organization	Health insurance network (HIN) must be governed by a board elected by small business members.	Similar.
Minimum Size	HIN must have significant market share as defined in regulations to permit effective exercise of market power.	At least 100 small businesses must participate.
Incentives for Formation	Preempts all state regulation except that related to small employer market reform and assessments for insurance solvency funds. (Protects against state premium taxes.)	Preempts state mandated benefit laws. (But, , these laws are also preempted for "basic" and "standard" coverage sold to small businesses, see below.)

ISSUE	ADMINISTRATION PROPOSAL	HOUSE REPUBLICAN (H.R. 5325)
MEDICAID REFORM		
General Approach	States have two options linked with tax credit. Option 1: Medicaid is retained with tax credit for families not eligible for Medicaid. Option 2: States may combine Medicaid with tax credit to establish a unified access program.	Incremental reform to increase state flexibility without new funding to expand coverage.
Coordinated Care	Option 1: States must shift all enrollees into coordinated care over 5 years. Option 2: Broad flexibility.	Eliminates need for states to obtain waiver to establish a mandatory coordinated care program.
Financing	Shifts Federal funding for acute care for non-elderly to a fixed per capita payment indexed for inflation.	Maintains current Federal/state cost matching formula.
Nursing Home Regulation	No provision.	Provides waiver from certain nursing home requirements.
MEDICAL SAVINGS ACCOUNTS		
General	No provision.	Employer contributions to a MSA are excluded from taxable income if contribution (i) does not exceed the applicable limit and (ii) is used to pay for insurance or out-of-pocket health or long-term care costs.
Contribution Limit	No provision.	Employers that provided health benefits for 3 years prior to setting up an MSA may contribute up to the lower of the employer's base-year health insurance contribution indexed by CPI or the 70th percentile of employer contributions nationwide. Other rules apply for other employers.
Employer and Employee Option	No provision.	MSAs may be set up at employer option; employees may choose between MSA and traditional insurance if offered. Alternative plans must have an equivalent actuarial value.
COST CONTAINMENT		
Preemption of State Mandates	Preempts all state laws requiring coverage of specific services or specific providers by any insurance policy.	Preemption only applies to plans provided to small employers.
Preemption of State Anti-Managed Care Laws	Extensive preemption of state laws.	Similar, but less extensive.
Prohibition on Physician Self-Referrals.	Endorsed in general terms in February white paper.	Extends current Medicare ban on clinical lab self-referrals to all payers and to radiology, radiation therapy, DME, physical therapy. Adds exceptions for doctors sharing a facility in the same building and cases where physician investment is needed to make high-tech facility available.
Medicare Savings	February 6 white paper discussed a number of potential options in general terms.	Shifts hospital update from fiscal year to calendar year. Reduces nationwide cap on clinical lab fee schedule to 80% of the median and eliminates annual inflation indexing.

ISSUE	ADMINISTRATION PROPOSAL	HOUSE REPUBLICAN (H.R. 5325)
MEDICAL MALPRACTICE		
Implementation of General Reforms (Excluding ADR)	Federal incentives for state to enact reforms (e.g., loss of certain Federal funds for states that fail to act).	Federal preemption of state laws, but keeps litigation in state courts by denying Federal question jurisdiction.
Cap on Non-Economic damages	$250,000 cap with inflation index. HHS waiver if cap conflicts with state constitution or for other "good cause".	$250,000 cap without indexing.
Installment Payment of Damages	Permitted at option of defendant.	Required for damages over $100,000
Offsets for Economic Damages Paid by Collateral Source	Award must be reduced by amounts payable from health insurance, workers compensation, etc.	Similar.
Cap on Attorney's Fees	None provided.	May not exceed 25% of first $150,000 of award or 15% of additional award.
Joint and Several Liability	Eliminated only for non-economic damage.	Eliminated for economic and non-economic damages.
Standard for Negligence	No change in state law specified.	Conduct must have been unreasonable at the time.
Use of Guidelines for Defense	No provision.	Compliance with HHS -approved guideline may be used as a defense. Failure to follow guideline may not be used as evidence of negligence.
Guideline Development	No new funding.	Authorizes $10 m in new funding for '93. $20 m for '94 and '95. Also provides for study of impact of guidelines on malpractice litigation.
Alternative Dispute Resolution	Mandatory, *non-binding*, arbitration: any case may go to trial after arbitration.	Mandatory *binding* ADR: trial only permitted after ADR for certain specified errors and appellant must prove that ADR verdict was incorrect.
Scope	Limited to claims arising from Medicare, Medicaid, CHAMPUS, VA, FEHB or private plans governed by ERISA or participating in a health insurance network.	Applies to all malpractice litigation.
Incentives to Accept Decision	If plaintiff rejects arbitration decision and fails to win damages at least 10% higher in court, plaintiff is required to pay attorney's fees.	Party that loses an appeal of an ADR decision must pay attorneys fees for opposing party.
ADMINISTRATIVE SAVINGS		
Electronic Claims Data Standards and Electronic Billing	HHS may establish electronic claims data standards and require electronic submission by 1995 if private sector does not act before then. Enforcement apples only to insurer.	HHS may establish data standards within 36 months after enactment and require electronic billing within 48 months. Enforcement applies to providers & insurers.
Use of Magnetized Health Benefit Cards for Medicare and Medicaid	No provision.	HHS required to implement program for use of magnetized ("swipe") cards for Medicare and Medicaid recipients. $25 million authorized for Medicare.
Coordination of Benefits	HHS may require by 1996 that insurers exchange of information listing all individuals entitled to benefits.	Similar provision. Also requires HHS to establish a Medicare & Medicaid secondary payer data bank.

ISSUE	ADMINISTRATION PROPOSAL	HOUSE REPUBLICAN (H.R. 5325)
Electronic Medical Data Standards for Hospitals and Other Providers	HHS shall establish standards for hospitals for by 1995. Hospitals must be in compliance and transmit data electronically for PRO review by 1996. (2 year extensions possible). May establish requirements for other providers	Similar, but effective in 1996. (Four year extensions possible.) Insurers are prohibited from requiring providers to submit medical data other than that specified by HHS.
Identification Numbers	Effective 1994, all insurers must use Social Security number for beneficiaries and Medicare number for providers.	Similar.
CONSUMER INFORMATION	States to provide price information for common health care services within 1 year and comparative quality and outcomes data for health plans and hospitals within 4 years. HHS backup with fees to cover cost.	Similar, but comparative quality and outcomes information to be provided within 6 years after enactment.
MISCELLANEOUS REFORMS		
Antitrust Exemptions for Hospitals	Antitrust exemptions for joint production ventures have been addressed in other Administration proposals.	Provides for case-by-case waiver by HHS in cases where hospitals share a high-cost high-technology facility.
Antitrust Exemption for Disciplinary Activities by Medical Societies	DOJ to provide "clarification" to state medical societies.	Provides exemption from Federal and state antitrust laws for medical societies that establish and enforce professional standards.

FACSIMILE TRANSMITTAL

Date/Time: 10:15 a.m. 6-19

To: Gail Wilensky
456-7739

From: Chip Kahn
225-4021

Re:

Number of Pages (including this page) 22

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515-6348

June 18, 1992

The Honorable Dan Rostenkowski, Chairman
Committee on Ways and Means
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Mr. Chairman:

We wrote to you on June 8 regarding H.R. 5325, which we introduced with 83 of our colleagues in the House, requesting immediate hearings and expressing the belief that it could and should form a starting point for bipartisan Committee deliberations on health care issues. To date, we have not received a reply.

What we have witnessed instead -- through press reports and unofficial information which has come out of your caucus's private meetings -- is an effort by Ways and Means Committee Democrats to undertake a partisan markup of legislation to create still another election year confrontation with the President. What happened to your interest this spring in proceeding with health reform on a joint, bipartisan basis? We have made repeated offers to work with you in that regard at both staff and Member levels. All have been rejected or have met with silence. According to press reports, Republicans will have an opportunity to offer amendments during the Committee's markup -- no different from any other markup and hardly any great concession to the spirit of bipartisanship.

H.R. 5325 has a great deal of support in the House and is worthy of serious consideration by the Committee and the House as a whole. The American public's views on health care have been made clear in public opinion survey after survey. Americans want change and expect their leaders in Washington to take the lead. However, they also want reasonable reform which will maintain the best of our system while reducing the inefficiencies and inequities in that system. We feel strongly that H.R. 5325 is a powerful downpayment on this mandate for change.

Many of H.R. 5325's provisions are supported by Republicans and Democrats alike, making it an ideal starting point for Committee deliberation. But rather than use it as an opportunity to attempt to forge a bipartisan consensus on health care reforms we can accomplish this year, the Committee process now appears to be designed to highlight partisan differences, rather than achieve bipartisan solutions.

We urge you to reconsider this apparent decision to move forward without any bipartisan discussion or input. We want to work with you, not against you. We are interested in legislation, not confrontation. That is why we are again appealing to you to establish a bipartisan framework for the development of health care legislation in the Ways and Means Committee.

Sincerely,

Robert H. Michel, M.C.
Republican Leader

Bill Archer, M.C.
Ranking Republican Member
Committee on Ways and Means

Bill Gradison, M.C.
Ranking Republican Member
Subcommittee on Health

PROPOSED AMENDMENTS TO POSSIBLE HEALTH CARE REFORM BILL

June 17, 1992

I. Substitute plans

(1) Single-payer health reform (Russo, Moody)

(2) Medicare-for-all (Gibbons, Stark, Donnelly)

(3) CDF proposal (Andrews)

II. Revisions to June 1 health care reform package

A. Amendments to cost containment section

(1) Revise GME payments to favor primary care (Dorgan)

(2) Clarify that rates would be maximum providers could charge (Levin)

(3) Change references from "HMOs" to "managed care plans" (Levin)

(4) Federal rates as default if States do not meet spending targets (Cardin)

(5) Delete prescription drug formulary (Cardin)

B. Amendments to health system reforms provisions

Health insurance reform

(6) Delete flat broker commission provision (Downey)

(7) Provide that insurance reforms do not apply to individual market (Dorgan)

(8) Pre-empt State laws that prohibit universities from offering graduating students health insurance (Kennelly)

(9) Delete Pilot Life provision (Kennelly)

(10) Delete HMO dual choice (Kennelly)

(11) Substitute for health insurance standards (Kennelly)

(12) Substitute demonstration for health insurance purchasing cooperatives (Kennelly)

(13) Prohibit consideration of pregnancy as a pre-existing condition (Levin)

Administrative simplification

(14) Delete health claims clearinghouse (Kennelly)

(15) Clarify uniform electronic claims format (Kennelly)

Fraud and abuse

(16) Tighter fraud and abuse controls regarding Medicaid providers (Rangel)

(17) Oncology-related DME ownership/referral exception (Jenkins, Andrews)

(18) Restrictions on physician ownership/referral (Dorgan)

Other health system rerorms including malpractice

(19) Sense of Congress on alternative dispute resolutions (Dorgan)

(20) National outcomes data base (Kennelly)

(21) Reporting and distribution of patient outcomes information (Levin)

(22) Medical malpractice (Cardin)

C. <u>Amendments to health benefits and initiatives provisions</u>

(23) Health insurance buy-in for children (Matsui)

(24) Clarify health insurance deduction for self-employed (Dorgan)

(25) Medicare prevention benefits (Coyne)

(26) Medicare budget neutral buy-in (Cardin)

(27) Medicaid coverage of residential substance abuse treatment for pregnant women (Rangel)

(28) Medicaid State poverty adjustment (Kennelly)

D. Other amendments

(29) Present Committee views as preamble or report language (Cardin)

III. Tax amendments

(1) Medical care savings accounts (Jacobs)

(2) Repeal health insurance credit and increase EITC family size adjuster (Kennelly)

(3) Accelerated death benefits (Kennelly)

(4) Clarify long-term care insurance tax policy (Kennelly)

(5) Clarify tax-exemption standards for non-profit hospitals (Donnelly)

IV. Medicare and other amendments

A. Medicare Part A amendments

(1) Puerto Rico DRGs (Rangel)

(2) Recoupment from NJ hospitals (Guarini)

(3) ZACH amendments (Dorgan)

(4) Hospital wage index hold harmless (Donnelly)

(5) Reduce disproportionate share threshold (Coyne)

(6) Epilepsy DRG amendment (Cardin)

B. Medicare Part B amendments

(7) Anatomic pathology, pap smears, and blood smears (Downey, Matsui, Kennelly)

(8) Payments to new physicians (Pickle, Levin)

(9) RB RVS policy for cancer physicians in PPS-exempt cancer hospitals (Pickle)

(10) Pay additional mental health practitioners (Rangel)

(11) Puerto Rico RB RVS (Rangel)

(12) Waive Part B late enrollment penalty (Downey)

(13) IOL payment limits and high technology lens adjustment (Matsui)

(14) Fee schedule for social workers (Dorgan)

(15) Psychologists defined as physicians under Medicare (Coyne)

(16) Use more recent data on physician geographic adjustment (Andrews)

(17) EKG payments (Andrews, Levin, Moody, Cardin)

(18) Respite care amendment (Levin)

(19) Medicare cancer coverage (Levin)

(20) EOMB extra-billing (Levin)

(21) EPO/immunosuppresive drugs (Levin)

(22) GAO study of credentials of teaching physicians (Levin)

(23) MMSD waiver (Moody, Stark, Cardin)

(24) Coverage for chiropractors (Moody)

(25) Coverage for speech pathology and audiology (Moody)

(26) Submission of claims within 30 days (Cardin)

(27) DME/CMN (Cardin)

(28) Expand EPO coverage (Cardin)

(29) Coverage of paramedic services (Kennelly)

C. Medicare Parts A and B amendments

(30) Prohibit regs that redistribute funds by more than specified (Rangel, Downey, Levin)

(31) State-funded family residence programs (Dorgan)

(32) Medicare QMB program (Moody)

D. Other

(33) Conditional waiver of foreign resident requirements for professionals serving in medically underserved areas (Kennelly)

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SUMMARY OF POSSIBLE HEALTH CARE REFORM BILL

June 1, 1992

COST CONTAINMENT

1. National global budget

   A. A national global budget would be set by statute for total national spending for health services

   B. Annual budget would initially be set for 1994 at the current trend minus 1% and phase down to the increase in the nominal gross domestic product (GDP) by 1998

      (1) Health care costs would stabilize at slightly more than 15% of the GDP in 1998

2. Medicare-type provider payment rates

   A. Setting rates

      (1) ProPAC and PhysPRC would study and recommend provider payment policies to the Congressional Committees

         (a) Recommendations would include the allocation of national expenditures among hospitals, physicians, and other sectors of the health care system

      (2) Growth in expenditures for each sector of the system would be set by statute consistent with the national global budget

      (3) Specific provider payment rates would be set by HHS

         (a) Specific rates would be set at levels estimated not to exceed rates of increase set for each sector of the health care system

         (b) Specific provider payment rates would generally be set using Medicare methods

(c) Rates would be the maximum which providers could charge for services payable by insurers or individuals

(i) Rates would exclude allowable Medicare-type extra-billing by physicians and other ambulatory providers

(d) Rates would not apply in States with State payment programs or in qualified HMOs

B. Acute care hospital services

(1) Adjusted Medicare-type DRG rates for hospitals

(a) New DRGs necessary for under-65 patients

(b) A standard hospital benefit package would be defined to facilitate DRG reimbursement

(i) Package would be based on Medicare benefits

(ii) Specific adjustments to the DRG payments would be defined to accommodate more or less extensive hospital benefits

(2) Rates would be adjusted by geographic area for wages and for non-labor input prices

(3) Rates would be set separately for hospitals in large urban areas and for all other hospitals

(4) Rates would be adjusted by individual hospital for the level of uncompensated care and for Medicaid payment levels

(5) Initial rates for private payers would be set based upon current average payments made by private payers

(6) Payments would be adjusted for the costs of graduate medical education, and would be designed to encourage training of primary care physicians

(7) Hospitals would report information needed to monitor expenditures

(a) All hospitals would report information under a uniform reporting system

C. Physician services

(1) Adjusted Medicare-type RB RVS rates for physicians

(a) New procedure codes and RB RVS units necessary for under-65 patients

(2) Rates would be adjusted geographically in the same manner as under Medicare

(3) Rates for private payers would be initially based on average payments made currently by private payers

(a) Rates would be adjusted to take into account amount of allowed extra-billing

(4) Physicians and other ambulatory providers would report information needed to monitor expenditures

D. Other ambulatory services

(1) Adjusted Medicare-type rates for other services

(a) Laboratories fees set at Medicare rates, and all services would be directly billed to insurers

(b) Rates for durable medical equipment would be set based on Medicare policies and rates

(c) Out-patient hospital fees would set by limits on year-to-year rate of increase, pending development of prospective system

(d) Rates for all other services would be set based on limits on year-to-year rate of increase

E. Prescription drugs

(1) Maximum rates of payment for each prescription drug would be set based on average wholesale price by HHS

(2) A national formulary would be established

F. Medicare-type limits would apply to extra-billing of patients by physicians and other ambulatory providers

3. State payment program opt-out

A. States could establish payment programs for hospital and/or physician services or for all services

(1) Federal Medicare-type payment rates would not apply to providers in States with approved programs

B. State programs would meet standards for organization and operation similar to waiver standards for Medicare hospital payments under current law

C. The total costs of services covered by State programs could not exceed the projected total costs for such services under Federal rates for private and public payers

(1) Cost determinations for State programs would be over rolling 36-month period

(2) States could carry forward annual savings and could spend savings in support of health programs

D. States that establish a a single-payer health insurance system that provides universal coverage could meet standards for provider payment program

E. States which currently operate an all-payer hospital payment system with a Medicare waiver could continue to operate under current rules

4. Qualified HMO opt-out

A. Qualified HMO plans would not be required to pay for services at the Medicare-type rates set by HHS

(1) The overall global budget and other payment policies would take expenditures by qualified HMOs into account but rates would not apply to these plans

(2) Qualified HMOs would be plans meeting current Medicare standards or current PHSA Title XIII standards

B. Qualified HMOs could negotiate payments to providers but providers could not charge higher rates to other payers to make up any shortfall

C. Incentives for expansion of qualified HMOs

(1) Improve access to marketplace by qualified HMOs

(a) Extend mandatory "dual choice" and expand dual choice to "multiple choice"

(b) Require that marketing materials for qualified HMOs be provided to every employee of every company in the service area

(2) Expand small employer access to competing health insurance plans

(a) Authorize states to establish regional health insurance purchasing cooperatives

(3) Preempt State laws that mandate that any "willing provider" be allowed to participate in qualified HMOs

(4) Adjust Medicare payments to risk contract HMOs for the lack of enrollment in HMOs of beneficiaries with Medicare as secondary payer

(5) GAO and CBO would study and recommend additional measures to encourage the development and expansion of qualified HMOs

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HEALTH SYSTEM REFORMS

5. Health insurance reform

A. Health insurance for all employer groups, including self-insured groups, would be subject to certain requirements

(1) Health insurance coverage could not discriminate against any eligible group or individual member of an eligible group based on health status or medical condition

(a) Taft-Hartley Trusts could restrict membership to those eligible under the terms of the Trust, but could not discriminate against any member otherwise eligible

(2) Health insurance premiums paid by members of groups could not be adjusted for an individual's medical status

(3) Any worker changing jobs with less than three-month break in employment-based insurance coverage including coverage under COBRA could not have new exclusion period applied

(a) Pre-existing condition exclusions would otherwise be limited to six months

(4) Right to sue for legal fees and damages

(a) Beneficiary's rights to recover legal fees and damages when benefits are denied would be protected for all group health insurance

B. Health insurers, other than self-insured employer groups, would

(1) Provide year-round open enrollment for groups and individuals within a geographic area

(a) Insurers offering coverage through an association or multiple employer arrangement could restrict membership in that line or block of business to the members of the association or arrangement

(i) Association or arrangement must be formed for a purpose other than the purchase of health insurance

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(b) Geographic areas would be MSAs and rural areas within a State

(2) Set premiums based upon community rates

(a) Community rates would be phased-in in equal increments over three years

(3) Guarantee renewability of coverage

C. Self-insurance

(1) Self-insurance would not be permitted for employers with up to 100 full-time employees

(2) Multiple Employer Welfare Arrangements (MEWAs) would be prohibited from self-insuring

D. Health insurance standards would be set by regulations issued by HHS

6. Administrative simplification

A. Uniform electronic billing for all providers and all payers

(1) A single, uniform coding system for all diagnoses and procedures would be developed and implemented

(2) Public domain software would be developed which could be used by hospitals, physicians and other providers to input data into the billing system

B. On-line system for verification of eligibility and benefits

(1) Verification of eligibility system through use of universal health insurance card and identification number

C. Uniform standards for utilization review and for medical audits of bills would be established

D. A national electronic health claims network would be created

(1) Providers would submit all bills to a health claims clearinghouse

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7. **Fraud and abuse**

A. National health care fraud control program

(1) A new all-payer national health care fraud control program would be established

(a) All-payer fraud and abuse policies would follow Medicare policies

(i) Prohibited activities would include submitting fraudulent claims for payment, kickbacks including payments to employees, and patient dumping

(b) For Medicare, providers could not provide anything to Medicare patients at less than full-market value to influence the beneficiary to receive health services

(c) Federal penalties for individuals convicted of health care fraud and abuse

(i) Penalties would include fines, triple damages, suspension from Medicare, Medicaid and other public programs, and loss of certification to bill private insurers through regional clearinghouses

(ii) Penalties for cases of health care fraud involving more than $25,000 would be up to 10 years in jail, fines, or alternative sentencing including community service in health manpower shortage areas or public health clinics

(iii) Intermediate sanctions on Medicare qualified HMOs would be authorized for violations of Medicare contracting requirements

(2) All qualified health insurance plans would provide information and data to fraud control program

(a) Federal penalties would be established for submitting false information to the national electronic health claims network for the purpose of fraud

(3) National system of unique provider and patient numbers

(a) Provider numbers would be based on universal provider identification numbers (UPIN) now being implemented

(b) Beneficiary numbers would be based upon Social Security numbers

(4) The Federal fraud and abuse staff under the Inspector General of HHS would be increased to administer the national fraud control program

(a) Fines would be used to meet the operating costs of the national health care fraud control program

(5) Guidelines would be established to protect confidentiality of health care data

B. Physician ownership/referral

(1) Ban on physicians referring patients to entities with which the physician has a financial relationship would be applied to services reimbursed by all payers

(2) Ban would be extended to specific list of abusive self-referral arrangements

C. Multiple Employer Welfare Arrangements

(1) Multiple Employer Welfare Arrangements would be prohibited from self-insuring

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EXPANSION OF HEALTH BENEFITS AND OTHER HEALTH INITIATIVES

8. Medicaid payment floor

   A. A floor would be set for Medicaid payments for hospital inpatient and outpatient services

      (1) Floor would be based on payments which would otherwise be paid using Medicare-level DRG payments

      (2) The floor could be set to 80% of the Medicare levels in 1996, 85% in 1997, and 90% thereafter

      (3) Floor would increase payments to rural and inner-city hospitals serving Medicaid patients

   B. A floor could be set for Medicaid payments for physician services

      (1) Floor would be based on payments which would otherwise be paid using Medicare-level RB RVS payments

   C. The additional costs of the Medicaid payment floor would be fully supported by Federal funds

9. Medicaid improvements

   A. Expanded health insurance coverage to low-income Americans under the Medicaid program. Coverage could include

      (1) All pregnant women and children with incomes below 200% poverty

      (2) All Americans with income below 200% poverty

         (a) Would provide health insurence to two thirds of the uninsured population

   B. The additional costs of expanding Medicaid coverage would be fully supported by Federal funds

10. Expansion of Medicare prevention benefits

    A. Medicare prevention benefits would be expanded

    B. New benefits covered would include

        (1) Annual mammograms for women over the age of 65

        (2) Colorectal cancer screening

        (3) Influenza vaccinations

        (4) Tetanus vaccinations

    C. Demonstration projects of additional prevention benefits would be authorized

    D. An OTA study would consider what process should be established to expedite consideration of additional expansions of Medicare prevention benefits

11. Medicare prescription drugs

    A. Benefits

        (1) Persons enrolled in Medicare Part B would be covered for new prescription drug benefit

            (a) Benefit would be effective in 1996

        (2) The prescription drug deductible would be $800 in 1996

            (a) The deductible would be increased to $850 in 1997, $900 in 1998 and would be indexed in subsequent years to the rate of growth in the prescription drug sector within the global budgets

        (3) Beneficiaries would contribute a 20 percent coinsurance as is now required of other Part B benefits

        (4) Beneficiary premiums would fund 25 percent of the cost of the drug benefit

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B. Coverage for low income Medicare beneficiaries

(1) Prescription drugs would be provided to low income beneficiaries eligible for the Qualified Medicare Beneficiary (QMB) program

(a) Qualified Medicare beneficiaries are those with income up to 100% poverty

(2) All individuals eligible for QMB benefits would be entitled to prescription drug benefits under the State Medicaid program

(3) Prescription drugs for QMBs would be fully funded with Federal dollars

(4) The QMB drug benefit would be effective in 1994

C. Payments for prescription drugs under Part B

(1) Payments would be at 80% of the lesser of the actual charge for the drug and a payment limit

(2) The payment limit for single source drugs and for multiple source drugs with restrictive prescriptions, would be the lesser of

(a) The 90th percentile of actual charges for the drug within a geographical area, and

(b) The sum of an administrative allowance plus the average wholesale price

(3) In the case of a multiple source drug without a restrictive prescription, the payment limit would be the administrative allowance plus the median of the average wholesale prices for the drug

(4) A program to assure appropriate prescribing and dispensing practices would be established

D. A participating pharmacy program would be established

(1) Participating pharmacies would agree to accept assignment on all Medicare claims for covered outpatient drugs

E. Point-of-sale electronic system

(1) A point-of-sale electronic system would be established for use by the national claims clearinghouse and participating pharmacies to use to submit claims for covered outpatient drugs

F. Prescription Drug Payment Review Commission

(1) An 11 member Prescription Drug Payment Review Commission would be established

(2) The Commission would submit an annual report to Congress regarding increases in drug prices, use of covered drugs, the national drug formulary, and administrative costs relating to covered drugs

12. Health insurance deduction for the self-employed

A. Self-employed individuals would be permitted to deduct 25 percent of health insurance expenses for health insurance through December 31, 1993

(1) The current deduction is scheduled to expire on June 30, 1992

B. Self-employed individuals would be permitted to deduct 100 percent of health insurance expenses, beginning in 1994

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Preliminary Estimates of Cost Containment Savings under Global Budget

June 11, 1992

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Current law growth in health expenditures	10.1%	9.8%	9.8%	9.7%	9.6%	9.4%	9.3%	9.0%	9.0%	9.0%
Growth under global budget	--	9.1	8.2	7.8	7.1	5.8	5.7	5.6	5.5	5.4
Savings to Federal government	--	$1	$7	$13	$22	$33	$51	$71	$91	$114
Savings to private sector	--	$6	$15	$31	$54	$94	$133	$175	$230	$291

Global budget effective January 1, 1994

Savings in billions of dollars

THE WHITE HOUSE

WASHINGTON

June 16, 1992

MEMORANDUM FOR ROGER B. PORTER

FROM: STEPHANIE FOSSAN

THROUGH: HANNS KUTTNER

SUBJECT: Action Now Health Care Reform Act

As a follow-up on a recent weekly report, I am sending you a description of Medical Savings Accounts that was prepared for the Vice President by Gail Wilensky and her staff. The House Republicans propose to allow employers to instigate Medical Savings Accounts under the name of "Medisave" accounts in their "Action Now Health Care Reform Act." I have also prepared a memo detailing their package as a whole. Like the Administration, the House Republicans do not believe in an "all-or-nothing" approach and want to accomplish reasonable reforms this year. The "Action Now Health Reform Act of 1992" includes the following provisions:

<u>To increase affordability and availability to health insurance for employees, the Act</u>:

- Mandates insurers make available health coverage to small employers for at least two alternate "MedAccess" plans. (The alternates include a basic package with essential care and preventive benefits and a standard plan more comparable to coverage now available. Unlike the Administration's approach, the House Republicans require the development of federal standards for their benefits packages.)
- Precludes the exclusion of coverage for small groups based on previous claims experience.
- Phases-in limits on preexisting condition restrictions, assurances of continuity and renewability of coverage, and limits on premium increases for the small group market.
- Eliminates pregnancy as a preexisting condition and provides coverage for babies at birth.
- Eliminates state benefit mandates.

<u>To provide fairness in health deductions</u>:

- Increases the tax deduction for the cost of health premiums for the self-employed from 25 to 100 percent.

To improve rural and community health:

- Establishes an Office of Emergency Medical Services (EMS) to provide technical assistance to state EMS programs.
- Provides incentives for improving state EMS programs through a matching grant program.
- Provides grants to states for demonstrations of telecommunications links between rural and urban health care facilities.
- Provides federal grants to states for the development of rural air transport systems for medical emergencies.
- Increases current authorization for Community and Migrant Health Centers (C/MHCs).
- Reduces cost of medical liability expenses for C/MHCs by covering their services under the Federal Tort Claims Act.
- Authorizes demonstration projects for communities to improve the delivery of health care services.

To contain costs in the health care system:

- Requires all medical liability disputes be considered by a dispute resolution system before entering the courts.
- Places a cap on non-economic damages.
- Requires that punitive damages be paid to states to assist efforts to reduce medical malpractice.
- Limits attorneys' fees.
- Eliminates joint and several liability.
- Increases authorization for the development of medical practice guidelines.
- Removes restrictions on managed care in state laws.
- Prohibits certain referrals to facilities in which that doctor holds an investment interest.

To reduce administrative costs:

- Mandates the use of standard claims forms, to be developed by HHS, for electronic transmission of health information.
- Requires HHS to introduce magnetized Medicare cards, similar to ATM cards.
- Requires states to make available information on the comparative value of medical services.

To implement "Medisave" medical savings accounts (MSAs):

- Allows employers to offer Medisave accounts.
- See attached sheet on MSAs.

To reform Medicaid management in the states:

- Allows states to provide coverage to Medicaid recipients through managed-care systems.
- Extends period for which states must re-apply for certain Medicaid waivers.
- Allows states to determine nursing home quality standards.

Attachment

MEDICAL SAVINGS ACCOUNT

What is a Medical Savings Account (MSA)?

A MSA is similar to an Individual Retirement Account. MSAs allow individuals and families to purchase lower-priced insurance, such as high deductible plans or tightly organized managed care plans, and to use the remaining funds that would have gone to pay for more expensive insurance plans in a MSA. The money in the MSA can be used for medical expenses during the year or can be rolled forward and used for medical expenses, including long-term care expenses, in future years. Ultimately, funds in the MSA can be used for retirement or for nonmedical purposes but would be taxable in these cases, as would the interest that had accumulated.

How do MSAs work?

Typically, employers provide health benefits to their employees by paying a substantial portion of the health insurance premium. In lieu of conventional health insurance, firms may elect to offer a less expensive health insurance plan, such as one that provides for a higher deductible. The resulting savings would be placed in the MSA.

For example, an employer may have been providing an insurance policy costing $4,800 annually, paying $4,000 of the premium (using pre-tax dollars), with the family paying the remaining $800 (also with pre-tax dollars). The employer might now offer a plan that has a much higher deductible, say $3,000 annually, and which might cost $1,800. The employer could then put the $2,200 that would have been spent ($4,000 - $1,800) into an MSA for the family that the family uses to pay for any medical expenses under the deductible or any expenses not covered by the policy. Any funds not used could be removed for the MSA and used for nonmedical purposes (subject to income tax) or could be rolled forward to be used in a future year. If rolled forward, only the interest accumulated on the money in the MSA would be taxable in the year of accumulation.

Advantages of MSAs

- MSAs will make individuals more cost conscious about their medical expenses, since they directly control the money in the MSA. The money in the MSA can be used for both medical and nonmedical purposes.

- By keeping some expenditures out of the insurance system, MSAs will reduce administrative costs as well as medical expenditures.

- MSAs make pre-tax funds available for long-term care insurance and expenses.
- MSAs can be structured to be budget neutral.
- MSAs are consistent with efforts to encourage savings.
- MSAs can be tried as an optional benefit that employers could offer.

United States Senate
Democratic Policy Committee
Washington, DC 20510-7050
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policy

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MITCHELL CHALLENGES PRESIDENT TO SUBMIT HEALTH CARE LEGISLATION BY MAY 6; SENATE DEMOCRATS TO PUSH FORWARD HEALTH CARE REFORM

Senate Majority Leader George J. Mitchell today called on President Bush to submit health care reform legislation to the Congress by May 6th, in time for the Senate Finance Committee to consider during its hearings. President Bush announced a health care proposal on February 6 but has yet to submit legislation. Mitchell made his comments during Senate floor debate on the Domenici substitute resolution to reduce entitlement programs.

Senator Lloyd Bentsen, Chairman of the Senate Committee on Finance, today announced that the Committee will hold hearings on comprehensive reform of health care costs on May 6 and 7, 1992.

Mitchell, in his statement today, was critical of the President's "absence of leadership on health care... After 3 years of study, the President finally made a speech more than 2 months ago on health care. And to this very moment, 12:39 pm, here in the middle of April, the President has not submitted a bill, and the administration will not tell us if or when they will submit a bill.

"....No health care legislation, comprehensive in nature, ca become law without the President's participation and active involvement. That has not occurred...We have proposed an alternative, and I invite the President to do the same...

"Senator Bentsen's committee is going to hold hearings on May 6. Why doesn't the administration submit a bill by May 6?"

During the two months since the President announced his proposal the administration's own projections show the nation spent an additional $132 billion on health care as medical costs continue to spiral out of control.

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Mitchell also announced today that he and his colleagues have agreed to a plan to develop consensus and to press forward expeditiously on health care reform legislation. This includes:

* The series of Senate Finance Committee hearings, due to begin May 6. The Senate Labor and Human Resources will also continue to hold hearings this spring on health care reform.

Next couple of weeks

* Creation of several Senate policy groups to address major health care issues such as cost containment, financing and small business concerns.

* Holding a series of briefings with Senators on the various comprehensive health care proposals.

* Creation of a steering committee to work closely with the various organizations and advocates concerned with the passage of comprehensive health care reform.

Want mbrs involved & move forward... trys to get AS many

In an effort to move this vital legislation forward, Mitchell also invited Senate Republicans and members of the Administration to discuss efforts on health care reform.

Senator Mitchell's statement follows:

I believe that this debate has served a very useful purpose. It has made clear, clearer than it has ever been, that the real problem confronting our society is the runaway increase in the cost of health care. This resolution has been criticized as unfair, and I join that criticism, because it would provide cuts in programs that are not the principal source of the problem, and avoid dealing with what is the principal source of the problem.

But I think the resolution does bring into focus, and causes us to debate and consider first the reality that we all know that the deficit is too large, and growing at too rapid a rate; and the very existence of the resolution and the very occurrence of the debate has made clear to Senators, and to the American people, that the crux of the problem, the root of the problem, is the rapidly escalating cost of health care.

The question has been posed here repeatedly today: Why should the compensation of a disabled veteran be cut because we are unwilling or unable to address the runaway costs of health care? It is a profound question. It is a very difficult question to answer.

I believe the answer is that the disabled veteran's compensation should not be cut. I believe the answer is that we should address the problem of health care. That is what the root cause of this is.

You look down this list of increases, you look down these programs that will be affected by this mandatory cap, and you see that the increase over and above the level set in the resolution is attributable almost entirely to health care costs.

The solution offered in the resolution is to cut other programs to make up for those costs, and then simply to provide a cap on the health care programs as well.

I do not think that is the answer. I think the resolution has served a useful purpose. But I think the answer is to deal with the problem of health care.

I hope that out of this debate comes a renewed determination that we will address comprehensive health care reform in this Congress in this year.

President Bush took office nearly 3 1/2 years ago. Health care was a problem then. Health care was a problem every single day that he has served as President and that we have sat in the Senate since he took office.

After 3 years of study, the President finally made a speech more than 2 months ago on health care. And to this very moment, 12:39 pm, here in the middle of April, the President has not submitted a bill, and the administration will not tell us if or when they will submit a bill.

I say there is an absence of leadership... a critical problem confronting every family in America, a critical problem contributing to the runaway budget deficits which the authors of this resolution are trying to control -- the intention to which I agree, but the manner in which I do not -- is a problem which affects every one of us in our society... and to this moment 3 1/2 years after taking office the President has yet to submit a bill on health care.

I have introduced legislation to deal with the problem of health care, which has as its principal objective controlling the runaway increase in the cost of health care.

When I introduced this bill, I said I do not present this as the perfect bill, as the only way, even as the best way to deal with health care. It is the product of 2 years of study and effort by a group of Senators who felt that we must bring runaway health costs under control.

We welcomed alternative suggestions, and I commend the Senator from Rhode Island, because he joined with a group of Republican Senators and made an alternative suggestion. But the Senator from Rhode Island knows deep in his heart and in his mind, just as I do, that no health care legislation, comprehensive in nature, can become law without the President's participation and active involvement. That has not occurred. Three-and-a-half years after he took office, 2 months and a week after he made a speech, we still do not have a bill-and we do not have any indication of if or when there will be a bill.

I will sit down with the Senator from Rhode Island, the Secretary of Health and Human Services, and any person the administration would like me to sit down with. I invite that participation right here and now. I will have a meeting at any time to try to get this thing moving.

But there has been no interest at all. All we have received are partisan speeches attacking our bill. That is what we have received.

All we got from the administration is partisan attacks on our bill. No effort to propose a positive alternative. I think this debate has crystallized this issue in a way that has not occurred up until now. I think this debate has made clear to everyone that we have to do something about runaway health care costs in our society. It is the root of the problem here.

[Discussion Draft II]

Jan. 28, 1992

102D CONGRESS
2ND SESSION

H. R.

IN THE HOUSE OF REPRESENTATIVES

Mr. _____ (for himself and [see attached list of co-sponsors]) introduced the following bill; which was referred to the Committee on

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A BILL

To amend the Internal Revenue Code of 1986, titles XVIII and XIX of the Social Security Act, and the Public Health Service Act to improve access to health insurance, contain health care costs, increase the availability of health care services to underserved populations, provide expanded preventive services to medicare beneficiaries, and encourage access to long-term care, 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 "Action Now Health Reform Act of 1992".

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

TITLE I—IMPROVED ACCESS TO AFFORDABLE HEALTH INSURANCE

Subtitle A—Health Deduction Fairness

SEC. 101. INCREASE IN DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS FROM 25 PERCENT TO 100 PERCENT.

(a) INCREASE IN DEDUCTION.—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 "25 percent of".

(b) DEDUCTION MADE PERMANENT.—Subsection (l) of section 162 of such Code is amended by striking paragraph (6).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1992.

Subtitle B—Increased Insurance Affordability and Availability for Employees of Small Employers

SEC. 111. ESTABLISHMENT AND ENFORCEMENT OF STANDARDS FOR SMALL EMPLOYER HEALTH INSURANCE PLANS.

(a) ESTABLISHMENT OF GENERAL STANDARDS.—

(1) ROLE OF NAIC.—The Secretary of Health and Human Services shall request the National Association of Insurance Commissioners to develop, within 9 months after the date of the enactment of this Act, model regulations that specify standards with respect to each of the following:

(A) The requirement, under section 113(a), that small employer carriers offer MedAccess plans.

(B) The basic benefits to be included in MedAccess plans under section 113(b).

(C) The requirements of guaranteed issue of MedAccess plans under section 113(c).

(D) The requirements of sections 114 and 115(b).

(E) The requirements of subsections (a) and (c) of section 115.

If the Association develops such regulations specifying such standards within such period, the Secretary shall review such standards to determine if they meet such requirements. Such review shall be completed within 30 days after the date the regulations are developed. Unless the Secretary determines within such period that the standards do not meet the requirements, such standards shall serve as the standards under this section.

(2) CONTINGENCY.—If the Association does not develop such model regulations within such period or the Secretary determines that such regulations do not meet the requirements described in paragraph (1), the Secretary shall specify, within 15 months after the date of the enactment of this Act, standards to carry out the requirements referred to in subparagraphs (A) through (E) of paragraph (1).

(3) EFFECTIVE DATE.—The standards provided under this subsection—

(A) shall apply to small employer health benefit plans offered in a State on or after the date the standards are implemented in the State under subsection (b)(1),

(B) with respect to the requirements referred to in paragraph (1)(D) (relating to requirements for initial writing of policies and limitations on premium increases), shall apply to small employer health benefit plans renewed on or after 3 years after the date such standards are implemented in the State under subsection (b)(1), and

(C) with respect to the requirements referred to in paragraph (1)(E) (relating to renewability and limitation on market reentry), shall apply to small employer health benefit plans renewed on or after the date such standards are implemented in the State under subsection (b)(1).

(b) APPLICATION OF STANDARDS THROUGH STATES.—

(1) APPLICATION OF ALL STANDARDS TO NEW PLANS.—

(A) IN GENERAL.—Each State shall submit to the Secretary, by the deadline specified in subparagraph (B), a report on the implementation and enforcement of the standards established under subsection (a) with respect to small employer health benefit plans offered not later than such deadline.

(B) DEADLINE FOR REPORT.—

(i) 1 YEAR AFTER STANDARDS ESTABLISHED.—Subject to clause (ii), the deadline under this subparagraph is 1 year after the date standards are established under subsection (a).

(ii) EXCEPTION FOR LEGISLATION.—In the case of a State which the Secretary identifies, in consultation with the National Association of Insurance Commissioners, as—

(I) requiring State legislation (other than legislation appropriating funds) in order for carriers and health benefit plans offered to small employers to meet the standards established under subsection (a), but

(II) having a legislature which is not scheduled to meet in 1993 in a legislative session in which such legislation may be considered,

the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1994. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(2) APPLICATION OF CONSUMER PROTECTION TO ALL PLANS.—Each State shall submit to the Secretary, by not later than 4 years after the date standards are established under subsection (a), a report on the implementation and enforcement of the standards established under subparagraphs (D) and (E) subsection (a)(1) (relating to requirements for initial writing of policies, limitations on premium increases, renewability, and limitation on market reentry) with respect to small employer health benefit

plans renewed not later than 4 years after the date such standards were established.

(3) MORE STRINGENT STATE STANDARDS PERMITTED.—Except as provided in section 112(b), a State may implement standards that are more stringent than the standards established under subsection (a).

(4) FEDERAL ROLE.—

(A) SECRETARIAL AUTHORITY.—If the Secretary determines that a State has failed to submit a report by the deadline specified under paragraph (1) or (2) or finds that the State no longer is carrying out its responsibility under the respective paragraph, the Secretary shall notify the State and provide the State a period of 30 days in which to submit such report or to carry out its responsibilities under the respective paragraph. If, after such 30-day period, the Secretary finds that such a failure has not been corrected, the Secretary shall provide for such mechanism for the implementation and enforcement of the standards established under subsection (a) in the State as the Secretary determines to be appropriate. Such standards shall apply to health benefit plans offered or re-

newed on or after 3 months after the applicable deadlines established under subparagraphs (A) through (C) of subsection (a)(3).

(B) ENFORCEMENT THROUGH EXCISE TAX.—

(i) 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. FAILURE BY CARRIER TO COMPLY WITH SMALL EMPLOYER HEALTH INSURANCE STANDARDS IN STATES WITHOUT APPROVED REGULATORY PROGRAMS.

"(a) IMPOSITION OF TAX.—There is hereby imposed a tax on the failure of any small employer carrier in any Federal Standard State to comply with the standards established under section 111(a) of the Action Now Health Reform Act of 1992.

"(b) AMOUNT OF TAX.—The tax imposed by subsection (a) shall be equal to 25 percent of the amounts received by the carrier (during the period such failure persists) for providing any health benefit plan to any small employer in the Federal Standard State.

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

"(d) EXCEPTIONS.—

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

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

"(B) such failure is corrected within the 30-day period beginning on earliest date the carrier knew, or exercising reasonable diligence would have known, that such failure existed.

"(2) 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 payment of such tax would be excessive relative to the failure involved.

"(e) DEFINITIONS.—For purposes of this section—

"(1) CARRIER; ETC.—The terms 'carrier', 'small employer carrier', 'health benefit plan', and 'small employer' have the meanings given such terms in section 118 of the Action Now Health Reform Act of 1992.

"(2) FEDERAL STANDARD STATE.—The term 'Federal Standard State' means any State with respect to which a determination is in effect under section 111(b)(4) of the Action Now Health Reform Act of 1992.".

(ii) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code is amended by adding at the end thereof the following new items:

"Sec. 4980C. Failure by carrier to comply with small employer health insurance standards in States without approved regulatory programs.".

(iii) NONDEDUCTIBLE OF TAX.—Paragraph (6) of section 275(a) of such Code (relating to nondeductibility of certain taxes) is amended by inserting "47," after "46,".

(iv) EFFECTIVE DATE.—The amendment made by clause (iii) shall apply to taxable yers beginning after December 31, 1992.

SEC. 112. PREEMPTION OF STATE BENEFITS MANDATES FOR PLANS THAT MEET CONSUMER PROTECTION STANDARDS.

(a) FINDING.—Congress finds that health benefit plans offered with respect to small employers affect interstate commerce.

(b) PREEMPTION.—In the case of a small employer health benefit plan that meets the standards with respect to the requirements referred to in subparagraphs (D) and (E) of section 111(a)(1), no provision of State law shall apply that requires the offering, as part of the health benefit plan with respect to such an employer, of any services, category of care, or services of any class or type of provider.

SEC. 113. REQUIREMENT FOR OFFERING OF BASIC, LOW COST PLAN (MEDACCESS PLAN).

(a) IN GENERAL.—Each small employer carrier which makes available in a State any small employer health benefit plan shall make available to each small employer in the State a MedAccess plan (as defined in subsection (b)).

(b) MEDACCESS PLAN DEFINED.—

(1) IN GENERAL.—In this subtitle, except as provided in paragraph (2), the term "MedAccess plan" means a health benefits plan (whether a managed-care plan, indemnity plan, or other plan) that—

(A) is designed to provide only basic hospital, medical, surgical, preventive, and risk assessment benefits (including prenatal care and well-baby care), specified under standards

under section 111(a)(1)(B), so as to make it affordable to small employers.

(B) is guaranteed issue (as described in subsection (c)), and

(C) meets the standards established under subparagraphs (D) and (E) section 111(a)(1) (relating to (relating to requirements for initial writing of policies, limitations on premium increases, renewability, and limitation on market reentry).

(2) SPECIAL RULES FOR HEALTH MAINTENANCE ORGANIZATIONS.—With respect to a carrier that is a Federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act), the term "MedAccess plan" means a plan of the type described in paragraph (1) but with benefits that are consistent with the requirements for the plans of such an organization under title XIII of such Act. With respect to a carrier that is not such a Federally qualified health maintenance organization but which is recognized under State law as a health maintenance organization, the term "MedAccess plan" means a plan of the type described in paragraph (1) but with bene-

fits that are consistent with the requirements of State law for the plans of such an organization.

(3) REVIEW OF MINIMUM BENEFIT STANDARDS.—The National Association of Insurance Commissioners is requested to periodically review the standards for minimum benefits described in paragraph (1)(A). The Association is requested to submit to the Secretary and the Congress its recommendations on changes that should be made in such standards.

(c) GUARANTEED ISSUE FOR MEDACCESS PLANS.—

(1) IN GENERAL.—Each MedAccess plan in a State—

(A) subject to paragraph (2) and (4), must accept every small employer in the State that applies for coverage under the plan;

(B) subject to paragraphs (2), (3), and (4), must accept for enrollment every individual who is a full-time employee (or, in the case of family enrollment with respect to such an employee, the employee's spouse and the employee's dependents who are under 19 years of age or who are full-time students and under 25 years of age) who applies for enrollment on a timely basis; and

(C) subject to paragraphs (2), (3), and (4), may not place any restriction on the eligibility of an individual to enroll, so long as such an individual is a full-time employee or the employee's spouse or dependent described in subparagraph (B).

(2) SPECIAL RULES FOR HEALTH MAINTENANCE ORGANIZATIONS.—In the case of a MedAccess plan offered by a health maintenance organization, the plan shall—

(A) limit the employers that may apply for coverage to those with eligible individuals residing in the service area of the plan,

(B) limit the individuals who may be enrolled under the plan to those who reside in the service area of the plan, and

(C) within the service area of the plan, deny coverage to such employers if the plan demonstrates that—

(i) it will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees, and

(ii) it is applying this subparagraph uniformly to all employers without regard to the health status, claims experience, or duration of coverage of those employers and their employees.

(3) EXCEPTION FOR CERTAIN LATE ENROLLEES.—

(A) IN GENERAL.—Except as provided in this paragraph, paragraph (1)(B) shall not apply to an eligible employee or dependent who fails to enroll in a health benefit plan during an initial enrollment period, if such period is at least 30 days long.

(B) EXCEPTION FOR THOSE WITH PREVIOUS EMPLOYER COVERAGE.—Subparagraph (A) shall not apply to an individual who—

(i) was covered under another employer health benefit plan at the time of the individual's initial enrollment period,

(ii) stated at the time of initial enrollment period that coverage under another employer health benefit plan was the reason for declining enrollment,

(iii) lost coverage under another employer health benefit plan as a result of

termination of employment, the termination of the other plan's coverage, death of a spouse, or divorce, and

(iv) requests enrollment within 30 days after termination of coverage under another employer health benefit plan.

(C) EXCEPTION FOR OPEN ENROLLMENT.—Subparagraph (A) shall not apply to an individual who—

(i) is employed by an employer which offers multiple health benefit plans, and

(ii) elects a different plan during an open enrollment period.

(D) EXCEPTION FOR COURT ORDERS.—Subparagraph (A) shall not apply to a spouse or minor child if a court has ordered coverage be provided for the spouse or child under a covered employee's health benefit plan and request for such coverage is made within 30 days after issuance of such court order.

(4) EXCEPTION FOR STATE ALLOCATION OF HIGH RISK INDIVIDUALS AND SMALL EMPLOYERS.—Paragraph (1) shall not apply in the case of a State which provides for the enrollment under a MedAccess plan of any small employer or individual

whose enrollment under each MedAccess plan would be required under such paragraph but for this paragraph.

SEC. 114. REQUIREMENTS RELATING TO INITIAL WRITING OF POLICIES.

(a) LIMITATIONS ON TREATMENT OF PRE-EXISTING CONDITIONS.—

(1) IN GENERAL.—A carrier may not impose (or require an employer to impose through a waiting period for coverage under a health benefit policy or similar requirement) a limitation or exclusion of benefits under a small employer health benefit plan relating to treatment of a condition based on the fact that the condition pre-existed the effectiveness of the policy if—

(A) the condition relates to a condition that was not diagnosed or treated within 6 months before the date of coverage under the plan,

(B) the limitation or exclusion extends over more than 12 months after the date of coverage under the plan, or

(C) the limitation or exclusion applies to an individual who, as of the date of birth, was covered under the plan.

(2) PREVIOUS SATISFACTION OF PRE-EXISTING CONDITION REQUIREMENT.—

(A) IN GENERAL.—In addition, each carrier shall waive any period applicable to a preexisting condition for similar benefits with respect to an individual to the extent that the individual was covered for the condition under a small employer health benefit plan that was in effect before the date of the enrollment under the carrier's plan.

(B) CONTINUOUS COVERAGE REQUIRED.—Subparagraph (A) shall no longer apply if there is a continuous period of more than 60 days on which the individual was not covered under an employer health benefit plan.

(b) LIMITS ON PREMIUMS.—

(1) LIMIT ON VARIATION OF INDEX RATES BETWEEN CLASSES OF BUSINESS.—

(A) IN GENERAL.—As a standard under section 112, the index rate for a rating period for any class of business of a small employer carrier may not exceed the index rate for any other class of business by more than 20 percent.

(B) EXCEPTIONS.—Subparagraph (A) shall not apply to a class of business if—

(i) the class is one for which the carrier does not reject, and never has rejected, small employers included within the definition of employers eligible for the class of business or otherwise eligible employees and dependents who enroll on a timely basis, based upon their claim experience or health status,

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

(ii) the class of business is currently available for purchase.

(2) LIMIT ON VARIATION OF PREMIUM RATES WITHIN A CLASS OF BUSINESS.—For a class of business of a small employer carrier, as a standard under section 112 the premium rates charged during a rating period to small employers with similar demographic or other relevant characteristics (not relating to claims experience, health status, or duration of coverage) for the same or similar coverage, or the rates which could be charged to such employ-

ers under the rating system for that class of business, shall not vary from the index rate by more than 25 percent of the index rate.

(3) LIMIT ON PERMISSIBLE RATE VARIATIONS.—Subject to paragraphs (1) and (2), as a standard under section 112, a carrier may establish rate variations based on factors such as geography, demography, and industry and plan design.

(4) LIMIT ON TRANSFER OF EMPLOYERS AMONG CLASSES OF BUSINESS.—As a standard under section 112, a small employer carrier may not involuntarily transfer a small employer into or out of a class of business. A small employer carrier may not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to demographic characteristics, claim experience, health status, or duration since issue.

(5) DEFINITIONS.—In this subsection:

(A) BASE PREMIUM RATE.—The term "base premium rate" means, for each class of business for each rating period, the lowest premium rate charged or which could have been charged under a rating system for that class of business by the small employer carrier to small

employers with similar demographic or other relevant characteristics (not relating to claims experience, health status, or duration of coverage) for health benefit plans with the same or similar coverage.

(B) CLASS OF BUSINESS.—The term "class of business" means, with respect to a carrier, all (or a distinct group of) small employers as shown on the records of the carrier.

(C) RULES FOR ESTABLISHING CLASSES OF BUSINESS.—For purposes of subparagraph (B)—

(i) a carrier may establish, subject to clause (ii), a distinct group of small employers on the basis that the applicable health benefit plans either—

(I) are marketed and sold through individuals and organizations which are not participating in the marketing or sale of other distinct groups of small employers for the carrier.

(II) have been acquired from another carrier as a distinct group, or

(III) are provided through an association with membership of not less than 100 small employers which has been formed for purposes other than obtaining insurance;

(ii) a carrier may not establish more than 2 groupings under each class of business because the carrier uses managed-care techniques which are expected to produce substantial variation in health care costs; and

(iii) notwithstanding clauses (i) and (ii), a Commissioner of Insurance of a State may, upon application, approve additional distinct groups upon a finding that such approval would enhance the efficiency and fairness of the small employer marketplace.

(D) INDEX RATE.—The term "index rate" means, with respect to a class of business, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate for the class.

(c) FULL DISCLOSURE OF RATING PRACTICES.—At the time a carrier offers a health benefit plan to a small

employer, the carrier shall fully disclose to the employer rating practices for small employer health benefit plans, including rating practices for different industries, populations, and benefit designs.

(d) ACTUARIAL CERTIFICATION.—Each carrier shall file annually with the State commissioner of insurance a written statement by a member of the American Academy of Actuaries (or other individual acceptable to the commissioner) that, based upon an examination by the individual which includes a review of the appropriate records and of the actuarial assumptions of the carrier and methods used by the carrier in establishing premium rates for applicable small employer health benefit plans—

(1) the carrier is in compliance with the applicable provisions of this section, and

(2) the rating methods are actuarially sound.

Each carrier shall retain a copy of such statement for examination at its principal place of business.

(e) REGISTRATION AND REPORTING.—Each carrier that issues any small employer health benefit plan in a State shall be registered or licensed with the State commissioner of insurance and shall comply with any reporting requirements of the commissioner relating to such a plan.

(f) USE OF MINIMUM PARTICIPATION REQUIREMENT.—A carrier may condition issuance, or renewal, of a health benefit plan to a small employer on the enrollment of a minimum number (or percentage) of its full-time employees, in accordance with standards established to carry out this section. Such standards shall require that any such conditions be imposed uniformly on employers of the same size.

SEC. 115. REQUIREMENTS RELATING TO RENEWAL.

(a) RENEWABILITY.—A carrier may not cancel a small employer health benefit plan or deny renewal of coverage under such a plan other than—

(1) for nonpayment of premiums,

(2) for fraud or other misrepresentation by the insured,

(3) for noncompliance with plan provisions,

(4) for failure to maintain (in accordance with standards established under section 114(f)) the number of enrollees under the plan at the number (or percentage) required under the plan,

(5) for misuse of a provider network provision, or

(6) because the carrier is ceasing to provide any small employer health benefit plan in a State, or, in

the case of a health maintenance organization, in a geographic area.

(b) LIMITATION ON PREMIUM INCREASES.—A carrier may not provide for an increase in the premium charged a small employer for a small employer health benefit plan in a percentage greater than such percentage as shall be specified in standards referred to in section 111(a)(1)(D). Such standards shall take into account increases in premiums charged for new coverage of small employers under the plan.

(c) LIMITATION ON MARKET REENTRY.—If a carrier terminates the offering of health benefit plans to small employers in an area, the carrier may not offer such a health benefit plan to any small employer in the area until 5 years have elapsed since the date of the termination

SEC. 116. ESTABLISHMENT OF REINSURANCE OR ALLOCATION OF RISK MECHANISMS FOR HIGH RISK INDIVIDUALS.

(a) ESTABLISHMENT OF STANDARDS.—

(1) ROLE OF NAIC.—The Secretary of Health and Human Services shall request the National Association of Insurance Commissioners to develop, within 9 months after the date of the enactment of this Act, models for reinsurance or allocation of risk mechanisms (in this section referred to as the "rein-

surance or allocation of risk mechanism'') for individuals and small employers who are enrolled under a small employer health benefit plan that meets the standards with respect to the requirements referred to in subparagraphs (D) and (E) of section 111(a)(1) and for whom a carrier is at risk of incurring high costs under the plan. If the Association develops such models within such period, the Secretary shall review such models to determine if they provide for an effective reinsurance or allocation of risk mechanism. Such review shall be completed within 30 days after the date the models are developed. Unless the Secretary determines within such period that such a model is not an effective reinsurance or allocation of risk mechanism, such remaining models shall serve as the models under this section.

(2) CONTINGENCY.—If the Association does not develop such models within such period or the Secretary determines that all such models do not provide for an effective reinsurance or allocation of risk mechanism, the Secretary shall specify, within 15 months after the date of the enactment of this Act, models to carry out this section.

(b) IMPLEMENTATION OF REINSURANCE OR ALLOCATION OF RISK MECHANISMS.—

(1) BY STATES.—Each State shall establish and fund one or more reinsurance or allocation of risk mechanisms by not later than the deadline specified in section 111(b)(1)(B). In order to assure the financial solvency of the mechanism, the State may, notwithstanding any provision of law to the contrary, impose charges on any entity (including a self-insured entity) providing employee-related health benefits, so long as such charges do not discriminate with respect to entities that would (but for this provision) not be subject to such charges.

(2) FEDERAL ROLE.—

(A) IN GENERAL.—If the Secretary determines that a State has failed to establish a reinsurance or allocation of risk mechanism under paragraph (1), the Secretary shall establish such a reinsurance or allocation of risk mechanism meeting the requirements of this paragraph.

(B) CARRIER ELECTION.—In a reinsurance or allocation of risk mechanism established by the Secretary under this paragraph, a carrier issuing a small employer health benefit plan that meets the standards with respect to the requirements referred to in subparagraphs (D

and (E) of section 111(a)(1) (relating to requirements for initial writing of policies, limitations on premium increases, renewability, and limitation on market reentry) may elect to secure reinsurance or allocation of risk for costs of the carrier with respect to the plan. Such an election must be made at the beginning of the year involved, and shall remain in effect for a period of 3 years, and is subject to extension for additional periods of 3 years.

(C) REINSURANCE MECHANISM.—Unless the Secretary determines under subparagraph (D) that an allocation of risk mechanism is the appropriate mechanism to use in a State under this paragraph, the Secretary shall establish for use under this section for each State a reinsurance mechanism under which—

(i) reinsurance shall be available for 90 percent of plan costs for an enrollee for a year after the plan has incurred payment obligations of $5,000 in the year and for 100 percent of plan costs for an enrollee for a year after the plan has incurred payment obligations of $10,000 in the year; and

(ii) the Secretary shall charge a carrier, for the reinsurance of an individual through the mechanism, a premium—

(I) in the case of individuals reinsured through the mechanism, equal to 500 percent of the premium that the carrier is charging the individual, or

(II) in the case of a group reinsured through the mechanism, equal to 150 percent of the premium that the carrier is charging the group.

(D) ALLOCATION OF RISK MECHANISM.—If the Secretary determines that, due to the nature of the insurance market in the State (including a relatively small number of small employer health benefit plans offered or a relatively small number of uninsurable small employers or individuals), an allocation of risk mechanism would be a better mechanism than a reinsurance mechanism, the Secretary shall establish for use under this section for a State an allocation of risk mechanism under which uninsurable individuals and small employers would be equi-

tably assigned among small employer health benefit plans.

(E) FINANCING DEFICIT FOR REINSURANCE MECHANISMS.—

(i) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 (relating to qualified pension plans, etc.) is amended by adding at the end thereof the following new section:

"SEC. 4980D. ADDITIONAL TAX TO FUND REINSURANCE IN STATES UNDER FEDERAL REINSURANCE.

"(a) IMPOSITION OF TAX.—There is hereby imposed a tax on the providing of any health benefit plan which covers any employee in a Federal reinsurance State.

"(b) AMOUNT OF TAX.—

"(1) IN GENERAL.—The tax imposed by subsection (a) shall be equal to the applicable percentage of the amount received by the provider of such plan for providing such plan in such Federal reinsurance State.

"(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the term 'applicable percentage' means, with respect to any State for any period, the lowest percentage estimated by the Secretary as generating sufficient revenues to carry out section

116(b)(2) of the Action Now Health Reform Act of 1992 in such State for such period.

"(c) LIABILITY FOR TAX.—The tax imposed by this section shall be paid by the provider of the health benefit plan.

"(d) DEFINITIONS.—For purposes of this section—

"(1) PROVIDER.—The term 'provider' means—

"(A) in the case of a health benefit plan provided through insurance, the carrier underwriting the plan;

"(B) in the case of a health benefit plan that is offered by a health maintenance organization, the organization, or

"(C) in the case of a self-insured plan, the plan administrator.

"(2) FEDERAL REINSURANCE STATE.—The term 'Federal reinsurance State' means any State with respect to which a determination is in effect under section 116(b)(2) of the Action Now Health Reform Act of 1992 and for which the Secretary of Health and Human Services has established a reinsurance mechanism under subparagraph (C) of such section for the State."

(ii) 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. 4980D. Additional tax to fund reinsurance in States under Federal reinsurance."

(c) CONSTRUCTION.—Nothing in this section shall be construed as to prohibit reinsurance or allocation of risk arrangements, whether on a State or regional basis, not required under this section.

SEC. 117. REGISTRATION OF ALL HEALTH BENEFIT PLANS REQUIRED.

Notwithstanding any other provision of law, each State commissioner or superintendant of insurance may, under State law, require each employer health benefit plan (including a self-insured plan) to be registered with such official, if the plan is not otherwise required to be registered or licensed with the official under section 114(e), and to provide the official with such information on the plan as may be necessary to carry out section 116. Insofar as the Secretary is exercising authority under section 116(b)(2), the Secretary may impose the requirement under the previous sentence in the same manner as a State commissioner of insurance may impose the requirement.

SEC. 118. GENERAL DEFINITIONS.

In this subtitle:

(1)(A) The term "carrier" means any entity which provides health insurance or health benefits in a State, and includes a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization, a multiple employer welfare arrangement or employee benefits plan (as defined under the Employee Retirement Income Security Act of 1974), or any other entity providing a plan of health insurance subject to State insurance regulation.

(B) The term "small employer carrier" means a carrier with respect to the issuance of a small employer health benefit plan.

(2) The term "health benefit plan" means any hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, or health maintenance subscriber contract, 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.

(2) The term "Secretary" means the Secretary of Health and Human Services.

(3)(A) The term "small employer" means an entity actively engaged in business which, on at least 50 percent of its working days during the preceding year, employed at least 2, but fewer than 36, full-time employees. For purposes of determining if an employer is a small employer, rules similar to the rules of subsection (b) and (c) of section 414 of the Internal Revenue Code of 1986 shall apply.

(B) The term "full-time employee" means, with respect to an employer, an individual who normally is employed for at least 30 hours per week by the employer.

(4) The term "small employer health benefit plan" means a health benefit plan which provides coverage to one or more full-time employees of a small employer.

(5) The term "State" means the 50 States, the District of Columbia, and Puerto Rico.

(6) The term "State commissioner of insurance" includes a State superintendent of insurance

Subtitle C—Improved Small Employer Purchasing Power of Affordable Health Insurance

SEC. 131. PREEMPTION FROM INSURANCE MANDATES FOR QUALIFIED SMALL EMPLOYER PURCHASING GROUPS.

(a) QUALIFIED SMALL EMPLOYER PURCHASING GROUP DEFINED.—For purposes of this section, an association is a qualified small employer purchasing group if—

(1) the association submits an application to the Secretary of Health and Human Services at such time and in such form as the Secretary may require; and

(2) on the basis of information contained in the application and any other information the Secretary may require, the Secretary determines that—

(A) the association is administered solely under the authority and control of its member employers.

(B) the association's membership consists solely of employers with not more than 100 employees (except that an employer member of the group may retain its membership in the group if, after the Secretary determines that the association meets the requirements of this para-

graph, the number of employees of the employer member increases to more than 100).

(C) with respect to each State in which its members are located, the association consists of not fewer than 100 employers, and

(D) at the time the association submits its application, the health benefit plans with respect to the employer members of the association are in compliance with applicable State laws relating to health benefit plans.

(b) PREEMPTION FROM INSURANCE MANDATES.—

(1) FINDING.—Congress finds that employer purchasing groups organized for the purpose of obtaining health insurance for employer members affect interstate commerce.

(2) PREEMPTION OF STATE MANDATES.—In the case of a qualified small employer purchasing group described in subsection (a), no provision of State law shall apply that requires the offering, as part of the health benefit plan with respect to an employer member of such a group, of any services, category of care, or services of any class or type of provider.

(3) PREEMPTION OF PROVISIONS PROHIBITING EMPLOYER GROUPS FROM PURCHASING HEALTH INSURANCE.—In the case of a qualified small employer

purchasing group described in subsection (a), no provision of State or local law shall apply that prohibits a group of employers from purchasing health insurance with respect to member employers of the group or their employees.

(c) EFFECTIVE DATE.—This section shall take effect 60 days after the date of the enactment of this Act.

Subtitle D—Clarification of Rules Applicable to Multiple Employer Welfare Arrangements (MEWAs)

SEC. 141. CLARIFICATION OF TREATMENT OF SINGLE EMPLOYER ARRANGEMENTS.

(a) IN GENERAL.—Section 3(40)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amended—

(1) in clause (i), by inserting "for any plan year of any such plan, or any fiscal year of any such other arrangement," after "single employer", and by inserting "during such year or at any time during the preceding 1-year period" after "common control";

(2) in clause (iii), by striking "common control shall not be based on an interest of less than 25 percent" and inserting "an interest of greater than 25

percent may not be required as the minimum interest necessary for common control", and by striking "and" at the end.

(3) by redesignating clause (iv) as clause (v), and

(4) by inserting after clause (iii) the following new clause:

"(iv) in determining, after the application of clause (i), whether benefits are provided to employees of two or more employers, the arrangement shall be treated as having only 1 participating employer—

"(I) if, at the time the determination under clause (i) is made, the number of individuals who are employees and former employees of any one participating employer and who are covered under the arrangement is greater than 95 percent of the aggregate number of all individuals who are employees or former employees of participating employers and who are covered under the arrangement, or

"(II) in the case of a multiple employer welfare arrangement established and maintained by a franchisor for a franchise network consisting of its franchisees, if, at the time the determination under clause (i) is made, the ag-

gregate number of all individuals who are employees and former employees of such franchisor and such franchisees and who are covered under the arrangement is greater than 95 percent of the aggregate number of all individuals who are employees or former employees of participating employers and who are covered under the arrangement, and".

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect July 1, 1992, except that the Secretary of Labor may issue regulations before such date under such amendments. The Secretary shall issue all regulations necessary to carry out the amendments made by this section not later than July 1, 1992.

SEC. 142. ESTABLISHMENT OF EXEMPTION PROCESS FOR EMPLOYEE WELFARE BENEFIT PLANS.

Not later than July 1, 1992, the Secretary of Labor shall prescribe regulations under section 514(b)(6)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(6)(B)) providing for exemptions of employee welfare benefit plans from section 514(b)(6)(A)(ii) of such Act (29 U.S.C. 1144(b)(6)(A)(ii)).

TITLE II—HEALTH CARE COST CONTAINMENT

Subtitle A—Medical Malpractice Reform

SEC. 201. DEFINITIONS.

As used in this subtitle:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM.—The term "alternative dispute resolution system" means a system that is enacted or adopted by a State to resolve medical malpractice liability claims without resort to, or as an alternative to, a judicial proceeding in a State court.

(2) CLAIMANT.—The term "claimant" means any person who brings a medical malpractice liability claim and, in the case of an individual who is deceased, incompetent, or a minor, the person on whose behalf such an action is brought.

(3) ECONOMIC DAMAGES.—The term "economic damages" means damages paid to compensate an individual for losses for hospital and other medical expenses, lost wages, lost employment, and other pecuniary losses.

(4) HEALTH CARE PROFESSIONAL.—The term "health care professional" means any individual who provides health care services in a State and who is

required by State law or regulation to be licensed or certified by the State to provide such services in the State.

(5) HEALTH CARE PROVIDER.—The term "health care provider" means any organization or institution that is engaged in the delivery of health care services in a State that is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State.

(6) INJURY.—The term "injury" means any illness, disease, or other harm that is the subject of a medical malpractice liability claim.

(7) MEDICAL MALPRACTICE LIABILITY ACTION.—The term "medical malpractice liability action" means any civil action brought pursuant to State law in which a plaintiff alleges a medical malpractice liability claim against a health care provider or health care professional.

(8) MEDICAL MALPRACTICE LIABILITY CLAIM.—The term "medical malpractice liability claim" means any claim relating to the provision of (or the failure to provide) health care services without regard to the theory of liability asserted, and includes any third-party claim, cross-claim, counter-

claim, or contribution claim in a medical malpractice liability action.

(9) NONECONOMIC DAMAGES.—The term "noneconomic damages" means damages paid to compensate an individual for losses for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of consortium, and other nonpecuniary losses.

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

(11) STATE.—The term "State" means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, and Guam.

PART I—UNIFORM STANDARDS FOR MALPRACTICE ACTIONS OR CLAIMS

SEC. 211. APPLICABILITY.

Except as provided in section 217, this part shall apply to any medical malpractice liability action brought in a Federal or State court and to any medical malpractice liability claim subject to an alternative dispute resolution system.

SEC. 212. CALCULATION AND PAYMENT OF DAMAGES.

(a) PERIODIC PAYMENTS FOR FUTURE LOSSES.—No person may be required to pay more than $100,000 in a single payment in economic or non-economic damages for expenses to be incurred in the future, but shall be permitted to make such payments on a periodic basis. The periods for such payments shall be determined by the court, based upon projections of when such expenses are likely to be incurred.

(b) LIMITATION ON NONECONOMIC DAMAGES.—The total amount of noneconomic damages that may be awarded to an individual and the family members of such individual for losses resulting from an injury which is the subject of an action or claim may not exceed $250,000, regardless of the number of health care professionals, health care providers, and health care producers against whom the action or claim is brought or the number of actions or claims brought with respect to the injury.

(c) MANDATORY OFFSETS FOR DAMAGES PAID BY A COLLATERAL SOURCE.—

(1) IN GENERAL.—The total amount of damages received by an individual shall be reduced (in accordance with paragraph (2)) by any other payment that has been or will be made to the individual to compensate the individual for the injury that was

the subject of the action or claim, including payment under—

(A) Federal or State disability or sickness programs;

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

(C) private disability insurance programs;

(D) employer wage continuation programs; and

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

(2) AMOUNT OF REDUCTION.—The amount by which an award of damages to an individual shall be reduced under paragraph (1) shall be—

(A) the total amount of any payments (other than such award) that have been made or that will be made to the individual to compensate the individual for the injury that was the subject of the action or claim; minus

(B) the amount paid by the individual (or by the spouse, parent, or legal guardian of the individual) to secure the payments described in subparagraph (A).

(d) ATTORNEY'S FEES.—A claimant's attorney's fees may not exceed—

(1) 25 percent of the first $150,000 of any award or settlement paid to the claimant; or

(2) 15 percent of any additional amounts paid to the claimant.

SEC. 213. JOINT AND SEVERAL LIABILITY FOR NONECONOMIC DAMAGES.

The liability of each defendant for noneconomic damages shall be several only and shall not be joint, and each defendant shall be liable only for the amount of noneconomic damages allocated to the defendant in direct proportion to the defendant's percentage of responsibility (as determined by the trier of fact).

SEC. 214. STATUTE OF LIMITATIONS.

No medical malpractice liability claim may be initiated after the later of—

(1) the expiration of the 2-year period that begins on the date the alleged injury that is the subject of the claim should reasonably have been discovered;

(2) the expiration of the 4-year period that begins on the date the alleged injury occurred; or

(3) in the case of an alleged injury suffered by a minor who has not attained 6 years of age, the date on which the minor attains 8 years of age.

(b) EXCEPTION FOR MINORS.—In the case of an alleged injury suffered by a minor who has not attained 6 years of age, no medical malpractice liability claim may be initiated after the expiration of the 2-year period that begins on the date the alleged injury should reasonably have been discovered, or the date on which the minor attains 8 years of age, whichever is later.

SEC. 215. UNIFORM STANDARD FOR DETERMINING NEGLIGENCE.

(a) STANDARD OF REASONABLENESS.—Except as provided in subsection (b), a defendant may not be found to have committed malpractice unless the defendant's conduct at the time of providing the health care services that are the subject of the action was not reasonable.

(b) ACTIONS BROUGHT UNDER STRICT LIABILITY.—Subsection (a) shall not apply to any action in which the claimant asserts that the defendant is liable under a theory of strict liability.

SEC. 216. SPECIAL PROVISION FOR CERTAIN OBSTETRIC SERVICES.

(a) IMPOSITION OF HIGHER STANDARD OF PROOF.—

(1) IN GENERAL.—In the case of a medical malpractice liability claim relating to services provided during labor or the delivery of a baby, if the defendant health care professional or health care pro-

vider did not previously treat the claimant for the pregnancy a court may not find that the defendant committed malpractice and may not assess damages against the defendant unless the malpractice is proven by clear and convincing evidence.

(2) APPLICABILITY TO GROUP PRACTICES OR AGREEMENTS AMONG PROVIDERS.—For purposes of paragraph (1), a health care professional or health care provider shall be considered to have previously treated an individual for a pregnancy if the professional or provider is a member of a group practice whose members previously treated the individual for the pregnancy or is providing services to the individual during labor or the delivery of a baby pursuant to an agreement with another professional or provider.

(b) CLEAR AND CONVINCING EVIDENCE DEFINED.—In subsection (a), the term "clear and convincing evidence" is that measure or degree of proof that will produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established, except that such measure or degree of proof is more than that required under preponderance of the evidence, but less than that required for proof beyond a reasonable doubt.

SEC. 217. IMPOSITION OF COSTS AND FEES ON PLAINTIFFS BRINGING FRIVOLOUS ACTIONS.

(a) IN GENERAL.—Upon the request of a defendant who prevails in a medical malpractice liability action, a court may require a plaintiff against whom the judgment was rendered to pay to the defendant the amount of the reasonable expenses incurred by the defendant because of the initiation of the action (including a reasonable attorney's fee) if the court finds that the action was frivolous.

[(b) STANDARDS FOR FINDING THAT ACTION IS FRIVOLOUS.—For purposes of subsection (a), a court shall find that an action is frivolous if—

(1) the action is not well grounded in fact or is not warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law; or

(2) the action was initiated for an improper purpose, including harassment, causing unnecessary delay, or causing a needless increase in the costs of litigation.--*this is taken from Rule 11 of the Federal Rules of Civil Procedure, which already gives Federal courts the power to impose these sanctions*]

SEC. 218. PREEMPTION.

(a) IN GENERAL.—This part supersedes any State law only to the extent that State law establishes higher payment limits, permits the recovery of a greater amount

of damages or the awarding of a greater amount of attorneys' fees, or establishes a longer period during which a medical malpractice liability claim may be initiated.

(b) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in subsection (a) shall be construed to—

(1) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(2) waive or affect any defense of sovereign immunity asserted by the United States;

(C) affect the applicability of any provision of the Foreign Sovereign Immunities Act of 1976;

(D) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

(E) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss a claim of a foreign nation or of a citizen of a foreign nation on the ground in inconvenient forum.

SEC. 219. EFFECTIVE DATE.

This part shall apply to medical malpractice liability claims initiated after the expiration of the 2-year period that begins on the date of the enactment of this Act.

PART II—GRANTS TO STATES FOR ALTERNATIVE DISPUTE RESOLUTION SYSTEMS

SEC. 221. GRANTS TO STATES.

(a) IN GENERAL.—The Secretary shall make grants over a 4-year period to States for the implementation and evaluation of alternative dispute resolution systems.

(b) ELIGIBILITY.—A State is eligible to receive a grant under this section if the State submits to the Secretary an application at such time, in such form, and containing such information and assurances as the Secretary may require, including—

(1) a description of the alternative dispute resolution system that the State intends to implement with amounts received under the grant;

(2) assurances that the State will comply with all data gathering requirements promulgated by the Secretary under section 222(a); and

(3) any information and assurances necessary to enable the Secretary to determine whether the State's alternative dispute resolution system meets the qualification standards for such systems developed by the Secretary under section 222(a).

(c) NUMBER OF GRANTS.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary shall award not less than 10 grants each fiscal year under this section.

(2) EXCEPTION.—Notwithstanding paragraph (1), the Secretary may award less than 10 grants under this section in a fiscal year if the Secretary determines that there are an inadequate number of applications submitted that meet the eligibility and approval requirements of this section in such fiscal year.

(d) DISSEMINATION OF INFORMATION TO OTHER STATES.—The Secretary shall disseminate information on the alternative dispute resolution systems implemented by the States receiving a grant under this section to other States, health care professionals, health care providers, and other interested parties.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for grants under this section $10,000,000 for each of the first 4 fiscal years beginning after the date of the enactment of this Act.

SEC. 222. ADMINISTRATION.

(a) STANDARDS AND REGULATIONS FOR ALTERNATIVE DISPUTE RESOLUTION GRANT PROGRAM.—

(1) IN GENERAL.—In consultation with the Administrator of the Agency for Health Care Policy and Research, the Secretary shall develop and promulgate standards and regulations necessary to carry out the grant program established under section 221, including—

(A) qualification standards for alternative dispute resolution systems that States must meet in order to receive grants under such section; and

(B) regulations establishing data gathering requirements for States receiving grants under such section.

(2) CRITERIA FOR PROGRAMS.—In developing qualification standards for alternative dispute resolution systems under paragraph (1)(A), the Secretary shall take into account the effectiveness of such systems in—

(A) supporting access to health care;

(B) encouraging improvements in the quality of health care;

(C) enhancing and not impairing the physician-patient relationship;

(D) encouraging innovation that leads to an improved level of health care;

(E) compensating for avoidable medical injury due to provider fault and not compensating for injury which is unavoidable by standard medical practice;

(F) resolving claims promptly and in amounts proportional to the injury;

(G) providing predictable outcomes; and

(H) operating efficiently in terms of financial costs, professional energies, and governmental processes.

(b) TECHNICAL ASSISTANCE.—The Secretary shall provide States with technical assistance to enable States to submit applications for grants under section 221, including information on the establishment and operation of alternative dispute resolution systems.

(c) EVALUATION OF ALTERNATIVE DISPUTE RESOLUTION SYSTEMS.—Not later than 5 years after awarding the first grant to a State under section 221, the Secretary shall prepare and submit to Congress a report describing and evaluating the alternative dispute resolution systems implemented by States with funds provided under such grants, and shall include in the report—

(1) information on—

(A) the effect of such systems on the cost of health care within the State,

(B) the impact of such systems on the access of individuals to health care within the State, and

(C) the effect of such systems on the quality of health care provided within such State; and

(2) an analysis of the feasibility and desirability of establishing a national alternative dispute resolution system.

Subtitle B—Expansion and Application of Medical Practice Guidelines

SEC. 231. INCREASE IN AUTHORIZATION OF APPROPRIATIONS FOR DEVELOPMENT OF MEDICAL PRACTICE GUIDELINES.

In addition to the amounts otherwise authorized to be appropriated under section 926 of the Public Health Service Act, there are authorized to be appropriated $10,000,000 for fiscal year 1993, $15,000,000 for fiscal year 1994, and $20,000,000 for fiscal year 1995 to develop and broadly disseminate medical practice guidelines under title IX of such Act.

SEC. 232. IMMUNITY FROM MALPRACTICE LIABILITY FOR PHYSICIANS FOLLOWING HHS PRACTICE GUIDELINES.

(a) IN GENERAL.—Section 1157(c) of the Social Security Act (42 U.S.C. 1320c–6(c)) is amended—

(1) in the matter preceding paragraph (1), by striking "such action;" and inserting "such action, or in compliance with or reliance upon the practice guidelines developed by the Administrator for Health Care Policy and Research under section 912(a) of the Public Health Service Act;"; and

(2) in paragraph (2), by striking the period at the end and inserting the following: ", or upon such practice guidelines.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to actions taken by physicians on or after January 1, 1992.

SEC. 233. STUDY OF ROLE OF PRACTICE GUIDELINES IN REDUCING MALPRACTICE COSTS.

(a) STUDY.—The Secretary of Health and Human Services, in consultation with the Administrator of the Agency for Health Care Policy and Research, shall undertake a study of the manner in which practice guidelines developed under section 913 of the Public Health Service Act may be used in reducing medical malpractice costs.

(b) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit a report on the study conducted under subsection (a) to the Congress and shall include in the report such recommendations for the application of practice guidelines in resolving medical malpractice liability disputes.

Subtitle C—Removing Restrictions on Managed Care

SEC. 241. REMOVING RESTRICTIONS ON MANAGED CARE.

(a) PREEMPTION OF STATE LAW PROVISIONS.—Subject to subsection (c), the following provisions of State law are preempted and may not be enforced:

(1) RESTRICTIONS ON REIMBURSEMENT RATES OR SELECTIVE CONTRACTING.—Any law that restricts the ability of a carrier to negotiate reimbursement rates with providers or to contract selectively with one provider or a limited number of providers.

(2) RESTRICTIONS ON DIFFERENTIAL FINANCIAL INCENTIVES.—Any law that limits the financial incentives that a health benefit plan may require a beneficiary to pay when a non-plan provider is used on a non-emergency basis.

(3) RESTRICTIONS ON UTILIZATION REVIEW METHODS.—Any law that—

(A) prohibits utilization review of any or all treatments and conditions,

(B) requires that such review be made (i) by a resident of the State in which the treatment is to be offered or by an individual licensed in such State, or (ii) by a physician in any particular specialty or with any board certified specialty of the same medical specialty as the provider whose services are being rendered,

(C) requires the use of specified standards of health care practice in such reviews or requires the disclosure of the specific criteria used in such reviews,

(D) requires payments to providers for the expenses of responding to utilization review requests, or

(E) imposes liability for delays in performing such review.

Nothing in subparagraph (B) shall be construed as prohibiting a State from (i) requiring that utilization review be conducted by a licensed health care professional or (ii) requiring that any appeal from such a review be made by a licensed physician or by a licensed physician in any particular specialty or with any board certified specialty of the same medical

specialty as the provider whose services are being rendered.

(b) GAO STUDY.—

(1) IN GENERAL.—The Comptroller General shall conduct a study of the benefits and cost effectiveness of the use of managed care in the delivery of health services.

(2) REPORT.—By not later than 4 years after the date of the enactment of this Act, the Comptroller General shall submit a report to Congress on the study conducted under paragraph (1) and shall include in the report such recommendations (including whether the provisions of subsection (a) should be extended) as may be appropriate.

(c) SUNSET.—Unless otherwise provided, subsection (a) shall not apply 5 years after the date of the enactment of this Act.

Subtitle D—Paperwork Simplification

SEC. 251. HOSPITAL MONITORING SYSTEMS.

(a) DEVELOPMENT OF STANDARDS.—

(1) IN GENERAL.—The Secretary of Health and Human Services, by not later than 2 years after the date of the enactment of this Act, shall develop standards—

(A) for a common set of hospital clinical patient data, and

(B) for the confidential transfer of data in electronic form.

(2) ADVISORY PANEL.—The standards under paragraph (1) shall be established in consultation with an advisory panel composed of experts in relevant fields, including hospital executives, hospital data base managers, physicians, health services researchers, insurers, other third-party payors, and representatives of labor and business.

(3) REPORT TO CONGRESS.—Not later than 3 years after the date of the enactment of this Act, the Secretary shall report to Congress recommendations regarding restructuring the medicare peer review quality assurance program given the availability of hospital data in electronic form.

(b) REQUIREMENT FOR SHARING OF HOSPITAL INFORMATION.—

(1) IN GENERAL.—Section 1866(a)(1)(F) of the Social Security Act (42 U.S.C. 1395cc(a)(1)(F)) is amended by adding at the end the following new clause:

"(iii) in the case of hospitals—

"(I) must maintain clinical data in electronic form on all inpatients, and

"(II) must transmit, electronically to the Secretary or a utilization and quality control peer review organization, a common set of clinical inpatient hospital data (maintained under subclause (I)) relating to any individual who has received inpatient hospital services for which payment may be made under part A of this title,

in accordance with the standards developed under section 241(a) of the Action Now Health Reform Act of 1992,".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall be effective for participation agreements as of 5 years after the date of the enactment of this Act.

(c) DEMONSTRATIONS AND RESEARCH ON MONITORING AND IMPROVING PATIENT CARE.—The Secretary shall provide grants to qualified entities to demonstrate (and conduct research concerning) the application of comprehensive information systems—

(1) in continuously monitoring patient care, and

(2) in improving patient care.

Up to $10,000,000 shall be available each fiscal year (beginning with fiscal year 1994 and ending with fiscal year 1998) from the Federal Hospital Insurance Trust Fund for grants under this subsection.

TITLE III—HEALTH CARE SAFETY NET

Subtitle A—Community Health Access

PART I—PRIMARY CARE GRANT PROGRAM

SEC. 301. GRANT PROGRAM TO PROMOTE PRIMARY HEALTH CARE SERVICES FOR UNDERSERVED POPULATIONS.

(a) AUTHORIZATION.—The Secretary of Health and Human Services shall provide for a program of grants to migrant and community health centers (receiving grants or contracts under section 329 or 330 of the Public Health Service Act) in order to promote the provision of primary health care services for underserved individuals. Such grants may be used—

(1) to promote the provision of off-site services (through means such as mobile medical clinics);

(2) to improve birth outcomes in areas with high infant mortality and morbidity;

(3) to establish primary care clinics in areas identified as in need of such clinics; and

(4) for recruitment and training costs of necessary providers and operating costs for unreimbursed services.

(b) CONDITIONS.—(1) Grants under this subsection shall only be made upon application, approved by the Secretary.

(2) The amount of grants made under this section shall be determined by the Secretary.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated—

(1) in fiscal year 1993, $100,000,000,

(2) in fiscal year 1994, $200,000,000,

(3) in fiscal year 1995, $300,000,000,

(4) in fiscal year 1996, $400,000,000, and

(5) in fiscal year 1997, $500,000,000,

to carry out this section. Of the amounts appropriated each fiscal year under this section, at least 10 percent shall be used for grants described in subsection (a)(1) and at least 10 percent shall be used for grants described in subsection (a)(2).

(d) STUDY AND REPORT.—The Secretary shall conduct a study of the impact of the grants made under this section to migrant and community health centers on access to health care, birth outcomes, and the use of emergency room services. Not later than 2 years after the date

of the enactment of this Act, the Secretary shall submit to Congress a report on such study and on recommendations for changes in the programs under this section in order to promote the appropriate use of cost-effective outpatient services.

PART II—ASSISTANCE TO FEDERALLY SUPPORTED HEALTH CENTERS

SEC. 311. LIABILITY PROTECTIONS FOR CERTAIN HEALTH CARE PROFESSIONALS.

(a) IN GENERAL.—Section 224 of the Public Health Service Act (42 U.S.C. 233) is amended by adding at the end the following new subsection:

"(g)(1) For purposes of this section, a public or nonprofit private entity receiving Federal funds under section 329, 330, or 340, and any officer, employee, or contractor of such an entity who is a physician or other licensed health care practitioner shall, while performing functions pursuant to any of such sections, be deemed to be an employee of the Public Health Service.

"(2) If, with respect to an entity or person deemed to be an employee for purposes of paragraph (1), a cause of action is instituted against the United States pursuant to this section, any claim of the entity or person for benefits under an insurance policy with respect to medical mal-

practice relating to such cause of action shall be subrogated to the United States.

"(3) This subsection shall apply with respect to a cause of action only if the claim accrues on or after the effective date of this subsection.".

(b) REQUIREMENT OF APPROPRIATE POLICIES AND PROCEDURES REGARDING HEALTH CARE PROFESSIONALS.—

(1) IN GENERAL.—Section 224 of the Public Health Service Act, as amended by subsection (a) of this section, is further amended by adding at the end the following new subsection:

"(h) The Secretary may not make a grant to an entity under section 329, 330, or 340 unless the entity—

"(1) has implemented appropriate policies and procedures to assure against malpractice in all health or health-related functions performed by the entity;

"(2) has reviewed and verified the professional credentials, references, claims history, fitness, professional review organization findings, and license status of its physicians and other licensed health care practitioners, and, where necessary, has obtained the permission from these individuals to gain access to this information; and

"(3) has no history of claims having been filed against it pursuant to this section, or, if such a history exists, has fully cooperated with the Attorney General in defending against any such claims and either has taken, or will take, such corrective steps to assure against such claims in the future.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

(c) AUTHORIZATION FOR THE ATTORNEY GENERAL TO EXCLUDE CERTAIN HEALTH CARE PROFESSIONALS FROM COVERAGE.—Section 224 of the Public Health Service Act, as amended by subsections (a) and (b) of this section, is further amended by adding at the end the following new subsection:

"(i)(1) Notwithstanding subsection (g)(1), the Attorney General, in consultation with the Secretary, may determine, after notice and opportunity for a hearing, that an individual physician or other licensed health care practitioner who is an officer, employee, or contractor of an entity described in subsection (g)(1) shall not be deemed to be an employee of the Public Health Service for purposes of this section, if treating such individual as such an employee would expose the Government to an unrea-

sonably high degree of risk of loss because such individual—

"(A) does not comply with the policies and procedures to assure against malpractice that the entity has implemented pursuant to subsection (h)(1);

"(B) has a history of claims filed against him or her pursuant to this section that is outside the norm for a Public Health Service physician or other licensed health care practitioner;

"(C) refused to reasonably cooperate with the Attorney General in defending against any such claim;

"(D) provided false information relevant to the individual's performance of his or her duties to the Secretary, the Attorney General, or an applicant for or recipient of funds under section 329, 330, or 340; or

"(E) was the subject of disciplinary action taken by a State medical licensing authority or a State or national professional society.

"(2) A final determination by the Attorney General under this subsection that an individual physician or other licensed health care professional shall not be deemed to be an employee of the Public Health Service shall be effective upon receipt by the entity employing such individual

of notice of such determination, and shall apply only to claims accruing after the date such notice is received.".

SEC. 312. HOSPITAL ADMITTING PRIVILEGES FOR CERTAIN HEALTH CARE PROVIDERS.

Section 224 of the Public Health Service Act, as amended by section 311 of this Act, is further amended by adding at the end the following new subsection:

"(j) In the case of a health care provider who is an officer, employee, or contractor of an entity described in subsection (g)(1), section 335(e) shall apply with respect to the provider to the same extent and in the same manner as such section applies to any member of the National Health Service Corps.".

SEC. 313. EFFECTIVE DATE.

Except as provided in section 311(b)(2), the amendments made by this part shall take effect on the date of the enactment of this Act.

Subtitle B—Rural Health Care Initiatives

SEC. 321. HEALTH PROFESSIONS TRAINING IMPROVEMENT.

(a) MEDICALLY UNDERSERVED AREA TRAINING INCENTIVES.—Part A of title VII of the Public Health Service Act (42 U.S.C. 292 et seq.) is amended by adding at the end thereof the following new section:

"SEC. 711. PRIORITIES IN AWARDING OF GRANTS.

"(a) ALLOCATION OF COMPETITIVE GRANT FUNDS.—In awarding competitive grants under this title or title VIII, the Secretary shall, among applicants that meet the eligibility requirements under such titles, give priority to entities submitting applications that—

"(1) can demonstrate that such entities—

"(A) have a high permanent rate for placing graduates in practice settings which serve residents of medically underserved communities; and

"(B) have a curriculum that includes—

"(i) the rotation of medical students and residents to clinical settings whose focus is to serve medically underserved communities;

"(ii) the appointment of health professionals whose practices serve medically underserved communities to act as preceptors to supervise training in such settings;

"(iii) classroom instruction on practice opportunities involving medically underserved communities;

"(iv) service contingent scholarship or loan repayment programs for students and

residents to encourage practice in or service to underserved communities;

"(v) the recruitment of students who are most likely to elect to practice in or provide service to medically underserved communities;

"(vi) other training methodologies that demonstrate a significant commitment to the expansion of the proportion of graduates that elect to practice in or serve the needs of medically underserved communities; or

"(2) contain an organized plan for the expeditious development of the placement rate and curriculum described in paragraph (1).

"(b) SERVICE IN MEDICALLY UNDERSERVED COMMUNITIES.—Not less than 50 percent of the amounts appropriated for fiscal year 1995, and for each subsequent fiscal year, for competitive grants under this title or title VIII, shall be used to award grants to institutions that are otherwise eligible for grants under such title, and that can demonstrate that—

"(1) not less than 15 percent of graduates of such institutions during the preceding 2-year period

are engaged in full-time practice serving the needs of medically underserved communities; or

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

"(c) WAIVERS.—A health professions school may petition the Secretary for a temporary waiver of the priorities of this section. Such waiver shall be approved if the health professions school demonstrates that the State in which such school is located is not suffering from a shortage of primary care providers, as determined by the Secretary. Such waiver shall not be for a period in excess of 2 years.

"(d) DEFINITIONS.—As used in this section:

"(1) GRADUATE.—The term 'graduate' means, unless otherwise specified, an individual who has successfully completed all training and residency requirements necessary for full certification in the health professions discipline that such individual has selected.

"(2) MEDICALLY UNDERSERVED COMMUNITY.—The term 'medically underserved community' means—

"(A) an area designated under section 332 as a health professional shortage area;

"(B) an area designated as a medically underserved area under this Act;

"(C) populations served by migrant health centers under section 329, community health centers under section 330, or federally qualified health centers under section 1905(l)(2)(B) of the Social Security Act;

"(D) a community that is certified as underserved by the Secretary for purposes of participation in the rural health clinic program under title XVIII of the Social Security Act; or

"(E) a community that meets the criteria for the designation described in subparagraph (A) or (B) but that has not been so designated.".

(b) MEDICALLY UNDERSERVED AREA TRAINING GRANTS.—Part F of title VII of such Act (42 U.S.C. 295g et seq.) is amended by adding at the end thereof the following new section:

"SEC. 790B. MEDICALLY UNDERSERVED AREA TRAINING GRANT PROGRAM.

"(a) GRANTS.—The Secretary shall award grants to health professions institutions to expand training pro-

grams that are targeted at those individuals desiring to practice in or serve the needs of medically underserved communities.

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

"(c) PRIORITY.—In awarding grants under this section, the Secretary shall give priority to applicants that demonstrate the greatest likelihood of expanding the proportion of graduates who choose to practice in or serve the needs of medically underserved areas.

"(d) USE OF FUNDS.—An institution that receives a grant under this section shall use amounts received under such grant to establish or enhance procedures or efforts to—

"(1) rotate health professions students from such institution to clinical settings whose focus is to serve the residents of medically underserved communities;

"(2) appoint health professionals whose practices serve medically underserved areas to serve as preceptors to supervise training in such settings;

"(3) provide classroom instruction on practice opportunities involving medically underserved communities;

"(4) provide service contingent scholarship or loan repayment programs for students and residents to encourage practice in or service to underserved communities;

"(5) recruit students who are most likely to elect to practice in or provide service to medically underserved communities; or

"(6) provide other training methodologies that demonstrate a significant commitment to the expansion of the proportion of graduates that elect to practice in or serve the needs of medically underserved communities.

"(e) ADMINISTRATION.—

"(1) REQUIRED CONTRIBUTION.—An institution that receives a grant under this section shall contribute, from non-Federal sources, either in cash or inkind, an amount equal to not less than 50 percent of the amount of the grant to the activities to be undertaken with the grant funds.

"(2) LIMITATION.—An institution that receives a grant under this section, shall use amounts received under such grant to supplement, not sup-

plant, amounts made available by such institution for activities of the type described in subsection (d) in the fiscal year preceding the year for which the grant is received.

"(f) DEFINITIONS.—As used in this section:

"(1) GRADUATE.—The term 'graduate' means, unless otherwise specified, an individual who has successfully completed all training and residency requirements necessary for full certification in the health professions discipline that such individual has selected.

"(2) MEDICALLY UNDERSERVED COMMUNITY.—The term 'medically underserved community' means—

"(A) an area designated under section 332 as a health professional shortage area;

"(B) an area designated as a medically underserved area under this Act;

"(C) populations served by migrant health centers under section 329, community health centers under section 330, or federally qualified health centers under section 1905(l)(2)(B) of the Social Security Act;

"(D) a community that is certified as underserved by the Secretary for purposes of par-

ticipation in the rural health clinic program under title XVIII of the Social Security Act; or

"(E) a community that meets the criteria for the designation described in subparagraph (A) or (B) but that has not been so designated.

"(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $15,000,000 for each of the fiscal years 1993 and 1994, and such sums as may be necessary for each of the fiscal years 1995 and 1996.".

(c) HEALTH PROFESSIONS INTEGRATION GRANTS.—Part F of title VII of such Act (42 U.S.C. 295g et seq.), as amended by subsection (b), is further amended by adding at the end thereof the following new section:

"SEC. 790C. HEALTH PROFESSIONS INTEGRATION GRANT PROGRAM.

"(a) GRANTS.—The Secretary shall award grants to eligible regional consortia to enhance and expand coordination among various health professions programs, particularly in medically underserved rural areas.

"(b) ELIGIBLE REGIONAL CONSORTIUM.—

"(1) IN GENERAL.—To be eligible to receive a grant under subsection (a), an entity must—

"(A) be a regional consortium consisting of at least one medical school and at least one

other health professions school that is not a medical school; and

"(B) prepare and submit an application containing a plan of the type described in paragraph (2).

"(2) PLAN.—As part of the application submitted by a consortium under paragraph (1)(B), the consortium shall prepare and submit a plan that described the proposed use of funds that may be provided to the consortium under the grant.

"(c) USE OF FUNDS.—A consortium that receives a grant under this section shall use amounts received under such grant to establish or enhance—

"(1) strategies for better clinical cooperation among different types of health professionals;

"(2) classroom instruction on integrated practice opportunities, particularly targeted toward rural areas;

"(3) integrated clinical clerkship programs that make use of students in differing health professions schools; or

"(4) other training methodologies that demonstrate a significant commitment to the expansion of clinical cooperation among different types of health

professionals, particularly in underserved rural areas.

"(d) LIMITATION.—A consortium that receives a grant under this section, shall use amounts received under such grant to supplement, not supplant, amounts made available by such institution for activities of the type described in subsection (c) in the fiscal year preceding the year for which the grant is received.

"(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $7,000,000 for each of the fiscal years 1993 and 1994, and such sums as may be necessary for each of the fiscal years 1995 and 1996.".

SEC. 322. GRANTS TO STATES REGARDING AIRCRAFT FOR TRANSPORTING RURAL VICTIMS OF MEDICAL EMERGENCIES.

Title XII of the Public Health Service Act (42 U.S.C. 300d et seq.) is amended by adding at the end thereof the following new part:

"PART D—MISCELLANEOUS GRANT PROGRAMS AND REQUIREMENTS

"SEC. 1241. GRANTS FOR SYSTEMS TO TRANSPORT RURAL VICTIMS OF MEDICAL EMERGENCIES.

"(a) IN GENERAL.—The Secretary shall make grants to States to assist such States in the creation or enhance-

ment of air medical transport systems that provide victims of medical emergencies in rural areas with access to treatments for the injuries or other conditions resulting from such emergencies.

"(b) APPLICATION AND PLAN.—

"(1) APPLICATION.—To be eligible to receive a grant under subsection (a), a State shall prepare and submit to the Secretary an application in such form, made in such manner, and containing such agreements, assurances, and information, including a State plan as required in paragraph (2), as the Secretary determines to be necessary to carry out this section.

"(2) STATE PLAN.—An application submitted under paragraph (1) shall contain a State plan that shall—

"(A) describe the intended uses of the grant proceeds and the geographic areas to be served;

"(B) demonstrates that the geographic areas to be served, as described under subparagraph (A), are rural in nature;

"(C) demonstrate that there is a lack of facilities available and equipped to deliver ad-

vanced levels of medical care in the geographic areas to be served;

"(D) demonstrate that in utilizing the grant proceeds for the establishment or enhancement of air medical services the State would be making a cost-effective improvement to existing ground-based or air emergency medical service systems;

"(E) demonstrate that the State will not utilize the grant proceeds to duplicate the capabilities of existing air medical systems that are effectively meeting the emergency medical needs of the populations they serve;

"(F) demonstrate that in utilizing the grant proceeds the State is likely to achieve a reduction in the morbidity and mortality rates of the areas to be served, as determined by the Secretary;

"(G) demonstrate that the State, in utilizing the grant proceeds, will—

"(i) maintain the expenditures of the State for air and ground medical transport systems at a level equal to not less than the level of such expenditures maintained by the State for the fiscal year preceding

the fiscal year for which the grant is received; and

"(ii) ensure that recipients of direct financial assistance from the State under such grant will maintain expenditures of such recipients for such systems at a level at least equal to the level of such expenditures maintained by such recipients for the fiscal year preceding the fiscal year for which the financial assistance is received;

"(H) demonstrate that persons experienced in the field of air medical service delivery were consulted in the preparation of the State plan;

"(I) contain such other information as the Secretary may determine appropriate.

"(c) CONSIDERATIONS IN AWARDING GRANTS.—In determining whether to award a grant to a State under this section, the Secretary shall—

"(1) consider the rural nature of the areas to be served with the grant proceeds and the services to be provided with such proceeds, as identified in the State plan submitted under subsection (b); and

"(2) give preference to States with State plans that demonstrate an effective integration of the proposed air medical transport systems into a compre-

hensive network or plan for regional or statewide emergency medical service delivery.

"(d) STATE ADMINISTRATION AND USE OF GRANT.—

"(1) IN GENERAL.—The Secretary may not make a grant to a State under subsection (a) unless the State agrees that such grant will be administered by the State agency with principal responsibility for carrying out programs regarding the provision of medical services to victims of medical emergencies or trauma.

"(2) PERMITTED USES.—A State may use amounts received under a grant awarded under this section to award subgrants to public and private entities operating within the State.

"(3) OPPORTUNITY FOR PUBLIC COMMENT.—The Secretary may not make a grant to a State under subsection (a) unless that State agrees that, in developing and carrying out the State plan under subsection (b)(2), the State will provide public notice with respect to the plan (including any revisions thereto) and facilitate comments from interested persons.

"(e) NUMBER OF GRANTS.—The Secretary shall award grants under this section to not less than 7 States

"(f) REPORTS.—

"(1) REQUIREMENT.—A State that receives a grant under this section shall annually (during each year in which the grant proceeds are used) prepare and submit to the Secretary a report that shall contain—

"(A) a description of the manner in which the grant proceeds were utilized;

"(B) a description of the effectiveness of the air medical transport programs assisted with grant proceeds; and

"(C) such other information as the Secretary may require.

"(2) TERMINATION OF FUNDING.—In reviewing reports submitted under paragraph (1), if the Secretary determines that a State is not using amounts provided under a grant awarded under this section in accordance with the State plan submitted by the State under subsection (b), the Secretary may terminate the payment of amounts under such grant to the State until such time as the Secretary determines that the State comes into compliance with such plan.

"(g) DEFINITION.—As used in this section, the term 'rural areas' means geographic areas that are located out-

side of standard metropolitan statistical areas, as identified by the Secretary.

"(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to make grants under this section, $15,000,000 for fiscal year 1993, and such sums as may be necessary for each of the fiscal years 1994 and 1995.".

SEC. 323. RURAL HEALTH CARE TELECOMMUNICATIONS DEMONSTRATION PROJECT.

(a) ESTABLISHMENT.—In order to demonstrate whether an interactive telecommunications system may improve the quality of health care provided to individuals residing in rural areas, the Secretary of Health and Human Services (hereafter referred to as the "Secretary") shall establish a demonstration project under which the Secretary shall award grants over a 3-year period to 5 States to establish and operate such a system.

(b) INTERACTIVE TELECOMMUNICATIONS SYSTEM DEFINED.—In this section, an "interactive telecommunications system" means a system that links rural health care facilities in a State to urban facilities and trauma care centers in the State (through methods such as interactive digital video, static video imaging systems, and telefacsimile machines) to assist rural facilities in stabilizing and treating patients.

(c) ELIGIBILITY OF STATES.—A State is eligible to receive a grant under the demonstration project established under subsection (a) if the State submits an application to the Secretary (at such time and in such form as the Secretary may require) containing such information as the Secretary may require.

(d) REPORT.—Not later than 1 year after the expiration of the 3-year period during which grants are awarded to States under the demonstration project established under subsection (a), the Secretary shall submit a report to Congress describing the project and analyzing the project's effect on the quality of health care provided to individuals residing in rural areas in the States receiving grants under the project.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for grants under the demonstration project established under subsection (a) not more than $15,000,000.

Subtitle C—State Flexibility

SEC. 351. PROTECTION AGAINST DISALLOWANCES FOR GOOD FAITH COMPLIANCE WITH REQUIREMENTS.

(a) IN GENERAL.—Section 1904 of the Social Security Act (42 U.S.C. 1396c) is amended—

(1) by inserting "(a)" after "1904.", and

(2) by adding at the end the following new subsection:

"(b)(1) The Secretary may not take any action against a State under subsection (a) or under section 1116 with respect to a State's failure to comply with a requirement of this title, for actions or inactions occurring before the date a final regulation to carry out such requirement has been promulgated, if—

"(A) the State has complied in good faith with such requirement, or

"(B) the State has not complied with such requirement and a regulation is required in order for the State to implement properly the requirement.

Subparagraph (B) shall be applied without regard to whether or not a provision of law states the requirement takes effect without regard to the timely promulgation of regulations.

"(2) Within 60 days of the date of the enactment of any Act which has the effect of changing any requirements for States under this title, the Secretary shall provide, by notice in the Federal Register, a statement as to whether or not, with respect to each such requirement, a regulation is needed in order for States to implement properly such requirement.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act and shall apply to disallowances taken on or after such date, regardless or whether or not the action (or inaction) giving rise to the disallowance occurred before, on, or after such date.

SEC. 352. AUTHORIZING WAIVER OF NURSING HOME REFORM REQUIREMENTS.

The Secretary of Health and Human Services may waive specified requirements of subsections (b) through (e) of section 1919 of the Social Security Act with respect to nursing facilities located in a State if the State provides assurances satisfactory to the Secretary (including, if appropriate, the implementation of an alternative State program) that the waiver of such requirements will not adversely affect the quality of life of the residents in such facilities.

TITLE IV—PREVENTIVE CARE UNDER MEDICARE

SEC. 401. 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 1993 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 the 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 the 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 payment limit established for screening fecal-occult blood tests under paragraph (1)(A). The Secretary may, with respect to tests performed in a year after 1995, 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, 1996.

"(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 1993, 120 percent of the payment limit established under paragraph (2)(A); or

"(ii) after 1993, 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 in-

dividual 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, 1993.

SEC. 402. 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-diptheria 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 401(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 previ-

ous influenza vaccine, and, in the case of a tetanus-diptheria booster, which is administered within the 119 months after a previous tetanus-diptheria booster;".

(c) CONFORMING AMENDMENT.—Section 1862(a)(7) of such Act (42 U.S.C. 1395y(a)(7)), as amended by section 401(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-diptheria boosters administered on or after January 1, 1993.

SEC. 403. 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 7 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 401(b)(4)(A) and 402(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 401(b)(4)(B) and 402(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, 1993.

SEC. 404. 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, 1993.

SEC. 405. OUTPATIENT DIABETES EDUCATION SERVICES.

(a) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)), as amended by section 403(a), is further amended—

(1) by striking "and" at the end of subparagraph (P);

(2) by adding "and" at the end of subparagraph (Q); and

(3) by adding at the end the following new subparagraph:

"(R) outpatient diabetes education services (as defined in subsection (oo)).".

(b) DEFINITION.—Section 1861 of such Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

"OUTPATIENT DIABETES EDUCATION SERVICES

"(oo)(1) The term 'outpatient diabetes education services' means educational and training services furnished to an individual with diabetes by or under arrangements with a certified provider (as described in paragraph (2)(A)) in an outpatient setting by an individual or entity who meets the quality standards described in paragraph (2)(B), but only if the physician who is managing the indi-

vidual's diabetic condition certifies that such services are needed under a comprehensive plan of care related to the individual's diabetic condition to provide the individual with necessary skills and knowledge (including skills related to the self-administration of injectable drugs) to participate in the management of the individual's condition.

"(2) In paragraph (1)—

"(A) a 'certified provider' is an individual or entity that, in addition to providing outpatient diabetes education services, provides other items or services for which payment may be made under this title; and

"(B) an individual or entity meets the quality standards described in this paragraph if the individual or entity meets quality standards established by the Secretary, except that the individual or entity shall be deemed to have met such standards if the individual or entity meets applicable standards established by the National Diabetes Advisory Board or is certified by the American Diabetes Association as qualified to furnish the services.".

(c) CONSULTATION WITH ORGANIZATIONS IN ESTABLISHING PAYMENT AMOUNTS FOR SERVICES PROVIDED BY PHYSICIANS.—In establishing payment amounts under section 1848(a) of the Social Security Act for physicians'

services consisting of outpatient diabetes education services, the Secretary of Health and Human Services shall consult with appropriate organizations, including the American Diabetes Association, in determining the relative value for such services under section 1848(c)(2) of such Act.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 1993.

SEC. 406. DEMONSTRATION PROJECTS FOR COVERAGE OF OTHER PREVENTIVE SERVICES.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services (hereafter referred to as the "Secretary") shall establish and provide for the conduct of 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 series 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 chlamydial testing and maternal serum alfa-fetoprotein.

(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, 1994, 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. 407. OTA STUDY OF PROCESS FOR REVIEW OF MEDICARE COVERAGE OF PREVENTIVE SERVICES.

(a) STUDY.—The Director of the Office of Technology Assessment (hereafter 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 Act, 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).

TITLE V—LONG-TERM CARE INITIATIVES

SEC. 501. TREATMENT OF LONG-TERM CARE INSURANCE OR PLANS.

(a) GENERAL RULE.—Chapter 79 of the Internal Revenue Code of 1986 (relating to definitions) is amended by inserting after section 7702A the following new section:

"SEC. 7702B. TREATMENT OF LONG-TERM CARE INSURANCE OR PLANS.

"(a) GENERAL RULE.—For purposes of this title—

"(1) a long-term care insurance contract shall be treated as an accident or health insurance contract,

"(2) amounts received under such a contract with respect to qualified long-term care services shall be treated as amounts received for personal injuries or sickness, and

"(3) any plan of an employer providing qualified long-term care services shall be treated as an accident or health plan.

"(b) LONG-TERM CARE INSURANCE CONTRACT.—

"(1) IN GENERAL.—For purposes of this title, the term 'long-term care insurance contract' means any insurance contract if—

"(A) the only insurance protection provided under such contract is coverage of qualified long-term care services and benefits incidental to such coverage,

"(B) such contract does not cover expenses incurred for services or items to the extent that such expenses are reimbursable under title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount,

"(C) such contract is guaranteed renewable.

"(D) such contract does not have any cash surrender value.

"(E) all refunds of premiums, and all policyholder dividends or similar amounts, under such contract are to be applied as a reduction in future premiums or to increase future benefits, and

"(F) such contract is certified under paragraph (3) by the Secretary of Health and Human Services as meeting the requirements of this subsection.

"(2) SPECIAL RULES.—

"(A) PER DIEM, ETC. PAYMENTS PERMITTED.—A contract shall not fail to be treated as described in paragraph (1)(A) by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

"(B) CONTRACT MAY COVER MEDICARE REIMBURSABLE EXPENSES WHERE MEDICARE IS SECONDARY PAYOR.—Paragraph (1)(B) shall not apply to expenses which are reimbursable

under title XVIII of the Social Security Act only as a secondary payor.

"(C) REFUNDS OF PREMIUMS.—Paragraph (1)(E) shall not apply to any refund of premiums on surrender or cancellation of the contract.

"(3) CERTIFICATION PROCESS.—

"(A) IN GENERAL.—For the purposes of paragraph (1), the Secretary of Health and Human Services (hereinafter in this paragraph referred to as the 'Secretary') shall establish a certification program (which meets the requirements set forth in subparagraph (B)) for long-term care insurance.

"(B) PROGRAM REQUIREMENTS.—A program meets the requirements of this subparagraph if under the program—

"(i) issuers may submit policies for certification,

"(ii) certifications are for periods of 1 year,

"(iii) there may be printed on each policy which is certified by the Secretary an emblem or symbol approved by the Sec-

retary which identifies the policy as so certified, and

"(iv) the Secretary notifies each State of each policy so certified.

"(C) STATE.—For purposes of this paragraph, the term 'State' includes the District of Columbia and any possession of the United States.

"(D) REGULATIONS.—The Secretary may prescribe such regulations as necessary or appropriate to carry out this paragraph.

"(c) QUALIFIED LONG-TERM CARE SERVICES.—For purposes of this section—

"(1) IN GENERAL.—The term 'qualified long-term care services' means necessary diagnostic, preventive, therapeutic, and rehabilitative services, and maintenance or personal care services, which—

"(A) are required by a chronically ill individual in a qualified facility, and

"(B) are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

"(2) CHRONICALLY ILL INDIVIDUAL.—

"(A) IN GENERAL.—The term 'chronically ill individual' means any individual who has

been certified by a licensed health care practitioner as—

"(i)(I) being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living (as defined in subparagraph (B)) due to a loss of functional capacity, or

"(II) having a level of disability similar (as determined by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in subclause (I), or

"(ii) having a similar level of disability due to cognitive impairment.

"(B) ACTIVITIES OF DAILY LIVING.—For purposes of subparagraph (A), each of the following is an activity of daily living:

"(i) BATHING.—The overall complex behavior of getting water and cleansing the whole body, including turning on the water for a bath, shower, or sponge bath, getting to, in, and out of a tub or shower, and washing and drying oneself.

"(ii) DRESSING.—The overall complex behavior of getting clothes from closets and drawers and then getting dressed.

"(iii) TOILETING.—The act of going to the toilet room for bowel and bladder function, transferring on and off the toilet, cleaning after elimination, and arranging clothes or the ability to voluntarily control bowel and bladder function, or in the event of incontinence, the ability to maintain a reasonable level of personal hygiene.

"(iv) TRANSFER.—The process of getting in and out of bed or in and out of a chair or wheelchair.

"(v) EATING.—The process of getting food from a plate or its equivalent into the mouth.

"(3) QUALIFIED FACILITY.—The term 'qualified facility' means—

"(A) a nursing, rehabilitative, hospice, or adult day care facility (including a hospital, retirement home, nursing home, skilled nursing facility, intermediate care facility, or similar institution)—

"(i) which is licensed under State law, or

"(ii) which is a certified facility for purposes of title XVIII or XIX of the Social Security Act, or

"(B) an individual's home if a licensed health care practitioner certifies that without home care the individual would have to be cared for in a facility described in subparagraph (A).

"(4) MAINTENANCE OR PERSONAL CARE SERVICES.—The term 'maintenance or personal care services' means any care the primary purpose of which is to provide needed assistance with any of the activities of daily living described in paragraph (2)(B).

"(5) LICENSED HEALTH CARE PRACTITIONER.—The term 'licensed health care practitioner' means any physician (as defined in section 1861(r) of the Social Security Act) and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary.

"(d) CONTINUATION COVERAGE EXCISE TAX NOT TO APPLY.—This section shall not apply in determining whether section 4980B relating to failure to satisfy con-

tinuation coverage requirements of group health plans) applies."

(b) CLERICAL AMENDMENT.—The table of sections for chapter 79 of such Code is amended by inserting after the item relating to section 7702A the following new item:

"Sec. 7702B. Treatment of long-term care insurance or plans."

(c) STUDY.—The Secretary of Health and Human Services shall (in consultation with the National Association of Insurance Commissioners, representatives of major aging organizations, and representatives of employee health benefits organizations) conduct a comprehensive study of—

(1) all policies being offered as of January 1, 1993, which are purported to provide benefits such as those described in section 7702B(c) of the Internal Revenue Code of 1986,

(2) the various methods that States use to regulate such policies,

(3) the sale, marketing, and promotional activities of such persons who issue such policies,

(4) specific methods to promote price competition of such policies; and

(5) specific methods for disseminating information as to the need and availability of such policies for individuals.

Such study shall be submitted to the Congress not later than January 1, 1994.

(d) ANNUAL REPORT.—The Secretary of Health and Human Services shall submit annually to the Congress a report of the program established pursuant to section 7702B(b)(3) of such Code. Such report shall include—

(1) types and numbers of policies certified under such program,

(2) types and numbers of policies not certified under such program,

(3) any recommendations such Secretary may have for changes in legislation or regulatory practices under such program, and

(4) the Secretary's recommendation whether such a certification program should continue.

SEC. 502. QUALIFIED LONG-TERM SERVICES TREATED AS MEDICAL CARE.

(a) GENERAL RULE.—Paragraph (1) of section 213(d) of the Internal Revenue Code of 1986 (defining medical care) is amended by striking "or" at the end of subparagraph (B), by redesignating subparagraph (C) as subparagraph (D), and by inserting after subparagraph (B) the following new subparagraph:

"(C) for qualified long-term care services (as defined in section 7702B(c)), or"

(b) TECHNICAL AMENDMENTS.—

(1) Subparagraph (D) of section 213(d)(1) of such Code (as redesignated by subsection (a)) is amended by striking "subparagraphs (A) and (B)" and inserting "subparagraphs (A), (B), and (C)".

(2) Paragraph (6) of section 213(d) of such Code is amended—

(A) by striking "subparagraphs (A) and (B)" and inserting "subparagraphs (A), (B), and (C)", and

(B) by striking "paragraph (1)(C)" in subparagraph (A) and inserting "paragraph (1)(D)".

(3) Paragraph (7) of section 213(d) of such Code is amended by striking "subparagraphs (A) and (B)" and inserting "subparagraphs (A), (B), and (C)".

(c) EXCLUSION FOR BENEFITS.—Subsection (b) of section 105 of such Code is amended by inserting "as benefits under a long-term care insurance contract (as defined in section 7702B(b)) or" after "to the taxpayer".

SEC. 503. TREATMENT OF PREFUNDED LONG-TERM CARE BENEFITS.

(a) IN GENERAL.—

(1) Paragraph (2) of section 419A(c) of the Internal Revenue Code of 1986 (relating to additional reserve for post-retirement medical and life insurance benefits) is amended by striking "or" at the end of subparagraph (A), by striking the period at the end of subparagraph (B) and inserting ", or", and by adding at the end thereof the following new subparagraph:

"(C) post-retirement long-term care benefits to be provided to covered employees."

(2) The paragraph heading for such paragraph (2) is amended by inserting ", LONG-TERM CARE." after "MEDICAL".

(b) RESERVE FOR LONG-TERM CARE BENEFITS MUST BE NONDISCRIMINATORY.—

(1) Paragraph (1) of section 419A(e) of such Code (relating to special limitation on reserves for medical benefits or life insurance benefits provided to retired employees) is amended by inserting ", long-term care benefits," after "medical benefits" each place it appears.

(2) The subsection heading for section 419A(e) of such Code is amended by inserting ", LONG-TERM CARE BENEFITS." after "MEDICAL BENEFITS".

(c) LONG-TERM CARE BENEFITS.—Subsection (f) of section 419A of such Code is amended by adding at the end thereof the following new paragraph:

"(8) LONG-TERM CARE BENEFIT.—The term 'long-term care benefit' means a benefit which provides (directly or through insurance) qualified long-term care services (as defined in section 7702B(c)). Such term shall not include any benefit provided through insurance unless the employee may elect to continue the insurance upon cessation of participation in the plan."

(d) RULES FOR CERTAIN TAX-EXEMPT ORGANIZATIONS.—

(1) Clause (ii) of section 512(a)(3)(B) of such Code is amended by inserting before the comma at the end thereof "(including long-term care benefits, as defined in section 419A(f)(8))".

(2) Clause (i) of section 512(a)(3)(E) of such Code is amended by striking "section 419A(c)(2)(A) for post-retirement medical benefits" and inserting "subparagraph (A) or (C) of section 419A(c)(2) for post-retirement medical and long-term care benefits".

SEC. 504. QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS PERMITTED TO BE OFFERED IN CAFETERIA PLANS.

Paragraph (2) of section 125(d) of the Internal Revenue Code of 1986 (relating to the exclusion of deferred compensation) is amended by adding at the end thereof the following new subparagraph:

"(D) EXCEPTION FOR LONG-TERM CARE INSURANCE CONTRACTS.—For purposes of subparagraph (A), a plan shall not be treated as providing deferred compensation by reason of providing any long-term care insurance contract (as defined in section 7702B(b)) if—

"(i) the employee may elect to continue the insurance upon cessation of participation in the plan, and

"(ii) the amount paid or incurred during any taxable year for such insurance does not exceed the premium which would have been payable for such year under a level premium structure."

SEC. 505. CERTAIN EXCHANGES OF LIFE INSURANCE CONTRACTS FOR LONG-TERM CARE INSURANCE CONTRACTS NOT TAXABLE.

Subsection (a) of section 1035 of the Internal Revenue Code of 1986 (relating to certain exchanges of insur-

ance contracts) is amended by striking the period at the end of paragraph (3) and inserting "; or", and by adding at the end thereof the following new paragraph:

"(4) a contract of life insurance or an endowment or annuity contract for a long-term care insurance contract."

SEC. 506. TAX TREATMENT OF ACCELERATED DEATH BENEFITS UNDER LIFE INSURANCE CONTRACTS.

Section 101 of the Internal Revenue Code of 1986 (relating to certain death benefits) is amended by adding at the end thereof the following new subsection:

"(g) TREATMENT OF CERTAIN ACCELERATED DEATH BENEFITS.—

"(1) IN GENERAL.—For purposes of this section, any amount paid or advanced to an individual under a life insurance contract on the life of an insured—

"(A) who is a terminally ill individual, or

"(B) who is a chronically ill individual (as defined in section 7702B(c)(2)) who is confined to a qualified facility (as defined in section 7702B(c)(3)),

shall be treated as an amount paid by reason of the death of such insured.

"(2) TERMINALLY ILL INDIVIDUAL.—For purposes of this subsection, the term 'terminally ill individual' means an individual who has been certified by a physician as having an illness or physical condition which can reasonably be expected to result in death in 12 months or less.

"(3) PHYSICIAN.—For purposes of this subsection, the term 'physician' has the meaning given to such term by section 213(d)(4)."

SEC. 507. EXCLUSION FROM GROSS INCOME FOR AMOUNTS WITHDRAWN FROM INDIVIDUAL RETIREMENT PLANS FOR QUALIFIED LONG-TERM CARE INSURANCE.

Subsection (d) of section 408 of the Internal Revenue Code of 1986 (relating to tax treatment of distributions from individual retirement plans) is amended by adding at the end thereof the following new paragraph:

"(8) DISTRIBUTIONS FOR QUALIFIED LONG-TERM CARE INSURANCE PREMIUMS.—If—

"(A) the amount of any distribution or payment is used (during the taxable year in which such distribution or payment occurs) to pay premiums for any policy of qualified long-term care insurance (as defined in section 849(b)) for the benefit of the payee or distribu-

tee, his spouse, or any parent of the payee or distributee or his spouse, and

"(B) such distribution or payment occurs after the date the payee or distributee attains 59½.

then such amount shall not be includible in the gross of such payee or distributee."

SEC. 508. EXCLUSION FROM GROSS INCOME FOR AMOUNTS ON THE SURRENDER OR CANCELLATION OF ANY LIFE INSURANCE POLICY WHICH ARE USED TO PAY PREMIUMS FOR QUALIFIED LONG-TERM CARE INSURANCE.

(a) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to items specifically excluded from gross income) is amended by redesignating section 136 as section 137 and by inserting after section 135 the following new section:

"SEC. 136. AMOUNTS RECEIVED ON CANCELLATION, ETC., OF LIFE INSURANCE CONTRACTS AND USED TO PAY PREMIUMS FOR QUALIFIED LONG-TERM CARE INSURANCE.

"No amount which would (but for this section) be includible in the gross income of an individual shall be so included on the whole or partial surrender, cancellation, or exchange of any life insurance contract during the tax-

able year to the extent that the amount otherwise includible in gross income is used during such year to pay premiums for any policy of qualified long-term care insurance (as defined in section 849(b)) for the benefit of such individual, his spouse, or any parent of such individual or spouse."

(b) CLERICAL AMENDMENT.—The table of sections for such part III is amended by striking out the last item and inserting in lieu thereof the following:

"Sec. 136. Amounts received on cancellation, etc., of life insurance contracts and used to pay premiums for qualified long-term care insurance.
"Sec. 137. Cross references to other Acts."

SEC. 509. TAX TREATMENT OF COMPANIES ISSUING QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.

(a) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—Section 818 of the Internal Revenue Code of 1986 (relating to other definitions and special rules) is amended by adding at the end thereof the following new subsection:

"(g) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—For purposes of this part—

"(1) IN GENERAL.—Any reference to a life insurance contract shall be treated as including a ref-

erence to a qualified accelerated death benefit rider on such contract.

"(2) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.—For purposes of this subsection, the term 'qualified accelerated death benefit rider' means any rider or addendum on, or other provision of a life insurance contract which provides for payments to an individual on the life of an insured upon such insured—

"(A) becoming a terminally ill individual (as defined in section 101(g)(2)), or

"(B) becoming a chronically ill individual (as defined in section 7702B(c)(2)) who is confined to a qualified facility (as defined in section 7702B(c)(3))."

(b) DEFINITIONS OF LIFE INSURANCE AND MODIFIED ENDOWMENT CONTRACTS.—

(1) RIDER TREATED AS QUALIFIED ADDITIONAL BENEFIT.—Paragraph (5)(A) of section 7702(f) of such Code is amended by striking "or" at the end of clause (iv), by redesignating clause (v) as clause (vi), and by inserting after clause (iv) the following new clause:

"(v) any qualified accelerated death benefit rider (as defined in section

§18(g)(2)) or any long-term care insurance contract rider which reduces the death benefit, or"

(2) TRANSITIONAL RULE.—For purposes of applying section 7702 or 7702A of the Internal Revenue Code of 1986 to any contract (or determining whether either such section applies to such contract), the issuance of a rider or addendum on, or other provision of, a life insurance contract permitting the acceleration of death benefits (as described in section 101(g) of such Code) or payments for qualified long-term care services (as defined in section 7702B of such Code) shall not be treated as a modification or material change of such contract.

SEC. 510. INCLUSION IN INCOME OF EXCESSIVE LONG-TERM CARE BENEFITS.

(a) IN GENERAL.—Part II of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to items specifically included in gross income) is amended by adding at the end thereof the following new section:

"SEC. 91. EXCESSIVE LONG-TERM CARE BENEFITS.

"(a) GENERAL RULE.—Gross income for the taxable year of any individual includes excessive long-term care benefits received by or for the benefit of such individual during the taxable year.

"(b) EXCESSIVE LONG-TERM CARE BENEFITS.—

"(1) IN GENERAL.—For purposes of this section, the term 'excessive long-term care benefits' means the excess (if any) of—

"(A) the aggregate amount which is not includible in the gross income of the individual for the taxable year by reason of the amendments made by the title V of the Action Now Health Reform Act of 1992 (determined without regard to this section and section 101(g)), over

"(B) the aggregate of $200 for each day during the taxable year that such individual—

"(i) was a chronically ill individual (as defined in section 7702B(c)(2)), and

"(ii) was confined to a qualified facility (as defined in section 7702B(c)(3)).

"(2) INFLATION ADJUSTMENT.—In the case of any taxable year beginning after 1992, the $200 in paragraph (1)(B) shall be increased by an amount equal to—

"(A) $200, multiplied by

"(B) the cost-of-living adjustment determined under section 1(f)(3), for the calendar year in which the taxable year begins, by substi-

tuting 'calendar year 1990' for 'calendar year 1989' in subparagraph (B) thereof.

If any dollar amount determined under this paragraph is not a multiple of $10, such dollar amount shall be rounded to the nearest multiple of $10 (or, if such dollar amount is a multiple of $5, such dollar amount shall be increased to the next higher multiple of $10)."

(b) CLERICAL AMENDMENT.—The table of sections for such part II is amended by adding at the end thereof the following new item:

"Sec. 91. Excessive long-term care benefits."

SEC. 511. EFFECTIVE DATE.

The amendments made by this title shall apply to taxable years beginning before, on, or after the date of the enactment of this Act.