United States, income, disability, perceived health status, or anticipated need for health services; or

(2) based on personal characteristics of a patient of the provider, such as race, age, gender, sexual orientation, language, religion, national origin, status of an eligible individual as a citizen of the United States, income, disability, perceived health status, or anticipated need for health services.

(c) OTHER SPONSOR ACTIVITIES.—A certified health benefit plan sponsor described in subsection (a) may not discriminate, or engage (directly or through contractual arrangements) in any other activity that has the effect of discriminating, against an individual or entity on the basis of race, age, gender, sexual orientation, language, religion, national origin, status of an eligible individual as a citizen of the United States, income, disability, perceived health status, or anticipated need for health services.

(d) BUSINESS NECESSITY.—Except in the case of intentional discrimination, a certified health benefit plan sponsor may not be considered to be in violation of this section, or of any regulations issued under this section, if the sponsor demonstrates, in a civil action under subsection (e), that each action of the sponsor that is otherwise prohibited under this section is required by a compelling business necessity and cannot be accomplished by less discriminatory means. Nothing in this subsection shall be construed to preclude the person alleging the violation from having an opportunity to present evidence to rebut the evidence presented in support of such demonstration.

(e) REMEDY.—A person who is aggrieved by a violation of this section may, in a civil action, obtain appropriate relief, including actual, compensatory, and punitive damages and equitable relief, against any appropriate party.

(f) ATTORNEY'S FEES AND COSTS.—In any action under subsection (e) in which the plaintiff substantially prevails, the court shall award the plaintiff reasonable attorney's fees (at generally prevailing hourly rates), reasonable expert witness fees, and other reasonable costs, unless the court finds that such award would not be appropriate.

(g) EXHAUSTION OF REMEDIES.—In an action under subsection (e), the court shall exercise jurisdiction without regard to whether the aggrieved individual has exhausted any administrative or other remedies that may be available to the individual under part 1 or that are otherwise provided by law.

(h) CONSTRUCTION.—Nothing in this section may be construed to permit a right of action with respect to any practice or activity that is explicitly authorized under section 5003(b)(3) or 5008(b)(4).

SEC. 9334. NONDISCRIMINATION IN FEDERALLY ASSISTED PROGRAMS.

(a) IN GENERAL.—No person in the United States shall, on the basis of race, age, gender, sexual orientation, language, religion, national origin, status of an eligible individual as a citizen of the United States, income, disability, perceived health status, or anticipated need for health services, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity receiving Federal financial assistance.

(b) PRIVATE REMEDY.—

(1) IN GENERAL.—A person who is aggrieved by a violation of this section may, in a civil action, obtain appropriate relief, including actual, compensatory, and punitive damages and equitable relief, against any appropriate party.

(2) ATTORNEY'S FEES AND COSTS.—In any action under this subsection in which the plaintiff substantially prevails, the court shall award the plaintiff reasonable attorney's fees (at generally prevailing hourly rates), reasonable expert witness fees, and other reasonable costs, unless the court finds that such award would not be appropriate.

(c) ADMINISTRATIVE POWERS.—

(1) IN GENERAL.—Each Federal department and agency which is empowered to extend Federal financial assistance to any health program or activity shall effectuate the provisions of this section with respect to such program or activity in accordance with the remedies, procedures and rights set forth in title VI of the Civil Rights Act of 1964.

(2) CONSTRUCTION.—Paragraph (1) shall not be construed to supersede, limit, or otherwise affect any provision of the Social Security Act or any duty or authority of the Secretary under such Act.

(d) DEFINITIONS.—For purposes of this section, the terms "program or activity", and "program" have the meaning given such terms in section 606 of the Civil Rights Act of 1964.

SEC. 9335. COLLECTION AND REPORTING OF DATA BY SECRETARY.

(a) IN GENERAL.—The Secretary shall promulgate regulations that provide for the routine collection, analysis, and reporting, by race, national origin, status of an eligible individual as a citizen of the United States, sex, language, income, age, and residence, of data collected from States, consumer purchasing cooperatives, certified health benefit plan sponsors, and any other person or entity determined appropriate by the Secretary that the Secretary determines are necessary or appropriate to determine whether such individuals and entities are complying with this part. The Secretary shall compile, analyze, and make public the data collected under this section.

(b) NO UNDUE BURDEN.—The regulations under subsection (a) shall include specifications ensuring that any data required to be collected under this section may be collected using the least burdensome method consistent with the efficient and effective administration of this part.

SEC. 9336. REGULATIONS.

Not later than 1 year after the date of the enactment of this Act, the Secretary shall issue regulations to carry out this part.

Subtitle E—Fraud and Abuse

PART 1—APPLICATION OF FRAUD AND ABUSE AUTHORITIES UNDER THE SOCIAL SECURITY ACT TO OTHER PAYERS

SEC. 9401. APPLICATION OF CIVIL MONEY PENALTIES TO ALL PAYERS.

(a) ACTIONS SUBJECT TO PENALTY.—Any person who is determined by the Secretary to have committed any of the following actions with respect to a certified health plan shall be subject to a penalty in accordance with subsection (b):

(1) ACTIONS SUBJECT TO PENALTY UNDER MEDICARE, MEDICAID, AND OTHER SOCIAL SECURITY HEALTH PROGRAMS.—Any action that would subject the person to a penalty under paragraphs (1) through (9) of section 1128A(a) of the Social Security Act if the action was taken with respect to title V, XVIII, XIX or XX of such Act.

(2) TERMINATION OF ENROLLMENT.—The termination of an individual's enrollment (including the refusal to re-enroll an individual) in violation of the applicable standards established under title V.

(3) DISCRIMINATING ON BASIS OF MEDICAL CONDITION.—The engagement in any practice that would reasonably be expected to have the effect of denying or discouraging the initial or continued enrollment in a certified health plan or medicare part C by individuals whose medical condition or history indicates a need for substantial future medical services.

(4) INDUCING ENROLLMENT ON FALSE PRETENSES.—The engagement in any practice to induce enrollment in a certified health plan or medicare part C through representations to in-

dividuals which the person knows or should know are false or fraudulent.

(b) PENALTIES DESCRIBED.—

(1) GENERAL RULE.—Any person who the Secretary determines has committed an action described in paragraphs (2) through (4) of subsection (a) shall be subject to a civil monetary penalty in an amount not to exceed $10,000 for each such determination.

(2) ACTIONS SUBJECT TO PENALTIES UNDER SOCIAL SECURITY ACT.—In the case of a person who the Secretary determines has committed an action described in paragraph (1) of subsection (a), the person shall be subject to the civil monetary penalty (together with any additional assessment) to which the person would be subject under section 1128A of the Social Security Act if the action on which the determination is based had been committed with respect to title V, XVIII, XIX, or XX of such Act.

(c) APPLICABILITY OF PROCEDURES UNDER SOCIAL SECURITY ACT.—The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to the imposition of a civil monetary penalty or assessment under this section in the same manner as such provisions apply with respect to the imposition of a penalty or assessment under section 1128A of such Act.

(d) TREATMENT OF AMOUNTS RECOVERED.—Any amounts recovered under this section shall be paid to the Secretary and disposed of as follows:

(1) Such portions of the amounts recovered as is determined to have been improperly paid from a certified health plan for the delivery of or payment for health care items or services shall be repaid to such plan.

(2) The remainder of the amounts recovered shall be deposited in the All-Payer Health Care Fraud and Abuse Control Account established under section 9412.

(e) NOTIFICATION OF LICENSING AUTHORITIES.—Whenever the Secretary's determination to impose a penalty or assessment under this section becomes final, the Secretary shall notify the appropriate State or local licensing agency or organization (including the agency specified in section 1864(a) and 1902(a)(33) of the Social Security Act) that such a penalty or assessment has become final and the reasons therefore.

SEC. 9402. APPLICATION OF CERTAIN CRIMINAL PENALTIES TO ALL PAYERS.

Any person who is determined by the Attorney General (in consultation with the Secretary) to have committed any action with respect to a certified health plan that would subject the person to a penalty under subsection (a) or (b) of section 1128B of the Social Security Act if the action was taken with respect to title V, XVIII, XIX, or XX of such Act shall be subject to the penalty (together with any assessment) that would apply if the action was taken with respect to any such title.

SEC. 9403. PRIVATE RIGHT OF ACTION.

(a) AVAILABILITY OF RIGHT OF ACTION TO INSURERS.—Subject to paragraphs (2) and (3), a carrier offering an insured health benefit plan and the sponsor of a self-insured health benefit plan that suffers financial harm as a direct result of the submission of claims by an individual or entity for payment for items and services furnished under the plan which makes the individual or entity subject to a civil monetary penalty under this part may, in a civil action against the individual or entity in the United States District Court, obtain damages against the individual or entity and such equitable relief as is appropriate.

(b) RIGHT CONTINGENT UPON REFUSAL TO BRING ACTION BY SECRETARY AND ATTORNEY GENERAL.—A carrier or sponsor may bring a civil action under this section only if the carrier or sponsor provides the Secretary and the Attorney General with written no-

tice of the intent to bring an action under this subsection, the identities of the individuals or entities the carrier or sponsor intends to name as defendants to the action, and all information the carrier or sponsor possesses regarding the activity that is the subject of the action that may materially affect the Secretary's decision to initiate a proceeding to impose a civil monetary penalty under this part against the defendants.

(c) CONDITIONS.—A carrier or sponsor may bring a civil action under this section only if any of the following conditions are met:

(1) During the 60-day period that begins on the date the Secretary receives the written notice described in paragraph (2), the Secretary does not notify the carrier or sponsor that the Secretary intends to initiate a proceeding to impose a civil monetary penalty under this section against the defendants.

(2) If the Secretary notifies the carrier or sponsor during the 60-day period described in subparagraph (A) that the Secretary intends to initiate a proceeding to impose a civil monetary penalty under this part against the defendants, the Secretary subsequently notifies the carrier or sponsor that the Secretary no longer intends to initiate such a proceeding against the defendants.

(3) After the expiration of the 2-year period that begins on the date the Secretary notifies the carrier or sponsor that the Secretary intends to initiate a proceeding to impose a civil monetary penalty under this part against the defendants, the Secretary has not made a good faith effort to initiate such a proceeding against the defendants.

(d) SET-ASIDE OF AMOUNTS TO ACCOUNT.—If a carrier or sponsor is awarded any amounts in an action brought under this section that are in excess of the damages suffered by the carrier or sponsor as a result of the defendant's activities, 10 percent of such amounts shall be withheld from the carrier or sponsor for payment into the Health Care Fraud and Abuse Control Account established under section 9412.

(e) STATUTE OF LIMITATIONS.—No action may be brought under this section more than 6 years after the date of the activity with respect to which the action is brought.

SEC. 9404. CONSTRUCTION OF SOCIAL SECURITY ACT REFERENCES.

(a) INCORPORATION OF OTHER AMENDMENTS.—Any reference in this part to a provision of the Social Security Act shall be considered a reference to the provision as amended under part 5 of subtitle D of title VIII.

(b) EFFECT OF SUBSEQUENT AMENDMENTS.—Except as provided in subsection (a), any reference to a provision of the Social Security Act in this part shall be deemed to be a reference to such provision as in effect on the date of the enactment of this Act, and (except as Congress may otherwise provide) any amendments made to such provisions after such date shall not be taken into account in determining the applicability of such provisions to individuals and entities under this Act.

PART 2—ESTABLISHMENT OF ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM

SEC. 9411. ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM.

(a) IN GENERAL.—Not later than January 1, 1996, the Secretary (acting through the Inspector General of the Department of Health and Human Services) and the Attorney General shall establish a program—

(1) to coordinate the functions of the Attorney General, the Secretary, and other organizations with respect to the prevention, detection, and control of health care fraud and abuse,

(2)(A) to conduct investigations, audits, evaluations, and inspections relating to health care fraud and abuse under the Public Health Service Act, titles V, XI, XVIII, XIX, and XX of the Social Security Act, medicare part C, and part 1 of this subtitle, and (B) to facilitate the conducting of such investigations, audits, evaluations, and inspections relating to the delivery of and payment for other health care services in the United States, and

(3) to facilitate the enforcement of this subtitle and other statutes applicable to health care fraud and abuse.

(b) COORDINATION WITH OTHER INSPECTORS GENERAL.—

(1) SCOPE OF AUTHORITY OF HHS INSPECTOR GENERAL.—The Inspector General of the Department of Health and Human Services may not exercise any authority under subsection (a)(2)(A) with respect to any matter which is subject to investigation, audit, evaluation, and inspection by the Inspector General of another executive department.

(2) SCOPE OF AUTHORITY OF OTHER INSPECTORS GENERAL.—The Inspector General of each of the Department of Defense, the Office of Personnel Management, and the Department of Veterans Affairs, and the Attorney General shall conduct audits, civil and criminal investigations, inspections, and evaluations relating to the prevention, detection, and control of health care fraud and abuse in violation of any Federal law, except that such an Inspector General may not conduct any investigation, audit, evaluation, or inspection with respect to the authorities described in subsection (a)(2)(A).

(c) COORDINATION WITH LAW ENFORCEMENT AGENCIES.—In carrying out the program under subsection (a), the Secretary and Attorney General may consult with, and arrange for the sharing of data and resources with Federal, State and local law enforcement agencies, State Medicaid Fraud Control Units, and State agencies responsible for the licensing and certification of health care providers (consistent with the requirements of subtitle C).

(d) COORDINATION WITH HEALTH PLANS.—In carrying out the program under subsection (a), the Secretary and Attorney General may consult with, and arrange for the sharing of data with representatives of certified health plans (consistent with the requirements of subtitle C).

(e) AUTHORITIES OF ATTORNEY GENERAL AND INSPECTOR GENERAL.—In carrying out duties under subsection (a), the Attorney General and the Inspector General are authorized—

(1) to conduct, supervise, and coordinate audits, civil and criminal investigations, inspections, and evaluations relating to the program established under such subsection; and

(2) to have access (including on-line access as requested and available) to all records available to certified health plans relating to the activities described in paragraph (1) (subject to restrictions based on the confidentiality of certain information under subtitle C).

(f) QUALIFIED IMMUNITY FOR PROVIDING INFORMATION.—The provisions of section 1157(a) of the Social Security Act (relating to limitation on liability) shall apply to a person providing information or communications to the Secretary or Attorney General in conjunction with their performance of duties under this section, in the same manner as such section applies to information provided to organizations with a contract under part B of title XI of such Act.

(g) AUTHORIZATIONS OF APPROPRIATIONS FOR INVESTIGATORS AND OTHER PERSONNEL.—In addition to any other amounts authorized to be appropriated to the Secretary and the Attorney General for health care anti-fraud and abuse activities for a fiscal year, there are authorized to be appropriated such additional amounts as may be necessary to enable the Secretary and the Attorney General to conduct investigations, audits, evaluations, and inspections of al-

legations of health care fraud and abuse and otherwise carry out the program established under subsection (a) in a fiscal year.

(h) USE OF POWERS UNDER INSPECTOR GENERAL ACT OF 1978.—For purposes of carrying out duties and responsibilities under this section, each Inspector General referred to in subsection (b) may exercise powers that are available to that Inspector General for purposes of audits, investigations, and other activities under the Inspector General Act of 1978 (5 U.S.C. App.).

(i) CONSTRUCTION OF FEDERAL AUTHORITY.—Nothing in this section may be construed to affect the authority of States to conduct investigations, audits, evaluations, and inspections relating to violations of State law.

(j) DEFINITION.—In this subtitle, the term "Inspector General" means the Inspector General of the Department of Health and Human Services.

SEC. 9412. ESTABLISHMENT OF ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—There is hereby created on the books of the Treasury of the United States an account to be known as the "All-Payer Health Care Fraud and Abuse Control Account" (in this section referred to as the "Anti-Fraud Account"), to be administered by the Inspector General of the Department of Health and Human Services. The Anti-Fraud Account shall consist of such gifts and bequests as may be made as provided in paragraph (2) and such amounts as may be deposited in such Anti-Fraud Account as provided in section 9401(d)(2) and title XI of the Social Security Act. It shall also include the following (but only with respect to activities of the Inspector General and the Attorney General under section 9411(a)(2)(A)):

(A) All criminal fines imposed in cases involving a Federal health care offense (as defined in subsection (d)).

(B) Penalties and damages imposed under the False Claims Act (31 U.S.C. 3729 et seq.), in cases involving claims related to the provision of health care items and services (other than funds awarded to a relator or for restitution).

(C) Administrative penalties and assessments imposed under titles XI, XVIII, and XIX of the Social Security Act and section 9401 (except as otherwise provided by law).

(D) Amounts paid under section 9403(d) (relating to a set-aside of amounts recovered under private right of action).

(D) Amounts resulting from the forfeiture of property by reason of a Federal health care offense.

Any such funds received on or after the date of the enactment of this Act shall be deposited in the Anti-Fraud Account.

(2) AUTHORIZATION TO ACCEPT GIFTS.—The Anti-Fraud Account is authorized to accept on behalf of the United States money gifts and bequests made unconditionally to the Anti-Fraud Account, for the benefit of the Anti-Fraud Account or any activity financed through the Anti-Fraud Account.

(b) USE OF FUNDS.—

(1) IN GENERAL.—Amounts in the Anti-Fraud Account shall be available without appropriation and until expended as determined jointly by the Secretary and Attorney General in carrying out the All-Payer Health Care Fraud and Abuse Control Program established under section 9411 (including the administration of the Program), and may be used to cover costs incurred in operating the Program, including—

(A) costs of prosecuting health care matters (through criminal, civil and administrative proceedings);

(B) costs of investigations (including equipment, salaries, administratively uncontrollable work, travel, and training of law enforcement personnel);

(C) costs of financial and performance audits of health care programs and operations;

(D) costs of inspections and other evaluations; and

(E) the costs of providing awards under section 3059(c)(2) of title 18, United States Code (as added by section 9428).

(2) FUNDS USED TO SUPPLEMENT AGENCY APPROPRIATIONS.—It is intended that disbursements made from the Anti-Fraud Account to any Federal agency be used to increase and not supplant the recipient agency's appropriated operating budget.

(c) ANNUAL REPORT.—The Inspector General shall submit an annual report to Congress on the amount of revenue which is generated and disbursed by the Anti-Fraud Account in each fiscal year.

(d) USE OF SUBACCOUNTS.—

(1) SUBACCOUNTS DESCRIBED.—The Account shall consist of—

(A) the Health Care Fraud and Abuse Expenses Subaccount; and

(B) the Health Care Fraud and Abuse Reserve Subaccount.

(2) EXPENSES SUBACCOUNT.—

(A) CONTENTS.—The Expenses Subaccount consists of—

(i) amounts deposited pursuant to subsection (a)(1); and

(ii) amounts transferred from the Reserve Subaccount under paragraph (3)(B).

(B) USE.—Amounts in the Expenses Subaccount shall be available to the Inspector General for the uses described in subsection (b).

(3) RESERVE SUBACCOUNT.—

(A) DEPOSITS.—An amount otherwise required under paragraph (2)(A) to be deposited in the Expenses Subaccount in a fiscal year shall be deposited in the Reserve Subaccount, if—

(i) the amount in the Expenses Subaccount is greater than $500,000,000; and

(ii) the deposit of that amount in the Expenses Subaccount would result in the amount in the Expenses Subaccount exceeding 110 percent of the total amount deposited in the Expenses Subaccount in the preceding fiscal year.

(B) TRANSFERS TO EXPENSES SUBACCOUNT.—

(i) ESTIMATION OF SHORTFALL.—Not later than the first day of the last quarter of each fiscal year, the Inspector General shall estimate whether sufficient amounts will be available during such quarter in the Expenses Subaccount for the uses described in paragraph (2)(B).

(ii) TRANSFER TO COVER SHORTFALL.—If the Inspector General estimates under paragraph (1) that there will not be available sufficient amounts in the Expenses Subaccount during the last quarter of a fiscal year, there shall be transferred from the Reserve Subaccount to the Expenses Subaccount such amount as the Inspector General estimates is required to ensure that sufficient amounts are available in the Expenses Subaccount during such quarter.

(C) LIMITATION ON AMOUNT CARRIED OVER TO SUCCEEDING FISCAL YEAR.—There shall be transferred to the general fund of the Treasury any amount remaining in the Reserve Subaccount at the end of a fiscal year (after any transfer made under subparagraph (B)) in excess of 10 percent of the total amount authorized to be deposited in the

Expenses Subaccount (consistent with subparagraph (A)) during the fiscal year.

(d) FEDERAL HEALTH CARE OFFENSE DEFINED.—The term "Federal health care offense" means a violation of, or a criminal conspiracy to violate—

(1) sections 226, 668, 1033, or 1347 of title 18, United States Code;

(2) section 1128B of the Social Security Act;

(3) sections 287, 371, 664, 666, 1001, 1027, 1341, 1343, or 1954 of title 18, United States Code, if the violation or conspiracy relates to health care fraud;

(4) sections 501 or 511 of the Employee Retirement Income Security Act of 1974, if the violation or conspiracy relates to health care fraud; or

(5) sections 301, 303(a)(2), or 303(b) or (e) of the Federal Food Drug and Cosmetic Act, if the violation or conspiracy relates to health care fraud.

(e) ACCOUNT PAYMENTS ADVISORY BOARD.—

(1) ESTABLISHMENT.—There is established the Account Payments Advisory Board, which shall make recommendations to the Inspector General regarding the equitable allocation of payments from the Anti-Fraud Account.

(2) MEMBERSHIP.—The Board shall consist of 10 members appointed by the Inspector General of the Department of Health and Human Services to represent Health Care Fraud and Abuse Control Units, of whom one shall be appointed—

(A) for each of the 10 regions established by the Director of the Office of Management and Budget under Office of Management and Budget Circular A-105, to represent Units in that region; and

(B) from among individuals recommended by the heads of those agencies in that region.

To the greatest extent feasible, the membership of the Board shall reflect the racial, ethnic, and gender composition of the population of the United States.

(3) TERMS.—The term of a member of the Board appointed under paragraph (2)(B) shall be 3 years, except that of such members first appointed 3 members shall serve an initial term of one year and 3 members shall serve an initial term of 2 years, as specified by the Inspector General at the time of appointment.

(4) VACANCIES.—A vacancy on the Board shall be filled in the same manner in which the original appointment was made, except that an individual appointed to fill a vacancy occurring before the expiration of the term for which the individual is appointed shall be appointed only for the remainder of that term.

(5) CHAIRPERSON AND BYLAWS.—The Board shall elect one of its members as chairperson and shall adopt bylaws.

(6) COMPENSATION AND EXPENSES.—Members of the Board shall serve without compensation, except that the Inspector General may pay the expenses reasonably incurred by the Board in carrying out its functions under this section.

(7) NO TERMINATION.—Section 14(a)(2) of the Federal Advisory Committee Act (5 U.S.C. App.) does not apply to the Board.

SEC. 9413. PAYMENTS TO STATES FOR HEALTH CARE FRAUD AND ABUSE CONTROL UNITS.

(a) PAYMENTS TO STATES.—

(1) IN GENERAL.—For each year for which a State has an annual plan approved under subsection (b)(3), and subject to the availability of appropriations authorized under subsection (e), the Inspector General of the Department of Health and Human Services shall pay to the State for each quarter an amount equal to 75 percent of the sums expended during the quarter by the Health Care Fraud and Abuse Control Unit de-

scribed in subsection (b)(1) in conducting activities described in that subsection.

(2) TIME OF PAYMENT.—The Inspector General shall make a payment under paragraph (1) for a quarter by not later than 30 days after the end of the quarter.

(b) STATE REQUIREMENTS FOR RECEIVING PAYMENTS.—A State is eligible to receive payments under subsection (a) if the State carries out the following activities:

(1) HEALTH CARE FRAUD AND ABUSE CONTROL UNIT REQUIREMENTS.—There is a Health Care Fraud and Abuse Control Unit established by the State which is a single identifiable entity of State government which is separate and distinct from any State agency with principal responsibility for the administration of health care programs, and meets the following requirements:

(A) The entity—

(i) is a unit of the office of the State Attorney General or of another department of State government that possesses statewide authority to prosecute individuals for criminal violations;

(ii) is in a State the constitution of which does not provide for the criminal prosecution of individuals by a statewide authority, and has formal procedures, approved by the Secretary, that assure it will refer suspected criminal violations relating to health care fraud or abuse in violation of Federal law to the appropriate authority or authorities of the State for prosecution and assure it will assist such authority or authorities in such prosecutions; or

(iii) has a formal working relationship with the office of the State Attorney General or the appropriate authority or authorities for prosecution and has formal procedures (including procedures under which it will refer suspected criminal violations to such office), that provide effective coordination of activities between the Health Care Fraud and Abuse Control Unit and such office with respect to the detection, investigation, and prosecution of suspected health care fraud or abuse in violation of Federal law.

(B) The entity conducts a statewide program for the investigation and prosecution of violations of all applicable State laws regarding any and all aspects of health care fraud and abuse in violation of Federal law.

(C) The entity has procedures for—

(i) reviewing complaints of the abuse or neglect of patients of health care facilities in the State, and

(ii) where appropriate, investigating and prosecuting such complaints under the criminal laws of the State or for referring the complaints to other State or Federal agencies for action.

(D) The entity provides for the collection, or referral for collection to the appropriate agency, of overpayments that—

(i) are made under any federally funded or mandated health care program required by this Act, and

(ii) it discovers in carrying out its activities.

(E) The entity employs attorneys, auditors, investigators, and other necessary personnel, is organized in such a manner, and provides sufficient resources, as is necessary to promote the effective and efficient conduct of its activities.

(2) SUBMISSION OF ANNUAL PLAN.—The Health Care Fraud and Abuse Control Unit of a State has a plan preventing, detecting, and controlling health care fraud and abuse in violation of State law which is approved by the Inspector General of the Department of Health and Human Services. The Inspec-

tor General shall approve a plan submitted under paragraph (3) by the Health Care Fraud and Abuse Control Unit of a State, unless the Inspector General establishes that the plan will not enable the Unit to prevent, detect, and control health care fraud and abuse in violation of Federal law.

(3) REPORTS.—The Health Care Fraud and Abuse Control Unit submits to the Inspector General an annual report containing such information as the Inspector General determines to be necessary.

(c) SEMIANNUAL REPORTS OF INSPECTOR GENERAL OF HEALTH AND HUMAN SERVICES.—The Inspector General shall include in its semiannual reports to the Congress under section 5(a) of the Inspector General Act of 1978 (5 U.S.C. App.) an assessment of the Inspector General of how well States are preventing, detecting, and controlling health care fraud and abuse.

(d) LIMITATION ON FEDERAL LAWS AFFECTED.—In this subsection, any reference to "Federal law" shall not include any law described in section 9411(a)(2)(A).

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for fiscal years beginning with fiscal year 1996 for payments under this section such sums as may be necessary for making such payments.

PART 3—AMENDMENTS TO CRIMINAL LAW

SEC. 9421. HEALTH CARE FRAUD.

(a) IN GENERAL.—Chapter 63 of title 18, United States Code, is amended by adding at the end the following:

"§ 1347. Health care fraud

"(a) Whoever knowingly executes, or attempts to execute, a scheme or artifice—

"(1) to defraud any health plan or other person, in connection with the delivery of or payment for health care benefits, items, or services;

"(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health plan or person in connection with the delivery of or payment for health care benefits, items, or services;

shall be fined under this title or imprisoned not more than 10 years, or both. If the violation results in serious bodily injury (as defined in section 1365 of this title) such person shall be imprisoned for life or any term of years.

"(b) As used in this section, the term 'health plan' has the meaning given such term in title V of the Guaranteed Health Insurance Act of 1994.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 63 of title 18, United States Code, is amended by adding at the end the following:

"1347. Health care fraud.".

SEC. 9422. FORFEITURES FOR VIOLATIONS OF FRAUD STATUTES.

(a) IN GENERAL.—Section 982(a) of title 18, United States Code, is amended by inserting after paragraph (5) the following:

"(6) The court, in imposing sentence on a person convicted of a Federal health care offense (as defined in section 9412(d) of the Guaranteed Health Insurance Act of 1994) shall order the person to forfeit any real or personal property that—

"(A) is used in the commission of the offense, if the offense results in a financial loss or gain of $50,000 or more; or

"(B) constitutes or is derived from proceeds traceable to the commission of the offense.".

(b) PROCEEDS OF HEALTH CARE FRAUD FORFEITURES.—Section 524(c)(4)(A) of title 28, United States Code, is amended by inserting "all proceeds of forfeitures relating to Federal health care offenses

(as defined in section 9412(d) of the Guaranteed Health Insurance Act of 1994), and" after "except".

SEC. 9423. FALSE STATEMENTS.

(a) IN GENERAL.—Chapter 47 of title 18, United States Code, is amended by adding at the end the following:

"§ 1033. False statements relating to health care matters

"(a) Whoever, in any matter involving a health plan, knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious, or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry, shall be fined under this title or imprisoned not more than 5 years, or both.

"(b) As used in this section the term 'health plan' has the meaning given such term in title V of the Guaranteed Health Insurance Act of 1994.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 47 of title 18, United States Code, is amended by adding at the end the following:

"1033. False statements relating to health care matters.".

SEC. 9424. BRIBERY AND GRAFT.

(a) IN GENERAL.—Chapter 11 of title 18, United States Code, is amended by adding at the end the following:

"§ 226. Bribery and graft in connection with health care

"(a) Whoever—

"(1) directly or indirectly, corruptly gives, offers, or promises anything of value to a health care official, or offers or promises a health care official to give anything of value to any other person, with intent—

"(A) to influence any of the health care official's actions, decisions, or duties relating to a health plan;

"(B) to influence such an official to commit or aid in the committing, or collude in or allow, any fraud, or make opportunity for the commission of any fraud, on a health plan; or

"(C) to induce such an official to engage in any conduct in violation of the lawful duty of such official; or

"(2) being a health care official, directly or indirectly, corruptly demands, seeks, receives, accepts, or agrees to accept anything of value personally or for any other person or entity, the giving of which violates paragraph (1) of this subsection;

shall be fined under this title or imprisoned not more than 15 years, or both.

"(b) Whoever, otherwise than as provided by law for the proper discharge of any duty, directly or indirectly gives, offers, or promises anything of value to a health care official, for or because of any of the health care official's actions, decisions, or duties relating to a health plan, shall be fined under this title or imprisoned not more than two years, or both.

"(c) As used in this section—

"(1) the term 'health care official' means—

"(A) an administrator, officer, trustee, fiduciary, custodian, counsel, agent, or employee of any health plan;

"(B) an officer, counsel, agent, or employee, of an organization that provides services under contract to any health plan;

"(C) an official or employee of a State agency having regulatory authority over any health plan;

"(D) an officer, counsel, agent, or employee of a health care sponsor; and

"(2) the term 'health care sponsor' means any individual or entity serving as the sponsor of a health plan for purposes of the Guaranteed Health Insurance Act of 1994, and includes the

joint board of trustees or other similar body used by two or more employers to administer a health plan for purposes of such Act.".

(b) CLERICAL AMENDMENT.—The table of chapters at the beginning of chapter 11 of title 18, United States Code, is amended by adding at the end the following:

"226. Bribery and graft in connection with health care.".

SEC. 9425. INJUNCTIVE RELIEF RELATING TO HEALTH CARE OFFENSES.

Section 1345(a)(1) of title 18, United States Code, is amended—

(1) by striking "or" at the end of subparagraph (A);

(2) by inserting "or" at the end of subparagraph (B); and

(3) by adding at the end the following:

"(C) committing or about to commit a Federal health care offense (as defined in section 9412(d) of the Guaranteed Health Insurance Act of 1994);".

SEC. 9426. GRAND JURY DISCLOSURE.

Section 3322 of title 18, United States Code, is amended—

(1) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(2) by inserting after subsection (b) the following:

"(c) A person who is privy to grand jury information concerning a health law violation—

"(1) received in the course of duty as an attorney for the Government; or

"(2) disclosed under rule 6(e)(3)(A)(ii) of the Federal Rules of Criminal Procedure;

may disclose that information to an attorney for the Government to use in any civil proceeding related to a Federal health care offense (as defined in section 9412(d) of the Guaranteed Health Insurance Act of 1994).".

SEC. 9427. THEFT OR EMBEZZLEMENT.

(a) IN GENERAL.—Chapter 31 of title 18, United States Code, is amended by adding at the end the following:

"§ 668. Theft or embezzlement in connection with health care

"(a) Whoever embezzles, steals, willfully and unlawfully converts to the use of any person other than the rightful owner, or intentionally misapplies any of the moneys, securities, premiums, credits, property, or other assets of a health plan or of any fund connected with such a plan, shall be fined under this title or imprisoned not more than 10 years, or both.

"(b) As used in this section, the term 'health plan' has the meaning given such term under title V of the Guaranteed Health Insurance Act of 1994.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 31 of title 18, United States Code, is amended by adding at the end the following:

"668. Theft or embezzlement in connection with health care.".

SEC. 9428. REWARDS FOR INFORMATION LEADING TO PROSECUTION AND CONVICTION.

Section 3059 of title 18, United States Code, is amended by adding at the end the following:

"(c)(1) The Attorney General may pay a reward not more than $50,000 to any person who furnishes information or services that lead to a conviction of a Federal health care offense as defined by section 9412 of the Guaranteed Health Insurance Act of 1994.

"(2) Rewards under this subsection are authorized to be paid out of the All-Payer Health Care Fraud and Abuse Control Account established under section 9412 of the Guaranteed Health Insurance Act of 1994.

"(3) An officer or employee of the United States (including a fiscal intermediary or carrier carrying out a program on behalf of the United States) or of a State or local government who furnishes information or renders services in the performance of official duty is ineligible for a payment under this subsection with respect to such information or services.

"(4) The granting or decision not to grant a reward under this subsection is not reviewable in any court.".

PART 4—AMENDMENTS TO CIVIL FALSE CLAIMS ACT

SEC. 9431. AMENDMENTS TO CIVIL FALSE CLAIMS ACT.

Section 3729 of title 31, United States Code, is amended—

(1) in subsection (a)(7), by inserting "or to a health plan" after "property to the Government";

(2) in the matter following subsection (a)(7), by inserting "or health plan" before "sustains because of the act of that person,";

(3) at the end of the first sentence of subsection (a), by inserting "or health plan" before "sustains because of the act of the person.";

(4) in subsection (c)—

(A) by inserting "the term" after "section,"; and

(B) by adding at the end the following: "The term also includes any request or demand, whether under contract of otherwise, for money or property which is made or presented to a health plan."; and

(5) by adding at the end the following:

"(f) HEALTH PLAN DEFINED.—For purposes of this section, the term 'health plan' has the meaning given such term under title V of the Guaranteed Health Insurance Act of 1994.".

PART 5—AMENDMENTS TO ANTI-FRAUD AND ABUSE PROVISIONS APPLICABLE TO MEDICARE, MEDICAID, AND STATE HEALTH CARE PROGRAMS

SEC. 9441. REFERENCE TO AMENDMENTS.

For provisions amending the anti-fraud and abuse provisions existing under the Social Security Act, see part 5 of subtitle D of title VIII.

PART 6—PREEMPTION OF STATE CORPORATE PRACTICE LAWS

SEC. 9451. PREEMPTION OF STATE LAWS PROHIBITING CORPORATE PRACTICE OF MEDICINE.

No provision of State or local law shall apply that prohibits a corporation from practicing medicine.

Subtitle F—Physician Ownership and Referral

PART 1—EXTENSION OF LIMITATIONS ON SELF-REFERRAL UNDER MEDICARE TO REFERRALS UNDER PRIVATE PLANS

SEC. 9501. LIMITATIONS ON PHYSICIAN SELF-REFERRAL UNDER PRIVATE PLANS.

The provisions of section 1877 of the Social Security Act shall apply to items and services (and payments and claims for payment for such items and services) furnished under any certified health plan in the same manner as such provisions apply to designated health services (and payments and claims for payment for such services) under title XVIII of the Social Security Act.

SEC. 9502. CONSTRUCTION OF SOCIAL SECURITY ACT REFERENCES.

(a) INCORPORATION OF OTHER AMENDMENTS.—Any reference in this part to a provision of the Social Security Act shall be considered a reference to the provision as amended under part 6 of subtitle D of title VIII.

(b) EFFECT OF SUBSEQUENT AMENDMENTS.—Except as provided in subsection (a), any reference to a provision of the Social Security Act in this part shall be deemed to be a reference to such provision as in effect on the date of the enactment of this Act, and (except as Congress may otherwise provide) any amendments made to such provisions after such date shall not be taken into account in determining the applicability of such provisions to individuals and entities under this Act.

PART 2—AMENDMENTS TO PHYSICIAN OWNERSHIP AND REFERRAL PROVISIONS UNDER MEDICARE

SEC. 9511. REFERENCE TO AMENDMENTS.

For provisions amending section 1877 of the Social Security Act, see part 6 of subtitle D of title VIII.

Subtitle G—Workforce Protection and Training

SEC. 9600. DEFINITIONS.

For purposes of this subtitle:

(1) EMPLOY.—The term "employ" includes to suffer or permit to work.

(2) EMPLOYEE.—

(A) IN GENERAL.—The term "employee" means—

(i) any individual employed by an employer or otherwise having the status of an employee, taking into account the factors described in subparagraph (B);

(ii) any officer of a corporation;

(iii) any individual (not described in clauses (i) through (ii)) who performs for remuneration services described in section 210(j) of the Social Security Act; and

(iv) an individual described in subparagraph (C).

(B) APPLICATION OF FACTORS REFLECTING ECONOMIC DEPENDENCE.—An individual shall be deemed to be employed taking into account (and to the extent that) the following factors apply:

(i) The individual has a low degree of control over the circumstances under which the services are performed.

(ii) The individual lacks opportunities for profit or loss in performing the services.

(iii) The individual does not have an investment in facilities or equipment used in performing the services.

(iv) The individual's relation with the person (for whom the services are provided) is not temporary.

(v) The services performed for the person represent a high percentage of all services performed by the individual.

(vi) The individual's performance of the services does not require a high degree of skill.

(C) INCLUSION OF CERTAIN CONTRACT RELATIONSHIPS.—The term "employee" includes, with respect to any employer which during the preceding year had gross receipts in excess of an amount specified by the Secretary of Labor (which amount shall not be less than $10,000,000), an individual who performs services for the employer if—

(i) the services are not performed by the individual as an employee of another employer or as a leased employee (as defined in paragraph (8)(C));

(ii) the contract or other arrangement for services contemplates that substantially all of such services are to be performed personally by such individual; and

(iii) the individual performs the services—

(I) on the premises owned or leased by the employer,

(II) using facilities or equipment in which the employer has a substantial investment, or

(III) using facilities and equipment in which the individual does not have a substantial investment.

(D) EXCLUSION OF VOLUNTEERS.—The term "employee" does not include any individual who volunteers to perform services for a public agency which is a State, a political subdivision of a State or an interstate governmental agency, if—

(i) the individual receives no compensation other than reasonable expenses or a nominal fee to perform the services for which the individual volunteered, and

(ii) such services are not the same type of services which the individual is employed to perform for such public agency.

An employee of a public agency which is a State, political subdivision of a State, or an interstate governmental agency may volunteer to perform services for any other State, political subdivision, or interstate governmental agency, including a State, political subdivision, or agency with which the employing State, political subdivision, or agency has a mutual aid agreement.

(E) EXCEPTION FOR CERTAIN IMMEDIATE FAMILY.—Except as provided by the Secretary of Labor in regulations, a child under the age of 18 shall not be considered to be an employee by virtue of service performed for the child's parent or guardian.

(F) EXCLUSION OF EMPLOYEES OUTSIDE THE UNITED STATES.—The term "employee" does not include an individual who does not reside in the United States.

(G) EXCLUSION OF FOREIGN EMPLOYMENT.—The term "employee" does not include an individual—

(i) with respect to service, if the individual is not a citizen or resident of the United States and the service is performed outside the United States, or

(ii) with respect to service, if the individual is a citizen or resident of the United States and the service is performed outside the United States for an employer other than an American employer (as defined in section 210(e) of the Social Security Act).

(H) EXCLUSION OF INMATES AS EMPLOYEES.—An individual shall not be treated as an employee by virtue of services performed in a penal institution by an inmate thereof or in a hospital or other health care institution by a patient thereof.

(I) APPLICATION OF CONTROL GROUP RULES FOR EMPLOYERS.—For purposes of this subtitle:

(i) Two or more trades or businesses, whether or not incorporated, shall be deemed a single employer if such trades or businesses are within the same control group.

(ii) The term "control group" means a group of trades or businesses under common control.

(iii) The determination of whether a trade or business is under common control with another trade or business shall be determined under regulations of the Secretary of Labor applying principles similar to the principles applied under section 4001(a)(14)(B) of the Employee Retirement Income Security Act of 1974.

(iv) Under regulations of the Secretary of Labor, all employees of organizations which are under common control with one or more organizations which are exempt from income tax under subtitle A of the Internal Revenue Code of 1986 shall be treated as employed by a single employer.

The regulations prescribed under clause (iv) shall be based on principles similar to the principles which apply to taxable organizations under clause (iii).

(J) ANTI-EVASION RULES.—An individual shall be treated as an employee of a person if the individual would otherwise be treated as such an employee but for an action which was undertaken by the person or another on the person's behalf to evade responsibilities imposed under this subtitle with respect to the individual as an employee.

(K) EXEMPTION OF EMPLOYEES WHO ARE MEMBERS OF CERTAIN RELIGIOUS FAITHS.—A member of certain religious faiths (as defined in section 1402(g) of the Internal Revenue Code of 1986) who elects to waive all benefits and payments provided under this Act (or the Social Security Act) with respect to the guaranteed national benefit package shall not be considered an employee for purposes of this subtitle. The election under the previous sentence shall be consistent with the waiver of benefits under section 202(v) of the Social Security Act.

(3) EMPLOYER.—

(A) IN GENERAL.—The term "employer"—

(i) means any person engaged in any activity, business or industry in commerce or affecting commerce that employs an individual;

(ii) includes any person who acts, directly or indirectly, in the interest of an employer in relation to any of the employees of such employer; and

(iii) includes any public agency (as defined in section 3(x) of the Fair Labor Standards Act, 29 U.S.C. 203(x)).

(B) COMMERCE.—The term "commerce" means trade, traffic, commerce, transportation, or communication among the several States, or between the District of Columbia or any Territory of the United States and any State or other Territory, or between any foreign country and any State, Territory, or the District of Columbia, or within the dis-

trict of Columbia or any Territory, or between points in the same State but through any other State or any Territory or the District of Columbia or any foreign country.

(C) AFFECTING COMMERCE.—The term "affecting commerce" means in commerce, or burdening or obstructing commerce or the free flow of commerce.

(D) SUCCESSOR EMPLOYER.—An employer is a "successor employer" if, based on the facts and circumstances, on balance after applying at least the following criteria, and consistent with any regulations promulgated by the Secretary of Labor, the employer has substantially assumed the employment-related responsibilities of another employer:

(i) Substantial continuity of the same business operations.

(ii) Use of the same plant, common facility, or work site.

(iii) Continuity of the work force.

(iv) Similarity of jobs and working conditions.

(v) Similarity of supervisory personnel.

(vi) Similarity in machinery, equipment, and productions methods.

(vii) Similarity of products or services.

(E) TREATMENT OF COMMON EMPLOYMENT.—The Secretary of Labor may promulgate regulations regarding responsibilities of employers in the case of common employment of an employee by such employers.

(4) FULL-TIME EQUIVALENT EMPLOYEES; PART-TIME EMPLOYEES.—

(A) IN GENERAL.—For purposes of this subtitle, subject to subparagraphs (D) and (E) a qualifying employee who is employed by an employer—

(i) for at least 120 hours in a month, is counted as one full-time equivalent employee for the month and shall be deemed to be employed on a full-time basis; or

(ii) for at least 40 hours, but less than 120 hours, in a month, is counted as a fraction of a full-time equivalent employee in the month equal to the full-time employment ratio (as defined in subparagraph (B)) for the employee and shall be deemed to be employed on a part-time basis.

(B) FULL-TIME EMPLOYMENT RATIO DEFINED.—For purposes of this subtitle, the term "full-time employment ratio" means, with respect to a qualifying employee of an employer in a month, subject to subparagraph (E), the lesser of 1 or the ratio of—

(i) the number of hours of employment such employee is employed by such employer for the month (as determined under paragraph (6)); to

(ii) 120 hours.

(C) FULL-TIME EMPLOYEE; PART-TIME EMPLOYEE.—For purposes of this subtitle, subject to subparagraphs (D) and (E), the terms "full-time employee" and "part-time employee" mean, with respect to an employer, an employee who is employed on a full-time basis or part-time basis (as specified in subparagraph (A)), respectively, by the employer.

(D) CONSIDERATION OF INDUSTRY PRACTICE.—As provided under rules established by the Secretary of Labor, an employee who is not described in subparagraph (C) shall be considered to be employed on a full-time or part-time basis by an employer (and to be a full-time or part-time employee of an employer) for a month (or for all months in a 12-month period) if the employee is employed by that employer on a continuing basis that, taking into

account the structure or nature of the employment in the industry, represents full time or part time employment, respectively.

(E) EMPLOYMENT AT EDUCATIONAL INSTITUTIONS.—With respect to employees of an institution of higher education (as defined in section 1201(a) of the Higher Education Act of 1965) or of an elementary or secondary school (as defined in section 1471 of the Elementary and Secondary Education Act of 1965) who are exempt under section 13 of the Fair Labor Standards Act of 1938—

(i) the employees shall be considered to be employed on a full-time basis (and to be a full-time employee) if they work the customary hours that constitute full-time employment as defined at such institution;

(ii) the number of hours and, with respect to less-than-full-time employees at such an institution, the number of such customary hours shall be substituted for 120 in subparagraphs (A) and (B)(ii); and

(iii) such employees who are regular seasonal employees who are not paid during summer months or other regular periods of the year, but are assured employment at the end of such periods, shall be considered to be employed year round.

(5) HEALTH CARE EMPLOYER.—The term "health care employer" means an employer that—

(A) provides health care items or services (including such items and services not included in the guaranteed national benefit package); or

(B) provides necessary related services, including administrative, food service, janitorial or maintenance services, to an entity that provides health care items or services (as described in subparagraph (A));

except that an employer that solely manufactures or provides goods or equipment to a health care employer shall not be considered a health care employer.

(6) HOURS OF EMPLOYMENT.—

(A) IN GENERAL.—For purposes of this subtitle, the Secretary shall specify the method for computing hours of employment for employees of an employer consistent with this paragraph. The Secretary shall take into account rules used for purposes of applying the Fair Labor Standards Act of 1938.

(B) HOURLY WAGE EARNERS.—In the case of an individual who receives compensation (in the form of hourly wages or compensation) for the performance of services, the individual is considered to be "employed" by an employer for an hour if compensation is payable with respect to that hour of employment, without regard to whether or not the employee is actually performing services during such hour.

(7) QUALIFYING EMPLOYEE.—

(A) IN GENERAL.—The term "qualifying employee" means, with respect to an employer for a month, an employee (other than a young dependent, as defined in subparagraph (B)) who is employed by the employer for at least 40 hours (as determined under paragraph (6)) in the month.

(B) YOUNG DEPENDENT DEFINED.—In subparagraph (A), the term "young dependent" means an eligible individual who is a young dependent (as defined in section 1003(b)(1)(B)) and is enrolled under a health plan as a family member (as defined in section 1104(c)(2)(B)).

(8) TREATMENT OF EMPLOYEE LEASING ARRANGEMENTS.—

(A) TREATMENT AS EMPLOYEE OF LEASING ORGANIZATION.—Except as provided in subparagraph (B), with re-

spect to any person (in this paragraph referred to as the "recipient") for whom a leased employee (as defined in subparagraph (C)) performs services the leased employee shall not be treated as an employee of the recipient.

(B) APPLICATION IN RELATION TO WORKFORCE STABILITY.—For purposes of applying sections 9621(b) and 9624(b) (relating to transitional provisions for workforce stability), leased employees shall be treated as employees of the recipient and of the leasing organization.

(C) LEASED EMPLOYEE.—For purposes of this paragraph, the term "leased employee" means any person who is not an employee of the recipient and who provides services to the recipient if—

(i) such services are provided pursuant to an agreement between the recipient and any other person (in this paragraph referred to as the "leasing organization"); and

(ii)(I) such services are of a type historically performed, in the business field of the recipient, by employees;

(II) the person provides services to the recipient for at least such number of hours per week (or such percentage of the person's time) as the Secretary of Labor specifies; or

(III) the tasks performed by the person are functionally integrated with the operations of the recipient and performed on the premises of (or using the facilities and equipment of) the recipient.

(9) TREATMENT OF EMPLOYEES IN THE ENTERTAINMENT INDUSTRY.—In the case of employees in the entertainment industry, the Secretary shall establish special rules to determine what constitutes full-time and part-time work in the industry. Such rules shall take into account the historic employment patterns in the industry.

(10) TREATMENT OF FRANCHISE NETWORKS.—

(A) IN GENERAL.—The Secretary of Labor shall prescribe regulations regarding the circumstances under which individuals performing services for a franchisee are treated as employees of a franchise network.

(B) DEFINITIONS.—For purposes of this paragraph, the terms "franchisee" and "franchise network" have the meanings given such terms in regulations of the Federal Trade Commission published in part 436 of title 16, Code of Federal Regulations.

(11) TREATMENT OF SALARIED EMPLOYEES AND EMPLOYEES PAID ON CONTINGENT OR BONUS ARRANGEMENTS.—In the case of an employee who receives compensation on a salaried basis or on the basis of a commission (or other contingent or bonus basis), rather than an hourly wage, the Secretary of Labor shall establish rules for the conversion of the compensation to hours of employment, taking into account the minimum monthly compensation levels for workers employed on a full-time basis under the Fair Labor Standards Act of 1938 and other factors the Secretary considers relevant.

(12) WAGES.—

(A) IN GENERAL.—The term "wages" has the meaning given such term in section 209(a) of the Social Security Act, except that paragraph (1) shall not apply.

(B) TIPS NOT INCLUDED.—The term "wages" does not include cash tips.

PART 1—GENERAL EMPLOYER RESPONSIBILITIES

SEC. 9601. PROHIBITION OF CERTAIN EMPLOYER DISCRIMINATION.

(a) PROHIBITION OF FAMILY DISCRIMINATION.—No employer may discriminate with respect to an employee on the basis of the family status of the employee or on the basis of the class of family enrollment selected with respect to the employee.

(b) EVASION OF OBLIGATIONS.—It shall be unlawful for any employer or other person to discharge, fine, suspend, expel, discipline, discriminate or otherwise take adverse action against any employee if a purpose of such action is to interfere with the employee's attainment of status as a qualifying employee, as a full-time employee, or as a part-time employee, or if a purpose of such action is to evade or avoid any obligation under this Act.

(c) ENFORCEMENT.—In the case of a person that violates a requirement of this section, the Secretary of Labor may impose a civil money penalty, in an amount not to exceed $10,000, for each violation with respect to each individual with respect to whom a violation occurred. The provisions of section 503 of the Migrant and Seasonal Agricultural Worker Protection Act (other than subsection (a)) shall apply to civil money penalties under this subsection in the same manner as such provisions apply to a penalty under such Act.

SEC. 9602. WHISTLEBLOWER PROTECTION.

(a) EMPLOYEE PROTECTIONS.—No entity under this Act may discharge, discriminate, or otherwise take adverse action against any employee with respect to compensation, terms, conditions, or privileges of employment because the employee (or any other person acting pursuant to a request of the employee) provided information to any Federal, State, or public or private supervisory agency or entity regarding a possible violation of any provision of this Act or any regulation issued pursuant to this Act.

(b) COURT ACTION.—

(1) IN GENERAL.—An employee or former employee who believes that such employee was discharged, discriminated, or otherwise subject to adverse action in violation of subsection (a), may file a civil action in the appropriate district court of the United States not later than two years after the date of such discharge, discrimination, or adverse action.

(2) DAMAGES.—If the court determines that a violation of subsection (a) has occurred, the plaintiff may obtain appropriate relief, including actual, compensatory, and punitive damages and equitable relief (including reinstatement).

(3) ATTORNEY'S FEES AND COSTS.—In any action under paragraph (1) in which the plaintiff substantially prevails, the court shall award the plaintiff reasonable attorney's fees (at generally prevailing hourly rates), reasonable expert witness fees, and other reasonable costs, unless the court finds that such award would not be appropriate.

SEC. 9603. EMPLOYER NEUTRALITY.

Federal funds appropriated to carry out this Act, other than funds appropriated pursuant to title XVIII, XIX, XXI, or XXII of the Social Security Act, may not be used to assist, promote, or deter union organizing.

PART 2—TRANSITIONAL PROVISIONS FOR WORKFORCE STABILITY

SEC. 9621. APPLICATION.

(a) LIMITATION TO TRANSITION PERIOD.—The provisions of this part are intended to minimize, to the extent possible, disruptions in established employment relationships during the period of transition to a restructured health care delivery system, and shall terminate on January 1, 2004.

(b) HEALTH CARE EMPLOYERS COVERED BY PART.—The provisions of this part, including references to displacing employers, hiring employers, successors and contractors, apply only to health care employers (including successor employers) that employ more than 15 covered employees on a typical business day.

(c) COVERED EMPLOYEES DEFINED.—In this part, the term "covered employee" means an employee of a health care employer.

(d) INCLUSION OF SUCCESSOR EMPLOYERS.—In this part, the term "employer" includes a successor employer of the employer.

SEC. 9622. OBLIGATIONS OF DISPLACING EMPLOYER AND AFFILIATED ENTERPRISES IN EVENT OF DISPLACEMENT.

(a) NOTICE.—A health care employer which displaces a preference eligible employee (as defined in subsection (e)) shall provide such employee with—

(1) written notice, no later than the date of displacement, of employment rights under this part; and

(2) notice of any existing or subsequent vacancies with the displacing employer, which notice may be given by posting of such vacancies wherever notices to applicants for employment are customarily posted, by listing such vacancies with the local employment services agency, or in such other manner as the Secretary of Labor, by regulation, may specify.

Any such vacancy shall remain open for applications by preference eligible employees for not less than 14 calendar days from the date on which the initial notice is provided.

(b) HIRING PREFERENCE.—

(1) IN GENERAL.—A preference eligible employee who—

(A) meets any qualifications described in paragraph (3); and

(B) applies during the notice period described in subsection (a)(2) for a vacant position with the displacing employer which is in the employee's occupational specialty and located in the same State or Metropolitan Statistical Area in which the employee was employed prior to the displacement,

shall be given the right to accept or decline the position before the employer may offer the position to an employee who is not a preference eligible employee.

(2) MULTIPLE APPLICATIONS.—When considering applications from more than one preference eligible employee described in paragraph (1), the hiring health care employer shall have discretion as to which of such employees will be offered the position.

(3) EMPLOYMENT QUALIFICATION REQUIREMENTS.—A hiring health care employer may establish reasonable employment qualifications for a vacancy to which this part applies, except that an employee who performed essentially the same work prior to the employee's displacement shall be deemed presumptively qualified for a comparable position.

(c) TERMINATION OF PREFERENCE ELIGIBILITY.—Subject to section 9621(a), a displaced employee's preference eligibility shall terminate at such time as the displaced employee obtains substantially equivalent employment with the displacing employer.

(d) NOTICE OF JOB OPENINGS.—A health care employer, to the extent practicable, shall list all job openings for covered employees with the job bank established by the Employment Service.

(e) DEFINITIONS.—In this part:

(1) PREFERENCE ELIGIBLE EMPLOYEE.—The term "preference eligible employee" means an employee who—

(A) has been employed as a covered employee for in excess of one year by a health care employer; and

(B) has been displaced by or has received notice of an impending displacement by such employer.

(2) DISPLACEMENT.—The term "displacement" includes a lay off, termination, significant cutback in paid work hours, or other loss of employment, except that a discharge for just cause

shall not constitute a displacement within the meaning of this paragraph.

SEC. 9623. EMPLOYMENT WITH OTHER HEALTH CARE EMPLOYERS.

A health care employer that replaces another health care employer in whole or in part through merger, consolidation, acquisition, contract, or other similar manner shall—

(1) provide employees who would otherwise be displaced the right to continued employment in the job positions previously held by such employees, unless the employer can establish that such positions no longer exist; and

(2) for six months from the date of their displacement by the predecessor, provide employees who are not rehired under paragraph (1) notice and the right to employment in any vacancies that become available in such job positions.

SEC. 9624. COLLECTIVE BARGAINING OBLIGATIONS DURING TRANSITION PERIOD.

(a) CONTINUATION OF PREVIOUSLY RECOGNIZED BARGAINING REPRESENTATIVES AND AGREEMENTS.—If a majority of the employees in an appropriate bargaining unit of employees of a health care employer consists of employees who were previously covered by a bargaining agreement or represented by an exclusive representative with respect to the terms and conditions of employment with the predecessor health care employer, and there has not been a substantial change in the operations performed by the employees in that unit, the employer shall recognize such representative as the exclusive representative for the unit and shall assume the bargaining agreement, except that if the application of this subsection would result in the recognition of more than one bargaining representative for a single unit, the question concerning which representative shall be recognized as the exclusive representative for the unit shall be resolved in accordance with applicable Federal or State law.

(b) JOINT EMPLOYER STATUS.—If employees of a contractor to a health care employer are assigned on a regular basis to perform work on the premises of a health care employer and the tasks performed by these employees are functionally integrated with the operations of the health care employer on whose premises such employees work, both the contractor and the health care employer shall be considered joint employers of the employees with respect to work performed on those premises for purposes of determining compliance with labor relations laws. Employees of such joint employers may not be excluded from a bargaining unit within either entity on the basis of such joint employer status.

SEC. 9625. GENERAL PROVISIONS.

(a) REGULATIONS.—Not later than 120 days after the date of enactment of this Act, the Secretary of Labor shall promulgate regulations to implement the requirements of this part.

(b) OTHER LAWS.—The standards and requirements of this part shall not preempt or excuse noncompliance with any other applicable Federal or State law, regulation, or municipal ordinance that establishes additional notice and preference standards or requirements concerning employee dislocation, employee representation, or collective bargaining.

(c) RULES OF CONSTRUCTION.—Nothing in this part shall be construed to excuse or otherwise limit the obligation of an employer to comply with the terms of any collective bargaining agreement or of any employee benefit plan that provides employees with rights in addition to those provided under this part.

(d) DISCRIMINATION.—In making decisions that would result in the displacement, retention, hiring or transfer of employees, a health care employer may not discriminate between or among employees on the basis of their protected status under this part or under any other Federal or State laws.

(e) ENFORCEMENT.—Unless otherwise specifically provided in this part, the enforcement provisions of section 107 of the Family

and Medical Leave Act of 1993 shall apply (except that the limitation of paragraph (1) of subsection (a) shall not apply) with respect to the enforcement of the individual rights, including notice requirements, provided under section 9622 and 9623. The collective bargaining and contractual rights provided under section 9624 shall be enforced through administrative and judicial procedures otherwise provided under Federal or State law with respect to such rights.

PART 3—RESPONSIBILITIES OF BOARD OF INQUIRY

SEC. 9631. REQUEST FOR APPOINTMENT OF BOARD OF INQUIRY.

(a) IN GENERAL.—A health care employer or a labor organization that has been lawfully certified or recognized as the representative of the employees of a health care employer for the purpose of engaging in collective bargaining concerning wages, hours and other terms and conditions of employment, may request that the Director of the Federal Mediation and Conciliation Service (referred to in this section as the "Director") appoint an impartial Health Care Board of Inquiry to investigate the issues involved in a collective bargaining dispute between the employer and the labor organization.

(b) TIME FOR REQUEST.—Such request may be made no earlier than 60 days after notice of the existence of a collective bargaining dispute has been provided to—

(1) the Federal Mediation and Conciliation Service in accordance with clause (A) or (B) of the last sentence of section 8(d) of the Labor Management Relations Act; or

(2) if the health care employer is otherwise exempt from coverage under such Act, any comparable State or territorial agency established to mediate and conciliate disputes to which notice is required to be given under applicable State law.

SEC. 9632. APPOINTMENT OF BOARD OF INQUIRY.

(a) IN GENERAL.—Except as provided in subsection (b), the Director shall appoint a Health Care Board of Inquiry not later than 10 days after receipt of a request under section 9631. Each such Board shall be composed of such number of individuals as the Director may deem desirable. No member appointed under this section shall have any interest or involvement in a health care employer, or a labor organization, involved in the collective bargaining dispute. To the greatest extent feasible, the membership of a Board shall reflect the racial, ethnic, and gender composition of the population of the community served by the health care employer involved.

(b) LIMITATION.—With respect to the appointment of a Health Care Board of Inquiry under paragraph (1), if the Director determines that—

(1) the health care employer is—

(A) otherwise exempt from coverage under the Labor Management Relations Act, as amended; and

(B) subject to State laws containing procedures for the resolution of impasses in collective bargaining that are comparable to those that would be followed by a Board of Inquiry under this section; or

(2) the parties involved have agreed to procedures for the resolution of the impasse in collective bargaining that are comparable to those that would be followed by a Board of Inquiry;

the Director may refuse the request for the appointment of such a Board.

SEC. 9633. PUBLIC FACT FINDING.

A Health Care Board of Inquiry appointed under this section shall investigate the issues involved in the dispute and make a written report thereon to the parties and to the Director within 30 days after the establishment of such a Board. The written report

shall contain the findings of fact together with the Board's recommendations for settling the dispute, with the objective of achieving a prompt, peaceful and just settlement of the dispute. The Board shall arrange for publication of such report within the community served by the health care employer involved.

SEC. 9634. COMPENSATION OF MEMBERS OF BOARD OF INQUIRY.

(a) EMPLOYEES OF FEDERAL GOVERNMENT.—Members of any Board established under this part who are otherwise employed by the Federal Government shall serve without compensation but shall be reimbursed for travel, subsistence, and other necessary expenses incurred by them in carrying out its duties under this section.

(b) OTHER MEMBERS.—Members of any Board established under this section who are not subject to paragraph (1) shall receive compensation at a rate prescribed by the Director but not to exceed the daily rate prescribed for GS-18 of the General Schedule under section 5332 of title 5, including travel for each day they are engaged in the performance of their duties under this section and shall be entitled to reimbursement for travel, subsistence, and other necessary expenses incurred by them in carrying out their duties under this part.

SEC. 9635. MAINTENANCE OF TERMS AND CONDITIONS OF EMPLOYMENT.

Beginning on the date on which a Board is requested under section 9631 and ending 15 days after the date any such Board has issued its report, no change in the terms and conditions of employment in effect prior to the expiration of the contract in the case of negotiations for a contract renewal, or in effect prior to the time the parties begin their bargaining in the case of an initial beginning negotiations, except by agreement, shall made by the parties to the collective bargaining dispute.

PART 4—WORKFORCE PRIORITIES UNDER FEDERAL PAYMENTS

SEC. 9641. PROGRAMS OF THE SECRETARY OF LABOR.

(a) IN GENERAL.—

(1) FUNDING.—(A) For purposes of carrying out the programs described in this section, and for carrying out section 9642, there is authorized to be appropriated $200,000,000 for fiscal year 1995 and each subsequent fiscal year.

(B) Of the total amount authorized for each fiscal year under subparagraph (A)—

(i) not more than $10,000,000 may be used to carry out the program under subparagraph (B) of subsection (b)(1);

(ii) not more than $25,000,000 may be used to carry out the program under subparagraph (C) of subsection (b)(1);

(iii) not more than $10,000,000 may be used to carry out the program under subparagraph (D) of subsection (b)(1);

(iv) not more than $3,000,000 may be used to carry out the provisions of section 9642; and

(v) the remainder of funds shall be used to carry out the program under subparagraph (A) of subsection (b)(1).

(2) ADMINISTRATION.—The programs described in this section and carried out with amounts made available under subsection (a) shall be carried out by the Secretary of Labor.

(b) RETRAINING PROGRAMS; ADVANCED CAREER POSITIONS; WORKFORCE ADJUSTMENT PROGRAMS.—

(1) IN GENERAL.—For purposes of subsection (a), the programs described in this section are the following:

(A) A program for skills upgrading and occupational retraining (including retraining health care workers for

more advanced positions as technicians, nurses, and physician assistants), and for quality and workforce improvement.

(B) A demonstration program to assist workers in health care institutions in obtaining advanced career positions.

(C) A program to ensure the expansion of the national job bank (established by the Employment Service of the Department of Labor) within local employment services agencies designed to address the needs of health care workers, subject to the following:

(i) Such job bank shall be available to all health care employers and health care workers in the community involved.

(ii)(I) With respect to each affected community, the local employment service agency or one-stop career center serving such community shall be allocated not less than one counselor whose responsibility shall include addressing the needs of health care workers.

(II) Such counselor shall ensure the solicitation of job openings from local health care employers and, not less frequently than once each month, ensure that such employers and other employers are contacted, and ensure that all job listings appropriate for health care workers adversely affected under this Act are monitored and updated regularly.

(III) Such counselor shall provide directly, or facilitate the provision of, labor exchange services by local employment service staff to eligible health care workers, including assessment, counseling, testing, job-search assistance, job referral and placement, and referral to training and educational programs.

(IV) If the impact of health care industry restructuring is such that the functions required under this clause cannot be satisfactorily provided by one counselor, additional counselors shall be allocated.

(iii) The job bank serving the community involved shall be subject to performance goals that measure the number of health care job openings and the proportion of health care employers in the community that list job openings. Such goals shall be adjusted based on specific economic, geographic, and other characteristics, including demonstrated difficulties with employer compliance.

(D) A program to provide for joint labor-management decision-making in the health care sector on workplace matters related to the restructuring of the health care delivery system provided for in this Act.

(2) USE OF FUNDS.—Amounts made available under subsection (a) for carrying out this section may be expended for program support, faculty development, trainee support, workforce analysis, and dissemination of information, as necessary to produce required performance outcomes.

(c) ADMINISTRATIVE REQUIREMENTS.—In carrying out the programs described in subsection (b), the Secretary of Labor shall, with respect to the organizations and employment positions involved, provide for the following:

(1) Joint labor-management implementation and administration.

(2) Discussion with employees as to training needs for career advancement.

(3) Commitment to a policy of internal hirings and promotion.

(4) Provision of support services.

(5) Consultations with employers and with organized labor.

SEC. 9642. NATIONAL INSTITUTE FOR HEALTH CARE WORKFORCE DEVELOPMENT.

(a) ESTABLISHMENT OF INSTITUTE.—The Secretary of Labor, in consultation with the Secretary of Health and Human Services, shall establish an office to be known as the National Institute for Health Care Workforce Development.

(b) DIRECTOR.—The Institute shall be headed by a Director, who shall be appointed by the Secretary of Labor.

(c) DUTIES.—

(1) RECOMMENDATIONS BY DIRECTOR.—The Director of the Institute shall make recommendations to the Secretary of Labor regarding—

(A) the supply of health care workers needed for proper staffing of the health care institutions serving the insured health benefit plans, and the self-insured health benefit plans, described in title V;

(B) the impact of this Act, and of related changes regarding health care, on health care workers and the needs of such workers with respect to education, training, and career development; and

(C) the development and implementation of high performance, high quality health care delivery systems, including employee participation committee systems, that will improve the health care delivery system by increasing the role, the responsibilities, and the area of independent decision-making authority of health care workers.

(2) RESPONSE TO RECOMMENDATIONS.—The Secretary of Labor, in acting upon the recommendations made under paragraph (1), may—

(A) issue timely and useful reports on health care worker supply and needs and on proper staffing of health care institutions;

(B) take actions to encourage the use of employee participation committees and other activities intended to promote the development of high performance, high quality health care delivery systems; and

(C) take such other actions as are authorized under this Act.

(d) ADVISORY BOARD.—

(1) IN GENERAL.—The Secretary of Labor shall establish an advisory board to assist in the development and implementation of recommendations under subsection (c)(1).

(2) COMPOSITION.—The advisory board established under paragraph (1) shall be composed of the following members with expertise in health care workforce issues:

(A) The Secretary of Labor.

(B) The Secretary of Health and Human Services.

(C) Five representatives of health care workers in organized labor to be appointed by Secretary of Labor.

(D) Five representatives of health institutions to be appointed by the Secretary of Health and Human Services.

(E) Two representatives from organizations that train and educate health care workers, to be appointed by the Secretary of Labor.

(F) Two representatives from consumer organizations to be appointed by the Secretary of Labor.

To the greatest extent feasible, the membership of the advisory board shall reflect the racial, ethnic, and gender composition of the population of the United States.

(e) STAFF, QUARTERS, AND OTHER ASSISTANCE.—The Secretary of Labor shall provide the Institute and the Advisory Board with such staff, quarters, and other administrative assistance as may be necessary for the Institute and the Advisory Board to carry out this section.

(f) COORDINATION.—The Secretary of Labor, in consultation with the Secretary of Health and Human Services, shall, to the extent practicable, ensure that the efforts under this section and sec-

tion 792 of the Public Health Service Act are coordinated to ensure that joint planning occurs to maximize the utilization of resources, to avoid duplication of effort, and to provide for the equitable division of responsibility.

(g) DEFINITIONS.—For purposes of this section:

(1) ADVISORY BOARD.—The term "Advisory Board" means the advisory board established under subsection (d).

(2) EMPLOYEE PARTICIPATION COMMITTEE.—The term "employee participation committee" means a committee of non-managerial workers at a health care facility which—

(A) is selected without employer interference by one or more labor organizations representing such workers or, if there is no such organization, by such workers;

(B) operates without employer interference; and

(C) consults with management on issues of efficiency, productivity, and quality of care.

(3) The term "Institute" means the Institute established under subsection (a).

(h) SUNSET.—Unless otherwise extended by law, the Institute is terminated on January 1, 2004.

TITLE X—LONG-TERM CARE

Subtitle A—Long-Term Care Program

SEC. 10001. ESTABLISHMENT OF LONG-TERM CARE PROGRAM FOR HOME AND COMMUNITY-BASED SERVICES.

The Secretary shall establish a long-term care program for grants to States under this subtitle to provide home and community-based services for individuals with severe disabilities without regard to age or income through approved State plans. Nothing in this subtitle may be construed to authorize the Secretary to delegate to the States the primary responsibility for interpreting the governing provisions of this subtitle.

SEC. 10002. INDIVIDUALS WITH SEVERE DISABILITIES.

(a) IN GENERAL.—In this subtitle, the term "individual with severe disabilities" means any individual within one or more of the following 4 categories of individuals:

(1) INDIVIDUALS REQUIRING HELP WITH ACTIVITIES OF DAILY LIVING.—An individual of any age who—

(A) requires hands-on or standby assistance, supervision, or cueing (as defined by the Secretary) to perform three or more activities of daily living (as defined in subsection (c)), and

(B) is expected to require such assistance, supervision, or cueing over a period of at least 100 days.

(2) INDIVIDUALS WITH SEVERE COGNITIVE OR MENTAL IMPAIRMENT.—An individual of any age—

(A) whose score, on a standard mental status protocol (or protocols) specified by the Secretary as appropriate for measuring the individual's particular condition, indicates either severe cognitive impairment or severe mental impairment, or both;

(B) who—

(i) requires hands-on or standby assistance, supervision, or cueing with one or more activities of daily living,

(ii) requires hands-on or standby assistance, supervision, or cueing with at least such instrumental activity (or activities) of daily living related to cognitive or mental impairment as the Secretary specifies, or

(iii) displays symptoms of one or more serious behavioral problems (that is on a list of such problems specified by the Secretary) which create a need for supervision to prevent harm to self or others; and

(C) whose is expected to meet the requirements of subparagraphs (A) and (B) over a period of at least 100 days.

(3) INDIVIDUALS WITH SEVERE OR PROFOUND MENTAL RETARDATION.—An individual of any age who has severe or profound mental retardation (as determined according to a protocol specified by the Secretary).

(4) SEVERELY DISABLED CHILDREN.—An individual under 6 years of age who—

(A) has a severe disability or chronic medical condition,

(B) but for receiving home and community-based services would require institutionalization in a hospital, nursing facility, or intermediate care facility for the mentally retarded, and

(C) is expected to have such disability or condition and require such services over a period of at least 100 days.

(b) DETERMINATION OF ELIGIBILITY.—

(1) IN GENERAL.—The determination of whether an individual is an individual with severe disabilities shall be made, by persons or entities (which may be local care coordination agen-

cies) specified under the State plan (under section 10004), using a uniform protocol consisting of an initial screening and assessment specified by the Secretary. A State may collect additional information, at the time of obtaining information to be used by such persons or entities to make such determination, in order to provide for the assessment and plan described in section 10004(b) or for other purposes. The determination of such persons or entities shall be made without regard to the individual's income or (except in the case described in subsection (a)(4)) the individual's age.

(2) INITIAL SCREENING PROCESS.—The plan shall provide a process for the initial screening of individuals who appear to have some reasonable likelihood of being an individual with severe disabilities.

(3) PERIODIC REASSESSMENT.—The determination that an individual is an individual with severe disabilities shall be considered to be in effect under the State plan for a period of not more than 12 months (or for such longer period in such cases as a significant change in an individual's condition that may affect such determination is unlikely). A reassessment shall be made if there is a significant change in an individual's condition that may affect such determination.

(4) FAIR HEARING PROCESS.—The State shall establish a fair hearing process for appeals of such determinations.

(c) ACTIVITY OF DAILY LIVING DEFINED.—In this subtitle, the term "activity of daily living" means any of the following: eating, toileting, dressing, bathing, and transferring.

SEC. 10003. HOME AND COMMUNITY-BASED SERVICES.

(a) SCOPE OF SERVICES.—

(1) IN GENERAL.—In this subtitle, the term "home and community-based services" includes, subject to paragraph (2), the following:

(A) Agency-administered and consumer-directed personal assistance services (as defined in paragraph (3)).

(B) Case management.

(C) Homemaker and chore assistance.

(D) Home modifications.

(E) Respite services.

(F) Assistive devices.

(G) Adult day services.

(H) Habilitation and rehabilitation.

(I) Supported employment.

(J) Home health services.

(L) Any other care or assistive services (approved by the Secretary) that a State determines will help individuals with severe disabilities to remain in their homes and communities.

(2) EXCLUSIONS.—Such term does not include coverage of the following:

(A) Room and board.

(B) Services furnished in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other institutional setting specified by the Secretary.

(C) Items and services to the extent coverage is provided for the individual under a certified health plan or under title XVIII of the Social Security Act or medicare part C.

(3) PERSONAL ASSISTANCE SERVICES DEFINED.—

(A) IN GENERAL.—In this subsection, the term "personal assistance services" includes hands-on and standby assistance, supervision, and cueing with activities of daily living, whether agency-administered or consumer-directed (as defined in subparagraph (B)).

(B) CONSUMER-DIRECTED; AGENCY-ADMINISTERED.—In this subtitle:

(i) The term "consumer-directed" means, with reference to personal assistance services or the provider of such services, services that are provided by an individual who is selected and managed (and, at the individual's option, trained) by the individual receiving the services.

(ii) The term "agency-administered" means, with respect to such services, services that are not consumer-directed.

(C) LIMITATION ON LICENSURE OR CERTIFICATION.—A State may not subject consumer-directed providers of personal assistance services to licensure, certification, or other requirements which the Secretary finds not to be necessary for the health and safety of individuals with severe disabilities.

(b) COST SHARING.—

(1) NO OR NOMINAL COST SHARING FOR POOREST.—No cost sharing (other than nominal cost sharing) may be imposed for individuals with income (as determined under paragraph (3)) less than 150 percent of the Federal poverty level (as defined in paragraph (4)) applicable to a family of the size involved.

(2) SLIDING SCALE FOR REMAINDER.—Cost sharing in the form of coinsurance (based on the amount paid under this subtitle for a service) shall be imposed—

(A) at a rate of 10 percent for individuals with severe disabilities with income not less than 150 percent, and less than 200 percent, of the applicable Federal poverty level;

(B) at a rate of 20 percent for such individuals with income not less than 200 percent, and less than 250 percent, of the applicable Federal poverty level; and

(C) at a rate of 25 percent for such individuals with income equal to at least 250 percent of such Federal poverty level.

(3) DETERMINATION OF INCOME FOR PURPOSES OF COST SHARING.—Each State, or an agency designated by the State, shall determine the income of an individual with severe disabilities for purposes of this subsection, in a manner specified by the Secretary.

(4) FEDERAL POVERTY LEVEL DEFINED.—In this subsection, the term "Federal poverty level" means, for a family for a year, the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved for the year.

(c) SPECIFICATION OF SERVICES TO BE COVERED.—

(1) IN GENERAL.—Each State shall specify, in its plan under section 10004—

(A) the methods and standards used to select the types, and the amount, duration, and scope, of home and community-based services to be covered under the plan and to be available to each category of individuals with severe disabilities;

(B) how the types, and the amount, duration, and scope of the services specified meet the needs of individuals within each of such categories;

(C) the extent and manner in which such services would be allocated among individuals with severe disabilities and categories of such individuals;

(D) the manner in which such services are coordinated with each other and with health and long-term care services available outside the plan for individuals with severe disabilities; and

(E) the manner in which individuals with severe disabilities will be assisted in obtaining services from other programs for which they may qualify (including home health services under title XVIII or medicare part C and

home and community-based services under a State plan approved under title XIX).

(2) FLEXIBILITY IN MEETING INDIVIDUAL NEEDS.—The services—

(A) shall be specified in a manner that permits sufficient flexibility for providers to meet the needs of individuals with severe disabilities in a cost effective manner;

(B) may be specified in a manner that takes into account the availability of informal care; and

(C) subject to subsection (a)(2)(B), may be delivered in an individual's home, a range of community residential arrangements, or outside the home (but not in an institutional setting).

SEC. 10004. ADMINISTRATION THROUGH STATE PLANS.

(a) IN GENERAL.—As a condition for the payment of funds to a State under section 10005, the State must have a plan for home and community-based services for individuals with severe disabilities approved by the Secretary. The Secretary may not approve such a plan unless the Secretary determines that the plan meets the requirements of subsection (b).

(b) PLAN REQUIREMENTS.—The requirements for a State plan are as follows:

(1) ELIGIBILITY PROCESS.—The plan shall provide for a process to determine if individuals are individuals with severe disabilities in accordance with section 10002(b).

(2) SPECIFICATION OF SERVICES, COST SHARING, TYPES OF PROVIDERS, AND REQUIREMENTS FOR PARTICIPATION.—The plan shall—

(A) specify, in accordance with section 10003(c), the home and community-based services to be provided under this subtitle to individuals with severe disabilities;

(B) impose cost sharing with respect to covered services in accordance with section 10003(b); and

(C) specify—

(i) the types of service providers eligible to participate in the program under the plan, and

(ii) any requirements for participation applicable to each type of service provider.

(3) PROVISION OF SERVICES.—

(A) ACCORDING TO PLAN OF CARE.—

(i) IN GENERAL.—The State plan shall provide for home and community-based services to an individual with disabilities only if such services are provided consistent with an individualized plan of care.

(ii) PLAN OF CARE.—Such plan of care shall—

(I) be based on an assessment of the individual's need for such services under section 10002(b)(1),

(II) be developed in consultation with the individual and the individual's family, and

(III) be periodically reviewed and updated, as appropriate (in accordance with section 10002(b)(3).

(iii) CONSTRUCTION.—Nothing in this subparagraph shall be construed as requiring a State (under the State plan or otherwise) to provide all the services specified in such a plan.

(B) CONSUMER CHOICE.—To the extent possible, preference is to be given to the choice of an individual with severe disabilities (and that individual's family) regarding which covered services to receive and the providers who will provide such services.

(4) PAYMENTS FOR SERVICES.—The plan provides for payment for services in accordance with the schedules and payment methodology specified in subsection (e).

(5) BUDGETING AND FISCAL MANAGEMENT.—

(A) LIMITATION ON ADMINISTRATIVE EXPENDITURES.—The plan shall contain assurances that not more than an amount or level (specified by the Secretary) of expenditures under the plan for all quarters in any fiscal year shall be for administrative costs.

(B) USE OF STATE FUNDS FOR MATCHING.—The plan shall provide assurances that Federal funds will not be used to provide for the State share of expenditures under this subtitle.

(C) BUDGET PRIORITY FOR CONTINUING CURRENT SERVICES FOR CURRENT RECIPIENTS.—The State plan shall give priority to the provision of such services to individuals who are already being provided services under the plan in a fiscal year during which insufficient funds are available to provide services to each individual eligible to receive such services under 10002(a).

(6) QUALITY ASSURANCE AND SAFEGUARDS.—The State plan shall provide for quality assurance and safeguards for applicants and beneficiaries in accordance with subsection (f).

(7) GENERAL ADMINISTRATION.—

(A) STATE AGENCY.—The plan shall designate a State agency or agencies to manage and coordinate benefits under the plan, in accordance with specifications included in the plan.

(B) USE OF LOCAL CARE COORDINATION AGENCIES.—A State may contract with or establish local care coordination agencies throughout the State to assure the availability of home and community-based services to individuals with severe disabilities residing throughout the State.

(C) COORDINATION.—The plan shall specify how the plan—

(i) will be integrated with the State plan for medical assistance under title XIX of the Social Security Act, State plans under titles V and XX of such Act, programs under the Older Americans Act of 1965, programs under the Developmental Disabilities Assistance and Bill of Rights Act, the Individuals with Disabilities Education Act, and any other Federal or State programs that provide services or assistance targeted to individuals with severe disabilities, and

(ii) will be coordinated with certified health plans.

(8) REPORTS AND INFORMATION TO SECRETARY; AUDITS.—The plan shall provide that the State will furnish to the Secretary—

(A) such reports, and will cooperate with such audits, as the Secretary determines are needed concerning the State's administration of its plan under this subtitle, including the processing of claims under the plan, and

(B) such data and information as the Secretary may require in order to carry out the purpose of the program.

(9) COMPLIANCE WITH WORKER REDEPLOYMENT NEGOTIATION REQUIREMENTS.—The plan shall meet the requirements of subtitle C (relating to negotiations regarding worker redeployment).

(c) STANDARDS FOR PLAN APPROVAL.—

(1) IN GENERAL.—The Secretary shall establish standards for the approval of State plans under this section.

(2) EFFECTIVENESS.—The approval of such a plan shall take effect as of the first day of the first fiscal year beginning after the date of such approval (except that any approval made before October 1, 1998, shall be effective as of such date). In order to budget funds allotted under this subtitle, the Secretary may establish a deadline for the submission of such a plan before the beginning of a fiscal year as a condition of its approval effective with that fiscal year.

(d) MONITORING STATE PERFORMANCE.—

(1) IN GENERAL.—The Secretary shall monitor the performance of States in carrying out plans under this section and shall, not less often than every two years, evaluate the performance of State agencies in carrying out their programmatic and fiscal responsibilities under this subtitle.

(2) PERFORMANCE MEASURES.—In evaluating such performance, the Secretary shall take into account at least the following:

(A) The State's ability to maintain plan expenditures within amounts for which Federal payments are available under section 10005.

(B) The plan's ability to maximize the provision of services within the State's allocation.

(C) The State's success at finding alternative sources of funding to pay for services authorized under a care plan.

(D) The plan's ability to maintain individuals with severe disabilities outside institutional settings.

(E) The State's ability to implement the requirement that the plan is a secondary payor to the State plan for medical assistance under title XIX of the Social Security Act under section 10005(f)(1).

(e) REQUIREMENTS RELATING TO PAYMENT FOR SERVICES.—

(1) IN GENERAL.—Subject to paragraph (2), payments for services under the State plan shall be made based on—

(A) the prospective payment system developed under paragraph (3)(B), or

(B) in the absence of such a system, the fee schedules developed under paragraph (3)(A), or

(C) in the absence of such a system or schedules, payment rates or methodologies developed by the providers for payment rates that are reasonable and ensure adequate provider participation and access to covered services of adequate quality.

(2) USE OF CASH PAYMENTS AND VOUCHERS.—

(A) IN GENERAL.—Under standards established by the Secretary under this section, a State plan may provide for the use of vouchers and cash payments directly to individuals with severe disabilities to pay for covered services.

(B) DETERMINATION OF PAYMENT RATES.—The plan shall specify the methods and criteria to be used to set rates for such cash payments and vouchers.

(C) USE OF INTERMEDIATE ENTITIES FOR CONSUMER-DIRECTED SERVICES.—With respect to consumer-directed services furnished to an individual with severe disabilities by a provider, the plan may provide that an entity, other than the individual or provider—

(i) would inform the individual and the provider of rights and responsibilities under all Federal and other applicable labor and tax laws, and

(ii) would act as the employer of the provider for purposes of assuming responsibility for effective billing and for payments for service tax withholding, unemployment compensation, and workers' compensation under such laws.

In such a case individuals with severe disabilities retain the right to select, hire, terminate, and direct the work of such a provider.

(3) DEVELOPMENT OF FEE SCHEDULES AND PROSPECTIVE PAYMENT SYSTEM.—

(A) IN GENERAL.—The Secretary shall develop fee schedules for payment for home and community-based services. Such schedules shall be—

(i) based on the estimated cost of visits by discipline or service,

(ii) adjusted to take into account variations in area wage levels and such other factors as the Secretary deems appropriate, and

(iii) adequate to ensure provider participation and access to covered services of adequate quality.

(B) DEVELOPMENT OF PROSPECTIVE SCHEDULE.—To the extent practicable, the Secretary shall develop a prospective payment system for payment for home and community-based services under this subtitle. Such a system shall adjust payment rates to take into account—

(i) variations in area wage levels, and

(ii) predictable differences in the cost and utilization of such services, based on degree of dependency in relation to activities of daily living and other case-mix severity indicators of resource needs.

To the extent possible, the unit of payment shall be established on a per-episode basis rather than per-visit basis. The payment rates under such a system shall be adequate to ensure provider participation and access to covered services of adequate quality.

(4) EXTRA BILLING NOT PERMITTED.—The plan shall restrict payment under the plan for covered services to those providers that agree to accept the payment under the plan (at the rates established under this subsection) and any cost sharing permitted or provided for under the plan as payment in full for services furnished under the plan.

(f) QUALITY ASSURANCE AND SAFEGUARDS.—

(1) QUALITY ASSURANCE REQUIREMENTS.—In order to assure the health and safety of individuals with severe disabilities, the Secretary shall establish, by not later than July 1, 1999, quality assurance and certification requirements—

(A) for providers to receive payments under a State plan for furnishing home and community-based services, and

(B) for enforcement of such requirements under the plan.

(2) SAFEGUARDS.—

(A) CONFIDENTIALITY.—The State plan shall provide safeguards which restrict the use or disclosure of information concerning applicants and beneficiaries to purposes directly connected with the administration of the plan.

(B) SAFEGUARDS AGAINST ABUSE.—The State plans shall provide, through methods other than reliance on State licensure processes, that individuals receiving home and community care under this subtitle are protected from neglect, physical and sexual abuse, financial exploitation, inappropriate involuntary restraint, and the provision of health care services by unqualified personnel in community care settings.

(C) SAFEGUARDS IN CASES OF CASH PAYMENTS AND VOUCHERS.—The State plans shall provide appropriate safeguards in cases where payment for program benefits is made by cash payments or vouchers given directly to individuals with severe disabilities.

(D) INCORPORATION OF PROVISIONS.—In carrying out this subsection, the provisions of subsections (f) through (h) of section 1929 of the Social Security Act (relating to minimum requirements for care and settings) shall apply under this subtitle in the same manner as they apply under such section.

(g) REGULATIONS.—The Secretary shall issue such regulations as may be appropriate to carry out this subtitle.

SEC. 10005. PAYMENTS TO STATES; MEDICAID MAINTENANCE OF EFFORT.

(a) IN GENERAL.—The Secretary shall authorize payment to each State with a plan approved under this subtitle, for each fiscal

year (beginning with fiscal year 2000), of an amount equal to six dollars for each seven dollars expended under the plan, but not to exceed the State allocation under subsection (b)(1) for the fiscal year plus the State's share of the reallotment pool under subsection (b)(3).

(b) ALLOCATION TO STATES.—

(1) ALLOCATION OF FEDERAL FUNDS.—The Secretary shall allocate all the national long-term care allocation amount (described in paragraph (2)) for each fiscal year among the States in accordance with a formula based on—

(A) the number of individuals with severe disabilities in the State within each of the categories of such individuals, and

(B) the average per capita spending amounts within each State within each of such categories for home and community-based services.

(2) NATIONAL LONG-TERM CARE ALLOCATION AMOUNT.—For any fiscal year, the national long-term care allocation amount is 125 percent of the Federal funds available under section 10006 for the fiscal year.

(3) STATE SHARE OF REALLOTMENT POOL.—

(A) IN GENERAL.—For purposes of subsection (a), the State's share of the reallotment pool for the fiscal year under this paragraph is equal to the State's share (as determined under subparagraph (B)) of the redistribution pool (as determined under subparagraph (C)) for the fiscal year.

(B) STATE SHARE.—For purposes of subparagraph (A), a State's share is equal to the ratio of—

(i) the State allocation under paragraph (1) for the fiscal year, to

(ii) the sum of such allocations for all fully participating States for the fiscal year.

(C) REDISTRIBUTION POOL.—For purposes of subparagraph (A), the redistribution pool for a fiscal year is equal to the amount by which the available Federal funds under section 10006 for the fiscal year exceeds the total payments made to States under paragraphs (1) and (2) of subsection (a) for the fiscal year.

(c) STATE ENTITLEMENT.—This subtitle constitutes budget authority in advance of appropriations Acts, and represents the obligation of the Federal Government to provide for the payment to States of amounts described in subsection (a).

(d) DISALLOWANCE OF CERTAIN EXCESSIVE ADMINISTRATIVE COSTS.—For purposes of subsection (a), administrative expenditures that are in excess of the amounts permitted under section 10004(b)(5)(A) shall not be treated as expenditures under the State plan.

(e) APPLICATION OF RULES REGARDING LIMITATIONS ON PROVIDER-RELATED DONATIONS AND HEALTH CARE RELATED TAXES.—The provisions of section 1903(w) of the Social Security Act shall apply to payments to States under this section in the same manner as they apply to payments to States under section 1903(a) of such Act.

(f) PAYMENTS ON ESTIMATES WITH RETROSPECTIVE ADJUSTMENTS.—The method of computing and making payments under this section shall be as follows:

(1) The Secretary shall, prior to the beginning of each quarter in a fiscal year, estimate the amount to be paid to the State under subsection (a) for such quarter, based on a report filed by the State containing its estimate of one-quarter of the total sum to be expended in such fiscal year, and such other information as the Secretary may find necessary.

(2) The Secretary shall provide for payment of the amount so estimated, reduced or increased, as the case may be, by any sum (not previously adjusted under this section) by which the

Secretary finds that the estimate of the amount to be paid the State for any prior period under this section was greater or less than the amount which should have been paid.

(g) REDUCTION OF PAYMENTS AUTHORIZED FOR FAILURE TO MAINTAIN MEDICAID EFFORT.—

(1) PAYER OF LAST RESORT.—The Secretary shall reduce the amount of payments otherwise made to a State under this section by the amount of any expenditures under this subtitle for services to individuals otherwise entitled to benefits under the title XVIII, medicare part C, a State plan approved under title XIX, or any certified health plan.

(2) MEDICAID MAINTENANCE OF EFFORT.—

(A) IN GENERAL.—The Secretary also may reduce the amount of payments otherwise made to a State in a fiscal year under this section by the amount by which—

(i) the State medicaid expenditures for home and community-based services in the fiscal year (as determined under subparagraph (B)), is less than

(ii) the maintenance of effort level for the State for the fiscal year (as determined under subparagraph (C)).

(B) STATE MEDICAID EXPENDITURES.—For purposes of this paragraph, a State's "medicaid expenditures for home and community-based services" in a fiscal year is—

(i) the gross amount expended on medical assistance under the State medicaid plan in the fiscal year for home and community-based services, including a reasonable allocation (determined by the Secretary) of administrative expenses attributable to the provision of such services, reduced by

(ii) the amount of the Federal financial participation attributable to such assistance and expenses under the medicaid program.

(C) MAINTENANCE-OF-EFFORT LEVEL.—For purposes of subparagraph (A)(ii), the "maintenance-of-effort level" for a State for a fiscal year (beginning with fiscal year 1998) is equal to—

(i) the State's medicaid expenditures for home and community-based services (as determined under subparagraph (B)) for fiscal year 1994,

(ii) increased by the total nominal growth in the gross domestic product between 1994 and 1997, and

(iii) increased for each year after 1998 and before the year in which the fiscal year involved ends by national medicare growth factor established under section 8201(c) for the year.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as requiring States to determine eligibility for medical assistance under the State medicaid plan on behalf of individuals receiving benefits under this subtitle.

SEC. 10006. FEDERAL FUNDING.

(a) FISCAL YEARS 1998 Through 2004.—For purposes of this subtitle, subject to subsection (c), the available Federal funds for all State plans under this subtitle—

(1) for fiscal year 1998 is $1.7 billion;
(2) for fiscal year 1999 is $1.5 billion;
(3) for fiscal year 2000 is $5.0 billion;
(4) for fiscal year 2001 is $6.6 billion;
(5) for fiscal year 2002 is $9.4 billion;
(6) for fiscal year 2003 is $19.3 billion; and
(7) for fiscal year 2004 is $22.6 billion.

(b) SUBSEQUENT FISCAL YEARS.—For purposes of this subtitle, subject to subsection (c), the available Federal funds for State plans under this subtitle for each fiscal year after fiscal year 2004 is the total available Federal funds under this section for the preceding fiscal year increased by the national medicare growth factor estab-

lished under section 8201(c) for the year in which such preceding fiscal year ends.

(c) SET ASIDE FOR SERVICES UNDER THE INDIAN HEALTH CARE IMPROVEMENT ACT.—The Secretary shall set aside and pay to the Indian Health Service for each fiscal year (beginning with fiscal year 2000), for payments under section 906 of the Indian Health Care Improvement Act, 0.8 percent of the available Federal funds otherwise provided under subsection (a) or (b). Such amounts shall be treated as a reduction of amounts available under this title for purposes of computing the amount of allocations to States under section 10005(b).

Subtitle B—Federal Standards for Private Long-Term Care Insurance Policies

PART 1—GENERAL REQUIREMENT; ESTABLISHMENT OF STANDARDS

Subpart A—General Requirement

SEC. 10101. GENERAL REQUIREMENT.

(a) APPROVED REGULATORY STATES.—No long-term care insurance policy (as defined in section 10111) may be issued, sold, or offered for sale in an approved regulatory State (as defined in section 10112(3)) on or after the date specified in section 10103 unless the policy has been certified by the State commissioner of insurance under such program as meeting the standards established by the approved regulatory program in the State.

(b) OTHER STATES.—No long-term care insurance policy may be issued, sold, or offered for sale in a State that is not an approved regulatory State on or after the date specified in section 10103 unless the policy has been certified by the Secretary (in accordance with such procedures as the Secretary may establish) as meeting the standards established under section 10102.

(c) TREATMENT OF ADVERTISING AND SOLICITING.—For purposes of this section, the advertising or soliciting with respect to a policy, directly or indirectly, shall be deemed the offering for sale of the policy.

SEC. 10102. ESTABLISHMENT OF STANDARDS.

(a) IN GENERAL.—The Secretary shall promulgate a regulation that provides standards that incorporate the requirements of part 2 and such standards shall apply under section 10101. Such regulations shall first be published by not later than July 1, 1995.

(b) CONSULTATION.—In promulgating regulations under this section, the Secretary shall consult with the National Association of Insurance Commissioners (in this subtitle referred to as the "NAIC") and with representatives of consumer groups.

SEC. 10103. DEADLINE FOR APPLICATION OF STANDARDS IN STATES.

(a) INITIAL STANDARDS.—With respect to the initial Standards established under section 10102, subject to subsection (b), for purposes of this part, the date specified in this section for a State is—

(1) the date the State establishes an approved regulatory program, or

(2) January 1, 1997,

whichever is earlier.

(b) STATE REQUIRING LEGISLATION.—In the case of a State which the Secretary identifies as—

(1) requiring State legislation (other than legislation appropriating funds) in order for the State regulatory program under section 10161 to be implemented; but

(2) having a legislature which is not scheduled to meet in a legislative session in which such legislation may be considered in the year following the year in which the standards (or subsequent standards) are established;

the date specified in this section 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 of the year following the year in which such standards (or subsequent standards) are established. 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.

SEC. 10104. RELATION TO STATE LAW.

(a) PREEMPTION.—Except as provided in subsection (b), the Standards established under section 10102 preempt provisions of State law which conflict with such Standards.

(b) STRICTER STANDARDS PERMITTED.—A State may apply standards that provide greater protection to policyholders of long-term care insurance policies than the Standards.

(c) GRANDPARENTING OF CURRENT POLICIES.—Except as a State may provide, the Standards shall not apply to policies issued before the date specified in section 10103, unless and until such policies are upgraded under section 10130(c)(2).

(d) EXEMPTION FOR CERTAIN POLICIES SUBJECT TO STATE PLAN AMENDMENTS UNDER MEDICAID.—The Standards shall not apply to a policy in connection with which assets or resources are disregarded in the manner described in section 1917(b)(1)(C)(ii) of the Social Security Act, but only if the policy is certified by the State pursuant to an amendment to the State medicaid plan under section 1902(r)(2) of such Act approved on or before August 1, 1994.

SEC. 10105. CODE OF CONDUCT WITH RESPECT TO ENDORSEMENTS.

Not later than July 1, 1995, the Secretary shall issue guidelines that shall apply to organizations and associations and their subsidiaries that provide endorsements of long-term care insurance policies, or that permit such policies to be offered for sale through the organization or association or subsidiary. Such guidelines shall include, at a minimum, the following:

(1) In endorsing or selling long-term care insurance policies, the primary responsibility of an organization or association or its subsidiary shall be to educate their members concerning such policies and assist such members in making informed decisions. Such organizations and associations and their subsidiaries may not function primarily as sales agents for insurance companies.

(2) Organizations and associations and their subsidiaries shall provide objective information regarding long-term care insurance policies sold or endorsed by such organizations, associations, and subsidiaries to ensure that members of such organizations, associations, and subsidiaries have a balanced and complete understanding of both the strengths and weaknesses of the policies that are being endorsed or sold.

(3) Organizations and associations and their subsidiaries selling or endorsing long-term care insurance policies shall disclose, in marketing literature concerning such policies that is provided to their members, the manner in which such policies and the insurance company issuing such policies were selected. If the organization, association, or subsidiary and the insurance company have interlocking directorates, the organization, association, or subsidiary shall disclose such fact to their members.

(4) Organizations and associations and their subsidiaries selling or endorsing long-term care insurance policies shall disclose, in marketing literature concerning such policies that is provided to their members, the precise nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the organization, association, or subsidiary receives from the endorsement or sale of the policies to its members. The Boards of Directors of organizations and associations and their subsidiaries selling or endorsing long-term care insurance poli-

cies shall review and approve the compensation arrangements relating to such policies.

(5) Organizations and associations and their subsidiaries selling or endorsing long-term care insurance policies to their members shall—

(A) disclose, in summary form, the most recent information available pertaining to the financial status (including solvency) of the carrier;

(B) make periodic actuarial or independent examinations of the policies, including their benefits, features, and rates;

(C) actively monitor the marking efforts, with respect to its members, of the carrier and its agents;

(D) review and approve all marketing materials or other insurance communications used to promote sales among, or sent to, members regarding such policies; and

(E) file with the State insurance commissioner of the State in which they are based—

(i) a copy of the policies,

(ii) a copy of the outline of coverage which accompanies such policies, and

(iii) a copy of each advertising and other marketing materials utilized in connection with the sale or endorsement of such policies.

SEC. 10106. REQUIREMENTS FOR AGENT TRAINING AND CERTIFICATION PROGRAMS.

(a) ESTABLISHMENT.—The Secretary shall establish requirements for a long-term care insurance agent training and certification program for insurance agents who desire to sell or offer for sale long-term care insurance policies. Under such program—

(1) the agent must pass either—

(A) a comprehensive examination on long-term care insurance coverage and appropriate sales techniques, or

(B) an equally comprehensive long-term care insurance portion of another examination required by a State in order for the agent to sell another insurance product in the State; and

(2) agents who have completed such program shall be certified as qualified to sell or offer for sale long-term care insurance policies.

(b) ADMINISTRATION.—The program established under subsection (a) shall be administered under an approved State regulatory program.

Subpart B—Definitions

SEC. 10111. LONG-TERM CARE INSURANCE POLICY.

(a) IN GENERAL.—In this subtitle, except as otherwise provided in this section, the term "long-term care insurance policy" means any insurance policy, certificate, or rider advertised, marketed, offered, or designed to provide coverage for each covered individual on an expense incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes a group or individual annuity or life insurance policy or rider which provides directly (or which supplements) long-term care insurance described in the previous sentence. Such term also includes an insurance policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity.

(b) POLICIES EXCLUDED.—Except as provided in subsections (c) and (d), in this subtitle the term "long-term care insurance policy" does not include any medicare supplemental policy (as defined in section 1882(g) of the Social Security Act) and any insurance which is offered primarily to provide—

(1) basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, or major medical expense coverage,

(2) disability income or related asset-protection coverage,

(3) accident only coverage,

(4) specified disease or specified accident coverage, or

(5) limited benefit health coverage.

(c) INCLUSION OF POLICIES MARKETED AS LONG-TERM CARE INSURANCE.—In this subtitle, the term "long-term care insurance policy" also includes any product which is advertised, marketed, or offered as long-term care insurance.

(d) DISCLOSURE REQUIREMENTS FOR CERTAIN DISABILITY INCOME POLICIES AND LIFE INSURANCE POLICIES.—

(1) IN GENERAL.—In this subtitle, the term "long-term care insurance policy" includes—

(A) a policy described in subsection (b)(2) under which the eligibility or amount of benefits are based on an assessment of functional ability (based on activities of daily living or otherwise), or

(B) a life insurance policy described in paragraph (3), if the disclosure requirements of paragraph (2) are not met.

(2) DISCLOSURE REQUIREMENTS.—The disclosure requirements of this paragraph for a policy are that—

(A) the policy discloses (in a form and manner specified in the Standards) the fact that the policy is not a long-term care insurance policy;

(B) the policy outlines how the benefits in the policy differ from the benefits required to be provided under the Standards of a long-term care insurance policy; and

(C) in the case of a life-insurance policy described in subsection (c), at the time of policy delivery there is provided to the purchaser and the beneficiary a policy summary that includes—

(i) an explanation of how the long-term care benefits interact with other components of the policy (including deductions from death benefits);

(ii) a description of the amount and length of benefits and the guaranteed lifetime benefits (if any) for each covered individual; and

(iii) any exclusions, reductions, and limitations on benefits of long-term care.

(3) CERTAIN LIFE INSURANCE POLICIES.—A life insurance policy described in this paragraph is one—

(A) which accelerates the death benefit specifically for—

(i) one or more of the qualifying events of terminal illness,

(ii) medical conditions requiring extraordinary medical intervention, or

(iii) permanent institutional confinement;

(B) which provides the option of a lump-sum payment for those benefits; or

(C) which provides benefits based on the use of nursing facility care.

SEC. 10112. OTHER TERMS.

In this subtitle:

(1) AGENT.—The term "agent" means—

(A) prior to 1 year after the date of the establishment of the agent training and certification requirements of section 10106, an individual who sells or offers for sale a long-term care insurance policy subject to the requirements of section 10101; and

(B) after the date referred to in subparagraph (A), an individual certified under a training and certification program established under section 10106.

(2) APPROVED REGULATORY PROGRAM; APPROVED REGULATORY STATE.—(A) The term "approved regulatory program" means a regulatory program in a State that the Secretary determines—

(i) provides for the application and enforcement of the standards established under section 10103, and

(ii) complies with the requirements of subpart B of part 3.

(B) APPROVED REGULATORY STATE.—The term "approved regulatory State" means a State with an approved regulatory program (as defined in subparagraph (A)).

(3) CARRIER.—The term "carrier" has the meaning given such term in section 5504.

(4) STANDARDS.—The term "Standards" means all standards established under section 10102 that apply in a State under section 10101.

(5) STATE COMMISSIONER OF INSURANCE.—The term "State commissioner of insurance" includes the State superintendent of insurance.

PART 2—STANDARDS

Subpart A—Policy Standards

SEC. 10121. USE OF STANDARD DEFINITIONS AND TERMINOLOGY AND UNIFORM FORMAT.

Each long-term care insurance policy shall, pursuant to the Standards—

(1) use uniform language and definitions for description of benefits, coverage, providers of covered services, facilities at which covered services are rendered, and eligibility for benefits, including definitions of "home and community care services", of "nursing facility services", and of "respite care", and

(2) use a uniform format and simple, easily understood English for presenting the marketing material and outline of coverage under such a policy.

SEC. 10122. MINIMUM BENEFITS; LIMITING CONDITIONS ON BENEFITS.

(a) MINIMUM BENEFITS.—

(1) IN GENERAL.—A long-term care insurance policy shall provide benefits either—

(A) for nursing facility services, but not for home and community care services, and be labeled prominently as a "nursing home care" policy;

(B) for home and community care services, but not for nursing facility services, and be labeled prominently as a "home and community care" policy; or

(C) for both nursing facility services and home and community care services, and be labeled prominently as a "comprehensive long-term care" policy.

(2) MUST OFFER ALL OPTIONS OR DISCLOSE LACK OF OPTIONS.—A carrier may not offer for sale to an individual a long-term care insurance policy described in one of the subparagraphs of paragraph (1) unless the carrier either (A) also offers for sale to the individual a policy described in each of the other 2 subparagraphs of that paragraph, or (B) discloses the fact that the carrier does not offer policies described in each of such subparagraphs.

(b) RESTRICTIONS ON CONDITIONS.—A long-term care insurance policy may not condition or limit eligibility—

(1) for benefits for a type of services to the need for or receipt of any other services, including prior hospitalization;

(2) for any benefit (where the need for such benefit has been established by an independent assessment of impairment) on any particular medical diagnosis (including any acute condition) or on one of a group of diagnoses;