(2) REPORT.—The Secretary of Labor shall submit to the Congress, by not later than two years after the date that this subtitle applies to a substantial number of employers in all States, a report on the findings of the study.

(b) WORKERS' COMPENSATION CARRIER FILINGS.—

(1) IN GENERAL.—Each workers' compensation carrier (other than a employer that is self-funded for the purpose of providing workers' compensation services) providing workers' compensation insurance in a State shall make a filing with an agency designated by the State at a time specified by the Secretary of Labor (but not earlier than one year after the date this subtitle applies to a substantial number of employers in the State). Such filing shall describe the manner in which such carrier has modified (or intends to modify) its premium rates for workers' compensation insurance provided in the State to reflect the changes brought about by the provisions in this subtitle. The filing shall include such actuarial projections and assumptions as necessary to support the modifications of such rates.

(2) REPORT TO SECRETARY.—Each State shall provide to the Secretary of Labor such information on filings made under paragraph (1) as the Secretary of Labor may specify.

SEC. 13023. PERMISSIBLE TERMS OF CERTAIN CONSTRUCTION INDUSTRY COLLECTIVE BARGAINING AGREEMENTS.

(a) IN GENERAL.—A construction industry collective bargaining agreement described in subsection (b) may include provisions relating to any of the following:

(1) A mechanism to resolve disputes relating to employee entitlement to workers' compensation benefits under applicable State workers' compensation law, including mediation or arbitration, so long as the rights and remedies of employees under such laws are not diminished.

(2) Providing benefits for injured workers or their survivors that are in addition to those provided under State workers' compensation law.

(3) Providing for a light duty, modified job, or return to work program.

(4) Providing for a vocational rehabilitation or training program.

(5) Providing for worker injury and illness prevention programs.

(b) CONSTRUCTION INDUSTRY COLLECTIVE BARGAINING AGREEMENT DESCRIBED.—A construction industry collective bargaining agreement described in this subsection is a collective bargaining agreement—

(1) between—

(A) an employer engaged primarily in the building and construction industry, and

(B) a labor organization—

(i) of which building and construction employee are members, and

(ii) which is not established, maintained, or assisted by conduct that constitutes an unfair labor practice under section 8(a) of the National Labor Relations Act;

(2) covering employees engaged (or who upon their employment will be engaged) in the building and construction industry; and

(3) that meets the prevailing standards for such an agreement in the applicable area.

(c) CONSTRUCTION.—Nothing in this section shall be construed to authorize an agreement described in subsection (b)—

(1) to reduce the benefits payable under applicable State workers' compensation laws, or

(2) to limit the rights or remedies provided to injured workers under such laws.

PART 4—DEMONSTRATION PROJECTS

SEC. 13031. AUTHORIZATION.

The Secretary of Health and Human Services and the Secretary of Labor are authorized to conduct demonstration projects under this part in one or more States with respect to—

(1) treatment of work-related injuries and illnesses;

(2) ways in which occupational health providers can promote safety and health in the workplace; and

(3) ways in which health providers can promote effective return to work of injured workers.

SEC. 13032. DEVELOPMENT OF WORK-RELATED PROTOCOLS.

(a) IN GENERAL.—Under this part, the Secretaries, in consultation with States and such experts on work-related injuries and illnesses as the Secretaries find appropriate, shall develop protocols (which may include protocols for utilization review) for the appropriate treatment of work-related conditions.

(b) TESTING OF PROTOCOLS.—The Secretaries shall enter into contracts with one or more certified health plans to test the validity of the protocols developed under subsection (a).

SEC. 13033. DEVELOPMENT OF CAPITATION PAYMENT MODELS.

The Secretaries shall develop, using protocols developed under section 13032 if possible, methods of providing for payment by workers' compensation carriers to certified health plans on a per case, capitated basis for the treatment of specified work-related injuries and illnesses.

PART 5—COMMISSION ON INTEGRATION OF WORKERS' COMPENSATION MEDICAL BENEFITS

SEC. 13041. COMMISSION.

(a) ESTABLISHMENT.—There is hereby created a Commission on Integration of Workers' Compensation Medical Benefits (in this part referred to as the "Commission").

(b) COMPOSITION.—

(1) IN GENERAL.—The Commission shall consist of the Director of the National Institute for Occupational Safety and Health (or the Director's designee) and 14 members appointed jointly by the Secretary of Health and Human Services and the Secretary of Labor. Appointed members of the Commission shall include the following:

(A) One or more individuals representing State insurance commissioners.

(B) One or more individuals representing State workers' compensation funds.

(C) One or more individuals representing organized labor.

(D) One or more members representing employers (other than workers' compensation insurance carriers).

(E) One or more members representing workers' compensation insurance carriers.

(F) One or more members of the medical profession having expertise in occupational health.

(G) One or more educators or researchers having expertise in the field of occupational health.

(H) One or more members of the legal profession who regularly represent workers' compensation claimants.

(I) One or more actuaries having expertise in the field of workers' compensation.

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

(2) NO COMPENSATION EXCEPT TRAVEL EXPENSES.—Members of the Commission shall serve without compensation, but

the Secretaries shall provide that each member shall receive travel expenses, including per diem in lieu of subsistence, in accordance with sections 5702 and 5703 of title 5, United States Code.

(3) QUORUM.—Eight members of the Commission shall constitute a quorum.

(c) DUTIES.—

(1) IN GENERAL.—The Commission shall study the feasibility of transferring financial responsibility for workers' compensation medical benefits to certified health plans. The Commission shall consider both the potential benefits and potential disadvantages of integration, including the likely impact on—

(A) the quality of medical care delivered to workers injured or made ill on the job;

(B) the incentives for employers to maintain safe workplaces; and

(C) workers' compensation indemnity benefit costs, medical costs and the overall cost of the workers' compensation system.

(2) ISSUES TO BE ADDRESSED.—The Commission shall consider the following issues:

(A) Whether and how to maintain financial incentives for employers to prevent work-related illness and injury and to reduce workers' compensation costs.

(B) Modifications of requirements for workers' compensation carrier and certified health plan reserves, including any associated transition issues relating to the modification of such requirements.

(C) The ability of certified health plans to set capitated payment rates for workers' compensation costs, including the lack of availability of data for use by plans in setting such rates.

(D) Coverage for benefits not included in the guaranteed national benefits package, including both services and cost-sharing, that are covered under State workers' compensation laws.

(E) Variation among States in eligibility for medical and rehabilitation benefits, and the scope of such benefits, compensable under State workers' compensation laws.

(F) The ability to move the financial responsibility for workers' compensation medical benefits from an experience-rated system to a community-rated system.

(G) The need to provide appropriate incentives to encourage certified health plans, providers of health care services, and employers to return injured employees to work as soon as possible.

(H) The effect of an integrated system on the ability to preserve adequate case management of workers' compensation cases.

(I) The impact of an injured worker's choice of provider on the costs of medical care, losses in wages and benefits, and quality of care.

(J) Whether and under what circumstances a State may demonstrate that the comprehensive workers' compensation law providing for medical benefits to injured workers in effect in that State obviates the need for transferring financial responsibility for workers' compensation medical benefits to certified health plans, taking into account the impact on injured workers.

(3) DEVELOPMENT OF PLAN.—The Commission shall, based on its study of the issues under paragraphs (1) and (2), develop a detailed plan for implementing the transfer of financial responsibility for workers' compensation medical benefits to certified health plans and make a recommendation as to whether such a transfer should be effected.

(d) STAFF SUPPORT.—The Secretaries shall provide staff support for the Commission.

(e) REPORT.—The Commission shall submit a report on its work to the President and to the Congress by not later than two years after the date of the enactment of this Act. The report shall include the plan developed and its recommendation under subsection (c)(3).

(f) TERMINATION.—The Commission shall terminate 90 days after the date of submission of its report under subsection (e).

(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

Subtitle B—Automobile Insurance

SEC. 13100. DEFINITIONS.

In this subtitle:

(1) INJURED INDIVIDUAL.—The term "injured individual" means, with respect to a certified health plan, an individual enrolled under the plan who has an injury or illness sustained in an automobile accident for which automobile insurance medical benefits are available.

(2) AUTOMOBILE INSURANCE MEDICAL BENEFITS.—The term "automobile insurance medical benefits" means, with respect to an enrollee, the comprehensive medical benefits for injuries or illnesses sustained in automobile accidents.

(3) AUTOMOBILE INSURANCE CARRIER.—The term "automobile insurance carrier" means an insurance company that underwrites automobile insurance medical benefits and includes an employer or fund that is financially at risk for the provision of automobile insurance medical benefits.

(4) AUTOMOBILE INSURANCE MEDICAL SERVICES.—The term "automobile insurance medical services" means items and services included in automobile insurance medical benefits and includes items and services (such as rehabilitation services and long-term care services) commonly used for treatment of injuries and illnesses sustained in automobile accidents.

SEC. 13101. PROVISION OF AUTOMOBILE INSURANCE MEDICAL BENEFITS THROUGH HEALTH PLANS.

(a) IN GENERAL.—An individual entitled to automobile insurance medical benefits and enrolled in a certified health plan shall receive automobile insurance medical services through the provision (or arrangement for the provision) of such services by the health plan.

(b) REFERRAL FOR SPECIALIZED SERVICES.—Each certified health plan shall provide for such referral for automobile insurance medical services as may be necessary to assure appropriate treatment of injured individuals.

(c) EXCEPTIONS.—Subsections (a) and (b) shall not apply shall not apply with respect to a health plan of the Department of Veterans Affairs, of the Indian Health Service, or of the Department of Defense and individuals enrolled in such a plan.

(d) ALTERNATIVE PERMITTED.—Subsection (a) shall not be construed as preventing an injured individual and an automobile insurance carrier from agreeing that automobile insurance medical services shall be provided other than by or through the certified health plan in which the individual is enrolled.

SEC. 13102. PAYMENT BY AUTOMOBILE INSURANCE CARRIER.

(a) PAYMENT.—

(1) IN GENERAL.—Except as provided in subsection (b), each automobile insurance carrier that is liable for payment for automobile insurance medical services furnished by or through a certified health plan, regardless of whether or not the services are included in the guaranteed national benefit package,

shall make payment for such services directly to the health plan.

(2) PRICE DISCRIMINATION PROHIBITED.—Fees charged an automobile insurance carrier by a certified health plan or health provider for automobile insurance medical services shall not exceed fees charged by such certified health plan or health provider for similar services provided to an injured individual for an injury or illness not sustained in an automobile accident.

(3) EXCEPTION FOR MEDICARE PART C ENROLLEES.—Each health provider or certified health plan providing automobile insurance medical services to an injured individual enrolled in medicare part C shall bill the automobile insurance carrier directly for such services, and each carrier liable for payment for such services shall make payment for such services directly to such health provider or certified health plan.

(b) ALTERNATIVE PAYMENT METHODOLOGIES.—Subsection (a) shall not apply—

(1) in the case of a State that establishes an alternative payment methodology (such as payment on a negotiated fee for each case) for payment for automobile insurance medical services; or

(2) in the case in which an automobile insurance carrier and the certified health plan negotiate alternative payment arrangements.

(c) LIMITATION OF LIABILITY OF INJURED INDIVIDUAL.—Nothing in this subtitle shall be construed as requiring an injured individual to make any payment (including payment of any cost sharing) to any certified health plan or health provider for the receipt of automobile insurance medical services for which an automobile insurance carrier is liable.

(d) PREVENTION OF DUPLICATE PAYMENT.—Except in accordance with other subsections of this section, nothing in this Act shall require any automobile insurance carrier or policyholder to make any duplicate payment to any certified health plan or health provider for automobile insurance medical services.

(e) REIMBURSEMENT FOR PAYMENTS MADE.—Nothing in this section shall impair the right of a certified health plan or automobile insurance carrier to seek reimbursement from any person legally responsible for a bodily injury or illness resulting from an automobile accident for payments made for automobile insurance medical services to treat such injury or illness.

SEC. 13103. CONSTRUCTION.

Nothing in this subtitle shall be construed as altering—

(1) the determination of whether or not a person is an injured individual and entitled to automobile insurance medical benefits under State law, or

(2) the scope of items and services available to injured individuals entitled to automobile insurance medical benefits under State law.

Subtitle C—Federal Employees' Compensation Act

SEC. 13201. APPLICATION OF POLICY.

(a) IN GENERAL.—Chapter 81 of title 5, United States Code, known as the Federal Employees' Compensation Act shall be interpreted and administered consistent with the provisions of subtitle A.

(b) CONSTRUCTION.—In applying subsection (a), subtitle A shall be applied as if the following modifications had been made in subtitle A:

(1) Any reference in section 13000, section 13001(c)(2)(D), or section 13014 to a State law is deemed to include a reference to chapter 81 of title 5, United States Code.

(2) The term "workers' compensation carrier" includes the Employees Compensation Fund (established under section 8147 of title 5, United States Code).

(c) APPLICATION TO CERTAIN OTHER LAWS.—

(1) IN GENERAL.—The provisions of section 13002(a)(2), relating to payment for workers' compensation services, shall apply to payment for medical services in the United States under the following laws, in the same manner as such provisions apply to the Federal Employees' Compensation Act under this section:

(A) The Longshore and Harbor Workers' Compensation Act (33 U.S.C. 901 et seq.).

(B) Cure for a seaman under general maritime law.

(C) The Federal Employers' Liability Act (45 U.S.C. 51 et seq.).

(2) CONSTRUCTION.—Nothing in this subsection shall be construed as altering—

(A) the remedies available under the laws described in subparagraphs (A) through (C) of paragraph (1);

(B) the determination of whether or not a person is entitled to benefits under such laws;

(C) the scope of items and services available under such laws; or

(D) the eligibility of any individual or class of individuals for benefits under such laws.

Subtitle D—Davis-Bacon Act and Service Contract Act

SEC. 13301. COVERAGE OF BENEFITS UNDER GUARANTEED HEALTH INSURANCE ACT OF 1994.

(a) DAVIS-BACON ACT.—Subsection (b)(2) of the first section of the Davis Bacon Act (40 U.S.C. 276a(b)(2)) is amended in the matter following subparagraph (B) by inserting after "local law" the following: "(other than benefits provided pursuant to the Guaranteed Health Insurance Act of 1994)".

(b) SERVICE CONTRACT ACT OF 1965.—The second sentence of section 2(a)(2) of the Service Contract Act of 1965 (41 U.S.C. 351(a)(2)) is amended by inserting after "local law" the following: "(other than benefits provided pursuant to the Guaranteed Health Insurance Act of 1994)".

Subtitle E—Effective Dates

SEC. 13401. GENERAL EFFECTIVE DATE; APPLICATION.

The provisions of subtitles A and B of this title shall take effect on January 1, 1997, and shall apply with respect to any individual covered under a certified health plan under this Act.

SEC. 13402. FEDERAL REQUIREMENTS.

The provisions of subtitle C of this title shall take effect on January 1, 1998.

TITLE XIV—FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

SEC. 14001. FINDINGS AND PURPOSES.

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

(1) The Federal Employees Health Benefits Program (in this section referred to as "FEHBP") has been providing tens of millions of Federal employees, retirees, and dependents with affordable, comprehensive health insurance for over 30 years.

(2) The FEHBP, as the only model of managed competition operating on a national basis, could make a significant contribution toward making affordable, comprehensive health insurance available to the Nation's underinsured and uninsured by enrolling members of the general public.

(3) The FEHBP has a better record than most private and public health programs in constraining the average rate of increases in annual health care costs, and offers the Nation a working model for constraining health care costs.

(4) The long-term viability of the FEHBP is critical to its contributing to increasing the availability of affordable, comprehensive health insurance to the general public.

(5) The long-term viability of the FEHBP is critical to the continued fulfillment of the Federal Government's obligation as the Nation's largest employer to provide affordable, comprehensive health benefits to its employees and retirees.

(6) To maintain the long-term viability of the FEHBP, the expansion of the program to serve the general public should be accomplished in a sound, prudent, and incremental manner.

(7) The enactment of certain insurance and health policy reforms as a part of national health care reform will eliminate features of the current system that would otherwise threaten the solvency of FEHBP health benefit plans and the long-term viability of the expanded program.

(8) Opening the FEHBP to the general public should be viewed as a complement to other broad-based health care reform initiatives, such as the creation of a nationwide system of affordable, comprehensive health care benefits available to all, to ensure the long-term viability of the FEHBP, to prevent the FEHBP from being overwhelmed administratively, and to protect the interests of existing FEHBP enrollees.

(9) The general public should have available the level of benefits, quality of service, and choice of plans and providers currently received by FEHBP enrollees and their dependents.

(10) The ultimate integration of existing FEHBP enrollees into community-rated pools should await the enactment of key insurance market reforms and an employer mandate, both to ensure the creation of stable insurance markets and to protect the interests of existing FEHBP enrollees.

(b) PURPOSES.—The purposes of this title are as follows:

(1) To provide tens of millions of Americans, many of whom have no or inadequate health insurance, with access to the same affordable, comprehensive health care benefits as are available to Federal employees and retirees.

(2) To permit the future integration of Federal employees and retirees into a FEHBP expanded to serve the general public.

(3) To make necessary changes in the FEHBP.

SEC. 14002. DEFINITIONS.

For the purpose of this title—

(1) the terms "FEHBP transition period" and "universal FEHBP" have the meanings given such terms by section 8903b of title 5, United States Code (as added by section 14301); and

(2) the term "contract year" is used in the same way as under chapter 89 of title 5, United States Code.

SEC. 14003. AMENDMENT OF TITLE 5, UNITED STATES CODE.

Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 5, United States Code.

Subtitle A—General Changes in Health Benefits for Federal Employees and Annuitants

SEC. 14101. TYPES OF BENEFITS.

(a) GUARANTEED NATIONAL BENEFITS.—

(1) IN GENERAL.—

(A) BENEFITS TO BE OFFERED.—Subsection (a) of section 8904 is amended to read as follows:

"(a) The benefits provided under each plan described in section 8903 shall be the same as the guaranteed national benefit package under subtitle A of title III of the Guaranteed Health Insurance Act of 1994.".

(B) CONFORMING AMENDMENTS.—Chapter 89 is amended—

(i) in section 8903(1) by striking "8904(1)" and inserting "8904(a)";

(ii) in section 8903(2) by striking "8904(2)" and inserting "8904(a)";

(iii) in section 8903(3) by striking "8904(3)" and inserting "8904(a)";

(iv) in section 8903(4)(A) by striking "8904(4)" and inserting "8904(a)"; and

(v) in section 8903a(b)(2) by striking "paragraph (1) or (2) of section 8904 of this title or both" and inserting "section 8904(a)".

(2) LEVELS OF BENEFITS.—

(A) Paragraphs (1) and (2) of section 8903 are amended by striking ", offering two levels of benefits,".

(B) Section 8905a(d)(1)(A)(i) is amended by striking "and level of benefits".

(C) Section 8906(d) is amended by striking "plan and level of benefits." and inserting "plan.".

(3) CLASSES OF ENROLLMENT.—

(A) Section 8905(a) is amended by striking "either as an individual or for self and family." and inserting "based on an appropriate class of enrollment.".

(B) Section 8905(c)(1) is amended in the first sentence by striking "as an individual or for self and family as provided in paragraph (2) of this subsection".

(C) Section 8905 is amended by adding a period at the end of subsection (b) and by striking the matter before subparagraph (A) of subsection (c)(2) and inserting the following:

"(2) Coverage under this subsection shall not be available except with respect to—".

(D) Section 8905(d) is amended to read as follows:

"(d) If an employee, annuitant, or other individual eligible to enroll in a health benefits plan under this chapter has a spouse who is also eligible to enroll, such individual may not be enrolled both as an employee, annuitant, or other individual eligible to enroll and as a family member of the spouse.".

(E) Section 8905a(d)(3)(A) is amended by striking "coverage either as an individual or, if appropriate, for self and family." and inserting "any appropriate class of enrollment.".

(F) Section 8905a(f)(3)(A) is amended by striking "for self and family" and inserting "under a class of enrollment that covered such individual".

(b) MAINTENANCE OF EFFORT.—

(1) IN GENERAL.—Chapter 89 is amended by inserting after section 8904 the following:

"§ 8904a. Maintenance of effort

"(a) For the purpose of this section, the term 'guaranteed national benefit package' means the guaranteed national benefit package referred to in section 8904(a).

"(b)(1) The Office of Personnel Management shall provide or contract for maintenance of effort policies which shall provide—

"(A) in the case of an individual covered by a comprehensive medical plan, coverage which, when considered together with the guaranteed national benefit package, is comparable to that which, during the year described in paragraph (3), was provided by the comprehensive medical plan with the largest number of enrollments in such year (as identified by the Office); and

"(B) in the case of an individual covered by any other plan under this chapter—

"(i) coverage for services and items which were available under the lower level of benefits offered by the service benefit plan during the year described in paragraph (3), but which are not included in the guaranteed national benefit package;

"(ii) coverage for services and items included in the guaranteed national benefit package, but not covered to the same extent as was the case under the lower level of benefits offered by the service benefit plan during the year described in paragraph (3), because of any limitation in amount, duration, or scope under the guaranteed national benefit package;

"(iii) coverage for deductibles, coinsurance, and copayments imposed under the guaranteed national benefit package, but not by the lower level of benefits offered by the service benefit plan during the year described in paragraph (3); or

"(iv) any combination thereof.

"(2) In developing maintenance of effort policies to be offered under this section, the Office of Personnel Management—

"(A) shall meet and confer with exclusive representatives of employees through a process to be established by the National Partnership Council; and

"(B) shall consult periodically with representatives of employees (other than those described in subparagraph (A)) and of annuitants.

"(3) The year described in this paragraph is the contract year immediately preceding the first contract year to which this section applies.

"(c) An individual shall be eligible to be covered by a maintenance of effort policy only so long as such individual is also covered by a health benefits plan under this chapter.

"(d)(1) The Government shall pay the total enrollment charge under this section in the case of any employee or annuitant for whom Government contributions are being made with respect to any health benefits plan under this chapter.

"(2)(A) Any payment under this subsection shall be made at the same time and in the same manner as if it were a Government contribution for a health benefits plan, and shall be made from the same appropriation or fund as from which any such Government contributions would, with respect to the employee or annuitant involved, be made.

"(B) The reference to Government contributions authorized by this section in section 8906(g) shall be considered to include payments under this subsection.

"(e) To the extent that maintenance of effort policies are provided through carriers, section 8902 shall, with respect to the administration of this section, apply to the extent practicable.

"(f) No requirement of law relating to limiting the offering of a supplemental health benefit policy shall apply to a maintenance of effort policy offered under this section.".

(2) CHAPTER ANALYSIS.—The analysis for chapter 89 is amended by inserting after the item relating to section 8904 the following:

"8904a. Maintenance of effort.".

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall take effect on the date of the enactment of this Act, and shall apply with respect to contract years beginning with the contract year described in paragraph (2).

(2) CONTRACT YEAR DESCRIPTION.—The contract year described in this paragraph is the contract year beginning in the first full calendar year throughout which the requirements of section 5007 of the Guaranteed Health Insurance Act of 1994 (relating to requirement of offering of guaranteed national benefit package by health benefit plans) will be met, or will be deemed to be met, with respect to insured health benefit plans in all the States, as determined by the Office of Personnel Management.

(3) SAVINGS PROVISION.—For purposes of applying the provisions of chapter 89 of title 5, United States Code, with respect to any contract year before the contract year described in paragraph (2), this section shall be treated as if it had not been enacted.

SEC. 14102. CONTRIBUTIONS FOR GUARANTEED NATIONAL BENEFITS; OTHER PROVISIONS TAKING EFFECT IN 1997.

(a) AVERAGE SUBSCRIPTION CHARGES.—Section 8906(a) is amended to read as follows:

"(a) The Office of Personnel Management shall determine the weighted average of the subscription charges in effect on the beginning date of each contract year for all health benefits plans under this chapter (for each class of enrollment).".

(b) GOVERNMENT CONTRIBUTION.—Section 8906(b) is amended—

(1) in paragraph (1) by striking "60 percent of the average subscription charge" and inserting "80 percent of the applicable weighted average subscription charge"; and

(2) in paragraph (2) by striking "75 percent of".

(c) PART-TIME CAREER EMPLOYMENT.—Section 8913 is amended by redesignating subsection (d) as subsection (e), and by inserting after subsection (c) the following:

"(d) The regulations of the Office may provide that, for purposes of carrying out this chapter in any contract year—

"(1) the term 'part-time career employment' shall (instead of the meaning which would otherwise apply) have the same meaning as being employed on a 'part-time basis' has under section 1106(a) of the Guaranteed Health Insurance Act of 1994, but only if, in the judgment of the Office, a greater number of employees would thereby qualify to be treated as occupying a position on a part-time career employment basis in such year; and

"(2) any appropriate adjustment in the method for determining the Government contribution under section 8906(b)(3) may be made if the alternative definition under paragraph (1) is applied.".

(d) DEFINITION OF CHILD.—Section 8901(5) is amended by striking "22;" and inserting "22, or such an unmarried dependent

child between 22 and 24 years of age who is a student regularly pursuing a full-time course of study or training in residence at an educational institution referred to in section 8341(a)(4)(C) (determined in a manner similar to that provided for by the last 2 sentences of section 8341(a));".

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall take effect on the date of the enactment of this Act, and shall apply with respect to contract years beginning with the contract year that begins in 1997.

(2) SAVINGS PROVISION.—For purposes of applying the provisions of chapter 89 of title 5, United States Code, with respect to any contract year before the first contract year to which the amendments made by this section shall apply, subsections (a) through (d) of this section shall be treated as if they had not been enacted.

(f) TRANSITION.—For contract years beginning on or after the date of the enactment of this Act and before the 1997 contract year, notwithstanding any other provision of law, the dollar amount of the Government contribution under section 8906(b)(1) of title 5, United States Code, may not be less than the dollar amount of the Government contribution under such section 8906(b)(1) in the previous contract year, increased by the same percentage as the percentage increase in the weighted average premium of all health benefit plans offered under chapter 89 of such title between the previous contract year and the year involved.

SEC. 14103. ANNUALIZATION OF OPEN ENROLLMENT PERIODS.

Section 8905(f)(1) is amended by striking "any contract term" and all that follows through "provide" and inserting "each contract year, provide".

SEC. 14104. SUBSIDIES FOR LOW-INCOME FEDERAL EMPLOYEES AND ANNUITANTS.

Section 8906 is amended by adding at the end the following:

"(j)(1) An employee enrolled under this chapter may be eligible for a premium certificate under part A of title XXII of the Social Security Act.

"(2) In the case of an individual enrolled under this chapter who is not an employee, but who would, if such individual were an employee, be eligible for such a premium certificate, for purposes of such part—

"(A) the individual shall be deemed to be an employee; and

"(B) the administrative entity responsible for administering the provisions of this chapter relating to the enrollment of such individual shall be deemed the employer of such individual."

SEC. 14105. PROVISIONS RELATING TO THE RETIRED FEDERAL EMPLOYEES HEALTH BENEFITS ACT.

(a) PROGRAM TERMINATION.—The Retired Federal Employees Health Benefits Act (Public Law 86-724; 74 Stat. 849) is repealed as of the date specified in subsection (c), and all contracts under such Act shall terminate not later than such date.

(b) CONTINUED AVAILABILITY OF COVERAGE FOR RETIRED EMPLOYEES.—

(1) IN GENERAL.—For purposes of health insurance coverage for any period after the date as of which coverage under the Retired Federal Employees Health Benefits Act ceases to be available as a result of the enactment of this section, retired employees who (but for this section) would be eligible for coverage under such Act shall be treated, for purposes of chapter 89 of title 5, United States Code, as if they were annuitants eligible to enroll under such chapter 89.

(2) AUTOMATIC COVERAGE.—In the case of any retired employee who is enrolled in a plan under the Retired Federal Employees Health Benefits Act during the last year in which coverage under such Act is offered, and who fails to elect to be covered under such chapter 89 or to decline such coverage with

respect to the following year, such retired employee shall be automatically enrolled in a service benefit plan under such chapter 89, as determined under regulations prescribed by the Office of Personnel Management.

(3) SURVIVORS.—For the purpose of this subsection, the term "retired employee" includes a survivor of the retired employee.

(c) SPECIFICATION OF DATE.—The date specified in this subsection is the first day of the first calendar year throughout which subsidies are available under section 8906(j)(2) of title 5, United States Code (as added by section 14104) to Federal annuitants.

(d) TREATMENT OF THE FUND.—After the date specified in subsection (c), the Retired Employees Health Benefits Fund shall temporarily remain available, and amounts in that fund shall subsequently be disbursed, in a manner comparable to that provided for under section 14402.

(e) REGULATIONS.—The Office shall prescribe such regulations as may be necessary to carry out this section.

SEC. 14106. TEMPORARY EMPLOYEES.

(a) NONEXCLUDABILITY.—Paragraph (4) of section 8913(b) is amended to read as follows:

"(4) an employee who is employed on a temporary basis, if such employee either—

"(A) has completed 3 months of current continuous employment (excluding any break in service of 5 days or less);

"(B) has been (or is reasonably expected to be) employed for a period of 4 months during the previous (or succeeding) 12-month period; or

"(C) meets such other employment requirements as the Office may prescribe.".

(b) REPEAL.—

(1) IN GENERAL.—Section 8906a is repealed.

(2) CHAPTER ANALYSIS.—The analysis for chapter 89 is amended by repealing the item relating to section 8906a.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall take effect on the date of the enactment of this Act and shall first apply to coverage provided on and after such month (not later than the first month that begins more than 3 months after the date of the enactment of this Act) as the Office of Personnel Management specifies.

(2) TRANSITION.—The Office of Personnel Management shall provide for such special enrollment procedures and other rules as may be required to provide for enrollment of individuals described in section 8913(b)(4) of title 5, United States Code, as amended by subsection (a), for coverage on or after the first month described in paragraph (1).

SEC. 14107. STANDARDIZED CLAIMS PROCESSING.

(a) IN GENERAL.—Section 8902 is amended by adding at the end the following:

"(o) A claim for payment or reimbursement under this chapter (whether electronic or otherwise) shall be submitted on such a standard form or in such a standard manner as may be required by the Office in relation to health benefit plans. Each contract under this chapter shall include appropriate provisions to carry out the preceding sentence.".

(b) APPLICABILITY.—The amendment made by subsection (a) shall be implemented as soon as practicable, but in no event later than January 1, 1996.

SEC. 14108. ADVANCE DIRECTIVES.

(a) IN GENERAL.—Section 8907 is amended by adding at the end the following:

"(c) The Office shall—

"(1) prepare information relating to the use of advance directives regarding the type and intensity of care which an individual desires in the event that such individual becomes unable to communicate by reason of incapacity due to illness or injury; and

"(2) require, as a condition for approval of any contract under section 8902 (and in accordance with the applicable provisions (if any) of the Guaranteed Health Insurance Act of 1994), that appropriate provisions be included so that such information may be made available to enrollees of the plan involved.".

(b) APPLICABILITY.—The amendment made by subsection (a) shall apply with respect to contract terms beginning on or after January 1, 1996.

SEC. 14109. COLLECTIVE BARGAINING AUTHORITY.

(a) IN GENERAL.—Any collective bargaining rights available under title 39, United States Code, before the date of the enactment of this Act, with respect to health benefits, shall continue to be available with respect to health benefits provided for as a result of the enactment of this Act.

(b) HOLD HARMLESS PROVISION.—In no event shall the Government contribution provided by the United States Postal Service be less than that required pursuant to a collective bargaining agreement under title 39, United States Code (if such agreement was ratified before the date of the enactment of this Act) while such agreement remains in effect. The preceding sentence shall be in addition to any requirement under section 1111(c) of this Act.

(c) AMENDMENT TO TITLE 39, UNITED STATES CODE.—Section 1005(f) of title 39, United States Code, is amended by striking "87 and 89" and inserting "87, 89, and 89A".

(d) RELATED PROVISION.—Notwithstanding any other provision of (or amendment made by) this Act, any health benefits plan of an organization described in section 5305(c) of this Act may operate without regard to the number of States in which it is licensed to issue group health insurance.

Subtitle B—Provisions Relating to Universal FEHBP

SEC. 14201. UNIVERSAL FEHBP.

For provisions relating to universal FEHBP, see subtitle D of title V of this Act.

Subtitle C—Transition Rules

SEC. 14301. TREATMENT OF COMPREHENSIVE MEDICAL PLANS.

(a) IN GENERAL.—Chapter 89 is amended by adding after section 8903a the following:

"**§ 8903b. Treatment of comprehensive medical plans**

"(a) For the purpose of this section—

"(1) the term 'FEHBP transition period' means the 7-year period beginning on the first day of the first contract year beginning after the contract year described in subsection (b);

"(2) any reference to a particular numbered year in the FEHBP transition period refers to the corresponding contract year in such period;

"(3) the term 'old rate' means, with respect to a plan, the subscription charge for such plan under this chapter, determined—

"(A) as if the Guaranteed Health Insurance Act of 1994 had not been enacted; but

"(B) subject to subsection (c)(2);

"(4) the term 'new rate' means, with respect to a plan, the subscription charge for such plan's corresponding universal FEHBP plan;

"(5) the term 'corresponding universal FEHBP plan', as used with respect to a comprehensive medical plan, means the plan required by subsection (d) to be offered under universal FEHBP in order that such comprehensive medical plan may be offered under this chapter;

"(6) the term 'universal FEHBP' means the health insurance program under subtitle D of title V of the Guaranteed Health Insurance Act of 1994;

"(7) the term 'comprehensive medical plan' means a plan described by section 8903(4); and

"(8) the term 'guaranteed national benefit package' means the guaranteed national benefit package referred to in section 8904(a).

"(b)(1) The contract year described in this subsection is the first contract year—

"(A) for which an affirmative certification is made under paragraph (2)(A) that, with respect to each community-rating area in which individuals eligible to enroll under this chapter reside, universal FEHBP is—

"(i) operating in a stable health insurance market;

"(ii) serving a representative population; and

"(iii) offering such a range of types of health plans as is provided under this chapter (including a plan which offers an unlimited choice of providers); and

"(B) by the end of which the following provisions of law are in effect with respect to all individuals eligible to enroll in universal FEHBP:

"(i)(I) Section 59B of the Internal Revenue Code of 1986 and section 1001(b) of the Guaranteed Health Insurance Act of 1994 (relating to individual mandate); or

"(II) sections 3451 and 3455 of the Internal Revenue Code of 1986 and section 1101(a) of the Guaranteed Health Insurance Act of 1994 (relating to employer mandates).

"(ii) Section 5004 of the Guaranteed Health Insurance Act of 1994 (relating to preexisting condition exclusions).

"(iii) Subsection (a) of section 5008 of the Guaranteed Health Insurance Act of 1994 (relating to community rating of premiums), except that such subsection shall not, for purposes of this subparagraph, be considered to be in effect until the completion of the transition period established under subsection (b) of such section for all States.

"(iv) Section 5007 of the Guaranteed Health Insurance Act of 1994 (relating to requirement of offering of guaranteed national benefit package by health benefit plans).

"(v) Section 5003 of the Guaranteed Health Insurance Act of 1994 (relating to open enrollment requirements).

"(vi) Part A of title XXII of the Social Security Act (relating to premium certificates).

"(2)(A) The Office of Personnel Management shall certify for each contract year, beginning with the 1999 contract year, whether or not universal FEHBP satisfies the conditions set forth in paragraph (1)(A).

"(B) The Office shall transmit a report on each certification under subparagraph (A), including the basis for the certification, to Congress and the President not later than the tenth day after the end of the contract year to which the certification relates (unless that tenth day is a Saturday, Sunday, or legal holiday, in which case the deadline shall be the next day which is not one of the aforementioned days).

"(3) For purposes of paragraph (2)(A), the condition under paragraph (1)(A)(i) shall not be considered to be satisfied unless the community-rated market sector in which universal FEHBP is oper-

ating is large enough to yield credible experience and permit the setting of stable rates.

"(c) Notwithstanding section 8902(i) or any other provision of this chapter—

"(1) the subscription charge for each comprehensive medical plan shall—

"(A) for the first year of the FEHBP transition period, be equal to the old rate;

"(B) for the second year of the FEHBP transition period, be equal to the sum of—

"(i) 75 percent of the old rate; and

"(ii) 25 percent of the new rate;

"(C) for the third year of the FEHBP transition period, be equal to the sum of—

"(i) 50 percent of the old rate; and

"(ii) 50 percent of the new rate; and

"(D) for the fourth year of the FEHBP transition period, be equal to the sum of—

"(i) 25 percent of the old rate; and

"(ii) 75 percent of the new rate; and

"(2) the areas for which rates are established under this subsection shall, beginning with not later than the rates determined for the second year of the FEHBP transition period, be the same as under universal FEHBP.

"(d) A contract under this chapter for a comprehensive medical plan may not be made, nor may any such plan be approved, for any year in the FEHBP transition period, unless the carrier agrees to offer (in the same area) a health benefits plan under universal FEHBP in such year.

"(e) All computations under this section shall be made with respect to each class of enrollment available under the plan involved.

"(f)(1) Except in such cases as the Office may provide, effective for items and services furnished after the expiration of the fourth year of the FEHBP transition period—

"(A) health insurance coverage under a plan described by section 8903(4) shall not be available under this chapter; and

"(B) in applying this chapter, any reference to such plans shall be disregarded.

"(2) In the case of any individual who is enrolled in a plan described in section 8903(4) as of the last day of the fourth year of the FEHBP transition period, and who fails to elect to be covered under a plan under either this chapter or universal FEHBP or to decline such coverage with respect to the following year, such individual (if eligible) shall be automatically enrolled in the corresponding or most similar plan offered under universal FEHBP for the same or most similar class of enrollment, as determined under regulations prescribed by the Office.

"(g) The Office shall prescribe such regulations as may be necessary to carry out this section.".

(b) TREATMENT OF RESERVES.—For provisions relating to treatment of reserves, see section 14402.

(c) CHAPTER ANALYSIS.—The analysis for chapter 89 is amended by inserting after the item relating to section 8903a the following:

"8903b. Treatment of comprehensive medical plans."

SEC. 14302. ELIGIBILITY FOR UNIVERSAL FEHBP.

(a) IN GENERAL.—Chapter 89 is amended by adding after section 8905a the following:

"§ 8905b. Election of coverage under universal FEHBP

"(a) For the purpose of this section, the terms 'FEHBP transition period' and 'universal FEHBP' have the meanings given such terms by section 8903b.

"(b) Effective after the fourth contract year of the FEHBP transition period, any individual who would be eligible to enroll in a

health benefits plan under this chapter if the Guaranteed Health Insurance Act of 1994 had not been enacted shall be eligible to enroll in a health benefits plan under universal FEHBP.

"(c) Enrollment and all other aspects of participation in universal FEHBP pursuant to this section shall be in accordance with chapter 89A (disregarding the applicability rule under section 8932(a)(2) and any provisions relating thereto). Nothing in this subsection or chapter 89A (including any provision incorporated under chapter 89A by reference) shall, with respect to any period before the end of the FEHBP transition period, have the effect of preventing an election of coverage under this chapter.

"(d) The Office of Personnel Management shall prescribe such regulations as may be necessary to carry out this section, including provisions under which any coverage under universal FEHBP shall, for purposes of subsections (b) and (d) of section 8905, be treated as coverage under this chapter.".

(b) COORDINATION OF OPEN ENROLLMENT PERIODS.—

(1) IN GENERAL.—Subsection (f)(1) of section 8905 is amended to read as follows:

"(f)(1) The Office shall provide for a period each year (beginning and ending on the same dates as the annual open enrollment period provided for under section 5305(a) of the Guaranteed Health Insurance Act of 1994 in such year) during which any employee, annuitant, former spouse, or other individual eligible to enroll in a health benefits plan under this chapter may—

"(A) commence, terminate, or transfer such individual's enrollment in a plan under this chapter or under universal FEHBP; or

"(B) make any other election allowable under regulations prescribed by the Office.".

(2) APPLICABILITY.—The amendment made by paragraph (1) shall take effect on the first day of the fourth year of the FEHBP transition period.

(c) COORDINATION PROVISIONS RELATING TO OTHER ENROLLMENT OPPORTUNITIES.—Section 8905 is amended by adding at the end the following:

"(g) The periods during which, and the reasons for which, any change allowable under subsection (e) or (f)(2) may be made shall be at least coextensive with the provisions of section 5305(a) of the Guaranteed Health Insurance Act of 1994 which relate to special enrollment periods.".

(d) CHAPTER ANALYSIS.—The analysis for chapter 89 is amended by inserting after the item relating to section 8905a the following:

"8905b. Election of coverage under universal FEHBP."

SEC. 14303. TREATMENT OF REMAINING PLANS.

(a) TREATMENT OF REMAINING PLANS.—Chapter 89 is amended by adding after section 8903b (as added by section 14301) the following:

"§ 8903c. Treatment of remaining plans

"(a) For the purpose of this section—

"(1) the terms 'FEHBP transition period' and 'universal FEHBP plan' have the meanings given such terms by section 8903b;

"(2) the rule of construction set forth in section 8903b(a)(2) applies;

"(3) the term 'experience-based rate' means, with respect to a plan, the subscription charge for such plan under this chapter, determined as if the Guaranteed Health Insurance Act of 1994 had not been enacted;

"(4) the term 'applicable community rate' means, with respect to a health benefits plan offered by a carrier under this chapter—

"(A) the subscription charge for the plan through which the guaranteed national benefit package is offered by such carrier under universal FEHBP within the community-rating area involved (if any); or

"(B) if subparagraph (A) cannot be applied, the weighted average of the subscription charges for the universal FEHBP plans which, in the preceding contract year, accounted for at least 80 percent of all enrollments under universal FEHBP (taken in descending order, starting with the plan which had the greatest number of enrollments) within the community-rating area involved, as determined by the Office of Personnel Management; and

"(5) the term 'community-rating area' means such an area as applied for purposes of section 5304(a)(1) of the Guaranteed Health Insurance Act of 1994.

"(b) Notwithstanding section 8902(i) or any other provision of this chapter, the subscription charge for each plan described by section 8903(1), (2), or (3) shall—

"(1)(A) for the fifth year of the FEHBP transition period, be equal to the sum of—

"(i) 75 percent of the experience-based rate; and

"(ii) 25 percent of the applicable community rate;

"(B) for the sixth year of the FEHBP transition period, be equal to the sum of—

"(i) 50 percent of the experience-based rate; and

"(ii) 50 percent of the applicable community rate; and

"(C) for the seventh year of the FEHBP transition period, be equal to the sum of—

"(i) 25 percent of the experience-based rate; and

"(ii) 75 percent of the applicable community rate; and

"(2) beginning with the rates for the fifth year of the FEHBP transition period, be determined on a community-by-community basis (except that nothing in this paragraph shall be considered to affect the way in which any experience-based rate, required for purposes of any computation under this section, is determined).

"(c) All computations under this section shall be made with respect to each class of enrollment available under the plan involved.

"(d)(1) Except in such cases as the Office may provide, effective for items and services furnished after the expiration of the FEHBP transition period—

"(A) health insurance coverage under a plan described by section 8903 (other than paragraph (4)) shall not be available under this chapter; and

"(B) in applying this chapter, any reference to such plans shall be disregarded.

"(2) In the case of any individual who is enrolled in a plan as of the last day of the FEHBP transition period, and who fails to elect to be covered under a plan under universal FEHBP or to decline such coverage with respect to the following year, such individual (if eligible) shall be automatically enrolled in the corresponding or most similar plan offered under universal FEHBP for the same or most similar class of enrollment, as determined under regulations prescribed by the Office.".

(b) TREATMENT OF RESERVES.—For provisions relating to treatment of reserves, see section 14402.

(c) CHAPTER ANALYSIS.—The analysis for chapter 89 is amended by adding after the item relating to section 8903b (as added by section 14301) the following:

"8903c. Treatment of remaining plans.".

Subtitle D—Post-Transition Provisions

SEC. 14401. INTEGRATION OF FEHBP AND UNIVERSAL FEHBP.

(a) IN GENERAL.—Title 5, United States Code is amended by inserting after chapter 89 the following:

"CHAPTER 89A—PROVISIONS FOR THE INTEGRATION OF FEHBP AND UNIVERSAL FEHBP

"Sec.
"8931. Definitions.
"8932. Applicability.
"8933. Coverage under universal FEHBP.
"8934. Provisions relating to plans offering the guaranteed national benefit package.
"8935. Eligibility for additional benefits.
"8936. Opportunities to enroll.
"8937. Regulations.

"§ 8931. Definitions

"For the purpose of this chapter—

"(1) any term used in this chapter which is defined for purposes of chapter 89 has the meaning given such term under such chapter; and

"(2) the term 'FEHBP transition period' has the meaning given such term by section 8903b(a)(1).

"§ 8932. Applicability

"(a) IN GENERAL.—

"(1) TO WHOM THIS CHAPTER APPLIES.—This chapter applies with respect to any employee, annuitant, or other individual who (but for the enactment of the Guaranteed Health Insurance Act of 1994) would be eligible for coverage under chapter 89 (as determined under subsection (b)).

"(2) PERIODS WITH RESPECT TO WHICH THIS CHAPTER APPLIES.—This chapter applies with respect to any period of coverage (with respect to any such individual) beginning after the end of the FEHBP transition period.

"(b) DETERMINING ELIGIBILITY FOR COVERAGE UNDER CHAPTER 89.—For purposes of making any determination under subsection (a)(1) as to whether or not a particular individual would be eligible for coverage under chapter 89, the provisions of such chapter (disregarding the effect of sections 8903b and 8903c) shall be applied, except that, in applying section 8905(b), any period of coverage under universal FEHBP shall be counted as a period of coverage under chapter 89.

"§ 8933. Coverage under universal FEHBP

"(a) IN GENERAL.—An individual to whom this chapter applies is eligible, for purposes of any period with respect to which this chapter applies, for health insurance coverage under universal FEHBP, in accordance with section 5303 of the Guaranteed Health Insurance Act of 1994.

"(b) FAMILY MEMBERS.—Under rules specified by the Office of Personnel Management, any individual who would be eligible to be enrolled as a family member of another individual under chapter 89 (as determined under section 8932) shall not be disqualified from being so enrolled under universal FEHBP by reason of the way in which 'family member' is defined for purposes of universal FEHBP.

"§ 8934. Provisions relating to plans offering the guaranteed national benefit package

"(a) CONTRIBUTIONS.—The individual and Government contributions for plans offering the guaranteed national benefit package under universal FEHBP shall be governed by the provisions of section 8906, except that, in applying such provisions for purposes of this section, any reference to the weighted average under section

8906(a) shall be treated as a reference to the weighted average of the applicable premiums under universal FEHBP.

"(b) PAYMENT OF CONTRIBUTIONS.—

"(1) IN GENERAL.—Any Government contribution under this section shall be payable from the appropriation or fund from which any Government contribution on behalf of the individual would have been payable under chapter 89.

"(2) PAYMENTS FOR ANNUITANTS.—Any Government contributions under this section on behalf of an annuitant shall be paid from annual appropriations which are authorized to be made for that purpose and which may be made available until expended.

"(3) CONTINUATION OF POSTAL SERVICE RULE.—The requirement of section 8906(g)(2) shall continue to apply with respect to this section in the same manner as it applies with respect to section 8906.

"(c) ELIGIBILITY FOR PREMIUM SUBSIDIES.—An individual to whom this chapter applies who is enrolled under a health benefits plan under universal FEHBP shall be eligible for premium subsidies (referred to in section 8906(j)) to the same extent and in the same manner as would be the case under section 8906(j) with respect to an employee or other individual enrolled in a plan under chapter 89.

"§ 8935. Eligibility for additional benefits

"(a) IN GENERAL.—An individual to whom this chapter applies who is enrolled under a health benefits plan under universal FEHBP—

"(1) may enroll in any supplemental health benefit policy under section 5302(b) of the Guaranteed Health Insurance Act of 1994 for which the individual is eligible;

"(2) is eligible to be covered by a maintenance of effort policy under subsection (b); and

"(3) is entitled to be provided a contribution under subsection (c).

"(b) MAINTENANCE OF EFFORT POLICIES.—

"(1) IN GENERAL.—The Office shall provide or contract for one or more maintenance of effort policies of the type described in section 8904a(b)(1)(A) and of the type described in section 8904a(b)(1)(B).

"(2) CONSULTATION.—In developing maintenance of effort policies to be offered under this subsection, the Office—

"(A) shall meet and confer with exclusive representatives of employees through a process to be established by the National Partnership Council; and

"(B) shall consult periodically with representatives of employees (other than those described in subparagraph (A)) and of annuitants.

"(3) ADMINISTRATION.—To the extent that maintenance of effort policies are provided through carriers, section 8902 shall, with respect to the administration of this section, apply to the extent practicable. No requirement of law relating to limiting the offering of a supplemental health benefit policy shall apply to a maintenance of effort policy offered under this section.

"(c) CONTRIBUTION.—

"(1) IN GENERAL.—The Government shall pay the total enrollment charge for a maintenance of effort policy under subsection (b) in the case of any employee or annuitant for whom Government contributions are being made with respect to any health benefits plan under universal FEHBP.

"(2) PAYMENT.—Any payment under this subsection shall be made at the same time and in the same manner as if it were a Government contribution for a health benefits plan under section 8934, and shall be made from the same appropriation or fund as from which any such Government contributions would, with respect to the employee or annuitant in-

volved, be made. In applying the previous sentence, the reference to Government contributions under this section in section 8934(b)(2) shall be considered to include payments under this subsection. The requirement of section 8906(g)(2) shall continue to apply with respect to this subsection in the same manner as it applies with respect to section 8906.

"§ 8936. Opportunities to enroll

"Enrollment in plans under universal FEHBP shall be governed by section 5305(a) of the Guaranteed Health Insurance Act of 1994, except that an election opportunity may not be denied if there occurs any event or circumstance which would, if it had occurred during the last year of the FEHBP transition period, have made such an election allowable under subsection (e) or (f)(2) of section 8905.

"§ 8937. Regulations

"The Office of Personnel Management shall prescribe such regulations as may be necessary to carry out this chapter.".

(b) CLERICAL AMENDMENT.—The table of chapters of subpart G of part III of title 5, United States Code, is amended by adding after the item relating to chapter 89 the following:

"89A. Provisions for the Integration of FEHBP and Universal FEHBP 8931".

SEC. 14402. FINAL ACCOUNTING AND DISTRIBUTION OF CERTAIN RESERVES OF CHAPTER 89 PLANS.

(a) DEFINITIONS AND RULE OF CONSTRUCTION.—For the purpose of this section—

(1) the terms "contingency reserve" and "special reserve" are used in the same way as such terms are used in section 890.503(c) of title 5, Code of Federal Regulations, as in effect on January 1, 1994;

(2) the term "qualified health plan distributee" means an individual who was enrolled—

(A) on December 31 of the fourth year of the FEHBP transition period, in a comprehensive medical plan described in section 8903(4) of title 5, United States Code; or

(B) on December 31 of the seventh year of the FEHBP transition period, in a plan described in section 8903(1), (2), or (3) of such title;

(3) the rule of construction set forth in section 8903b(a)(2) of such title applies; and

(4) the term "FEHBP transition period" has the meaning given such term by section 8903b of such title.

(b) COMPREHENSIVE MEDICAL PLANS NO LONGER IN CHAPTER 89.—

(1) FINAL ACCOUNTING.—During the fifth year of the FEHBP transition period, the Office of Personnel Management shall perform a final accounting for the preceding calendar year for each contract with a qualified health maintenance carrier (other than an experience-rated carrier) entered into under section 8902(l) of such title (as such section was in effect during such calendar year).

(2) AVAILABILITY FOR DISTRIBUTION.—After the final accounting under paragraph (1), any balance remaining in the contingency reserve of any such plan shall be available for distribution in accordance with subsection (d).

(3) DETERMINATION OF QUALIFIED HEALTH PLAN DISTRIBUTEES.—The Office shall determine who is a qualified health plan distributee with respect to each plan subject to paragraph (1).

(c) EXPERIENCE-RATED PLANS NO LONGER IN CHAPTER 89.—

(1) FINAL ACCOUNTING.—

(A) FEE FOR SERVICE PLANS.—Except as provided in subparagraph (B), during the third year beginning after the seventh year of the FEHBP transition period, the Of-

fice shall perform a final accounting for such seventh year for each plan described by section 8903(1), (2), or (3).

(B) COMPREHENSIVE MEDICAL PLANS.—In the case of a plan described by section 8903(4) that is not subject to subsection (b), the Office shall perform a final accounting during the sixth year of the FEHBP transition period for the fourth year of such period.

(2) RECONCILIATION OF RESERVE BALANCES.—Each final accounting required by paragraph (1) shall reconcile the contingency reserves and special reserves of a plan, as follows:

(A) CLAIM AND SPECIAL RESERVES.—First, if the amounts in the reserve for incurred-but-unpaid benefit claims are—

(i) insufficient to meet incurred-but-unpaid benefit claims of a plan, such claims shall be paid from the special reserve of the plan (if available);

(ii) insufficient, in combination with any available special reserve of the plan, to meet incurred-but-unpaid benefit claims of a plan, such deficit shall be a negative addition to the plan's special reserve; or

(iii) greater than the actual incurred-but-unpaid benefit claims, any excess amount in such reserve shall be transferred to the plan's special reserve.

(B) TREATMENT OF THE SPECIAL RESERVE OF A PLAN.—Second, if the balance of the special reserve of a plan after subparagraph (A) is carried out is—

(i) greater than zero, the plan shall transfer the amount in the special reserve to the Office of Personnel Management for credit to the plan's contingency reserve; or

(ii) less than zero, the moneys in the contingency reserve of the plan shall be transferred to the special reserve in an amount that is sufficient to increase the balance of the special reserve to zero or, if less, an amount that is equal to the balance in such contingency reserve.

(C) PRE-DISTRIBUTION PAYMENTS TO PLAN SPECIAL RESERVES FROM COMBINED CONTINGENCY RESERVES.—Third, after payments from plan contingency reserves are made under subparagraph (B), remaining balances of all plan contingency reserves shall be combined, and payments shall be made from such aggregate balance (if any) to plans with negative special reserves to increase such special reserves to zero.

(D) AVAILABILITY FOR DISTRIBUTION.—Fourth, any balance remaining in the aggregate contingency reserves after subparagraph (C) is carried out shall be available for distribution in accordance with subsection (d).

(3) DETERMINATION OF QUALIFIED HEALTH PLAN DISTRIBUTEES.—The Office shall determine who is a qualified health plan distributee with respect to each plan subject to paragraph (1).

(d) DISTRIBUTION OF REMAINING CONTINGENCY RESERVES.—

(1) GENERAL RULE.—

(A) DISTRIBUTION.—Amounts available for distribution pursuant to subsections (b)(2) and (c)(2)(D) shall be distributed to the qualified health plan distributees living on the date of distribution, the United States Government, and the United States Postal Service.

(B) AMOUNTS.—Such amounts shall be distributed in sums which the Office determines, in accordance with regulations which the Office shall promulgate, to be proportional to their respective contributions to health plans (determined without regard to any collective bargaining agreement under title 39, United States Code) made dur-

ing the plan year for which a final accounting is made under this section.

(C) REMAINING AMOUNTS REDISTRIBUTED TO UNITED STATES GOVERNMENT AND UNITED STATES POSTAL SERVICE.—Amounts which could not be distributed to a qualified health plan distributee under subparagraph (A) after reasonable efforts shall be redistributed to the United States Government or the United States Postal Service, as appropriate.

(2) INDIVIDUAL LIMITED TO ONE DISTRIBUTION.—An individual who is determined to be a qualified health plan distributee under both subsections (b)(3) and (c)(3) may receive only one distribution under paragraph (1)(A).

(3) TREATMENT OF MONEYS RECEIVED BY THE UNITED STATES GOVERNMENT AND THE UNITED STATES POSTAL SERVICE.—

(A) UNITED STATES GOVERNMENT.—Amounts received by the United States Government pursuant to paragraph (1) shall be deposited in a special account of the Employees Health Benefits Fund. Such amounts shall be available to be used only for purposes which benefit the health of Federal employees and annuitants, including payment for the Government-provided maintenance of effort policies required by section 8935 of title 5, United States Code, as directed by Congress.

(B) UNITED STATES POSTAL SERVICE.—Amounts received by the United States Postal Service pursuant to paragraph (1) shall be deposited in a special account in the Postal Service Fund (established by section 2003 of title 39, United States Code). Such amounts shall be available to be used only for purposes which benefit the health of employees and annuitants of the United States Postal Service, including—

(i) payment for the Government-provided maintenance of effort policies required by section 8935 of title 5, United States Code, or

(ii) contributions to the financial stability of health benefits plans established on behalf of employees and annuitants of the United States Postal Service, to be made in a manner that is proportional to the number of employees and annuitants of the United States Postal Service to whom each such plan (or its predecessor) provided health benefits on the last day of the plan's participation under chapter 89 of title 5, United States Code,

as directed by Congress.

(4) DEADLINE FOR DISTRIBUTIONS.—The distributions under paragraph (1)(A) shall be completed no later than 42 months following the end of the FEHBP transition period.

(e) MID-TRANSITION PERIOD REPORT.—Not later than December 31 of the seventh year of the FEHBP transition period, the Office shall submit a report to the Congress which shall include the projected amount to be distributed under subsection (d), as well as the proposed regulations for carrying out the distribution thereunder.

SEC. 14403. TREATMENT OF INDIVIDUALS RESIDING ABROAD.

(a) IN GENERAL.—Chapter 89 is amended by adding at the end the following:

"§ 8915. Health insurance program for individuals residing abroad

"(a)(1) The Office of Personnel Management, upon making the determination described in paragraph (2), shall by regulation establish, directly or by contract, a program under which employees, annuitants, and other individuals who (but for the enactment of the Guaranteed Health Insurance Act of 1994) would be eligible for coverage under this chapter and who, because of residence abroad

or other unusual circumstances, have special needs shall be eligible for health insurance.

"(2) The determination described in this paragraph is a determination that the establishment of a health insurance program is necessary to assure that health benefits made available under this chapter are available to the individuals described in paragraph (1) because health insurance coverage would otherwise cease to be available as a result of the enactment of the Guaranteed Health Insurance Act of 1994.

"(b) To the extent practicable, terms and conditions of coverage provided to individuals under such program shall be the same as the terms and conditions of coverage which would otherwise apply under this chapter to employees.

"(c) Any Government contribution payable under such program shall be made from the appropriation or fund from which any Government contribution would have been payable under this chapter on behalf of the individual involved, except that, in the case of an annuitant, any such contribution shall be payable from amounts appropriated pursuant to section 8906(g) (or similar authority under this chapter or chapter 89A).".

(b) CHAPTER ANALYSIS.—The analysis for chapter 89 is amended by adding at the end the following:

"8915. Health insurance program for individuals residing abroad.".

Subtitle E—Miscellaneous Provisions

SEC. 14501. TECHNICAL AND CONFORMING AMENDMENTS.

(a) TITLE 5, UNITED STATES CODE.—Title 5, United States Code, is amended as follows:

(1) In section 1308(c), by striking "chapter 89" and inserting "chapter 89 and relevant aspects of universal FEHBP (as defined in chapter 89A)".

(2) In section 3374(b) (in the matter following paragraph (3)), by inserting "(or, instead of chapter 89, any other applicable health benefits system)" after "89 of this title".

(3) In section 3582(a)(2)—

(A) by striking "89" each place it appears and inserting "89 (or 89A, as applicable)"; and

(B) by striking "Benefits Fund" and inserting "Benefits Fund (or the Universal FEHBP Health Benefits Fund)".

(4) In section 6386—

(A) by striking "chapter 89" and inserting "chapter 89 (or 89A)"; and

(B) by striking "(described in section 8909)," and inserting "described in section 8909 (or the Universal FEHBP Health Benefits Fund described in section 5306 of the Guaranteed Health Insurance Act of 1994, as the case may be),".

(b) OTHER REFERENCES TO CHAPTER 89.—Any reference in any provision of law in effect on the day before the date of the enactment of this Act, other than in a provision of law amended by subsection (a)—

(1) to coverage under chapter 89 of title 5, United States Code, shall be deemed to be a reference to coverage under chapter 89 or 89A of such title, as appropriate; and

(2) to the "Employees Health Benefits Fund" shall be deemed to be a reference to that fund or the Universal FEHBP Health Benefits Fund, as appropriate.

SEC. 14502. REPORT ON CONFORMING LEGISLATIVE CHANGES.

The Office of Personnel Management shall, by not later than 6 months after the date of the enactment of this Act, submit to Congress proposed legislation that conforms provisions of law to the amendments made by this title.

SEC. 14503. TREATMENT OF POSTAL SERVICE PLANS AS MULTIEMPLOYER PLANS.

For purposes of this Act (and laws amended by this Act), any health plan offered exclusively to employees of the United States Postal Service shall be treated as if it were a multiemployer plan (as defined in section 5102(c)(3) of this Act) in operation prior to September 1, 1993.

TITLE XV—DEPARTMENT OF VETERANS AFFAIRS

SEC. 15001. BENEFITS AND ELIGIBILITY THROUGH DEPARTMENT OF VETERANS AFFAIRS MEDICAL SYSTEM.

(a) DVA AS A PARTICIPANT IN HEALTH CARE REFORM.—

(1) IN GENERAL.—Title 38, United States Code, is amended by inserting after chapter 17 the following new chapter:

"CHAPTER 18—ELIGIBILITY AND BENEFITS UNDER ENROLLMENT-BASED SYSTEM

"SUBCHAPTER I—GENERAL

"1801. Definitions.

"SUBCHAPTER II—ENROLLMENT

"1811. Enrollment: veterans.
"1812. Enrollment: CHAMPVA eligibles.
"1813. Enrollment: family members.
"1814. Exclusive enrollment eligibility categories.

"SUBCHAPTER III—BENEFITS

"1821. Benefits for VA enrollees.
"1822. Chapter 17 benefits.
"1823. Supplemental benefits packages and policies.
"1824. Limitation regarding veterans enrolled with health plans outside Department.

"SUBCHAPTER IV—FINANCIAL MATTERS

"1831. Premiums, copayments, etc.
"1832. Recovery of cost of certain care and services.
"1833. Health Plan Fund.
"1834. Guaranteed funding of Government costs

"SUBCHAPTER I—GENERAL

"§ 1801. Definitions

"For purposes of this chapter:

"(1) The term 'qualified health benefit plan' means an entity that is a qualified health benefit plan for purposes of the Guaranteed Health Insurance Act of 1994.

"(2) The term 'VA health plan' means a health plan that is established and operated by the Secretary under section 7341(a) of this title.

"(3) The term 'transitional VA health plan' means a VA health plan that is operated by the Secretary during the period before January 1, 1999.

"(4) The term 'GHIA-qualified VA health plan' means a VA health plan that is certified under title V of the Guaranteed Health Insurance Act of 1994 as a qualified health benefit plan for operation under such Act after December 31, 1998.

"(5) The term 'VA enrollee' means an individual enrolled under subchapter II of this chapter in a VA health plan.

"(6) The term 'guaranteed national benefit package' means the package of benefits that as of January 1, 1999, is required to be provided by a qualified health benefit plan under title III of the Guaranteed Health Insurance Act of 1994.

"SUBCHAPTER II—ENROLLMENT

"§ 1811. Enrollment: veterans

"Each veteran who is an eligible individual within the meaning of section 1001 of the Guaranteed Health Insurance Act of 1994 may enroll with a VA health plan. After December 31, 1998, a veteran who wants to receive the benefits that are included in the guaranteed national benefit package through the Department shall

enroll with a VA health plan that is GHIA-qualified VA health plan.

"§ 1812. Enrollment: CHAMPVA eligibles

"(a) ELIGIBILITY.—An individual described in subsection (b) who is an eligible individual within the meaning of section 1001 of the Guaranteed Health Insurance Act of 1994 may enroll with a VA health plan.

"(b) APPLICABILITY.—This section applies to the following individuals who are not otherwise eligible for medical care under chapter 55 of title 10 (CHAMPUS):

"(1) The surviving spouse or child of a veteran who (A) died as a result of a service-connected disability, or (B) at the time of death had a total disability permanent in nature, resulting from a service-connected disability.

"(2) The surviving spouse or child of a person who died in the active military, naval, or air service in the line of duty and not due to such person's own misconduct.

"§ 1813. Enrollment: family members

"(a) ELIGIBILITY.—The Secretary shall authorize a VA health plan to enroll members of the family of an enrollee under section 1811 or 1812 of this title. The enrollee shall have the option of enrolling in the VA health plan as an individual or with family members, in accordance with the provisions of the Guaranteed Health Insurance Act of 1994.

"(b) ENROLLMENT ELIGIBILITY TO SURVIVE DEATH OF VETERAN.—An individual who is enrolled with a VA health plan pursuant to subsection (a) as a member of the family of a veteran enrolled under section 1811 of this title shall not lose eligibility to be enrolled with VA health plans by reason of the death of that veteran.

"(c) MEMBERS OF FAMILY.—For purposes of this section, the members of the family of an enrollee are those individuals (other than the enrollee) included within the term 'family' as defined in section 3(a) of the Guaranteed Health Insurance Act of 1994.

"§ 1814. Exclusive enrollment eligibility categories

"Eligibility of individuals for enrollment in a VA health plan shall be exclusively as provided in this subchapter.

"SUBCHAPTER III—BENEFITS

"§ 1821. Benefits for VA enrollees

"The Secretary shall ensure that each VA health plan provides to each individual enrolled with it the items and services in the guaranteed national benefit package. Such benefits are entitlements for each enrolled individual.

"§ 1822. Chapter 17 benefits

"(a) CARE AND SERVICES NOT INCLUDED IN GUARANTEED NATIONAL BENEFIT PACKAGE.—In the case of care and services that may be provided under chapter 17 of this title that are not included in the guaranteed national benefit package, the Secretary shall provide to any veteran (whether or not enrolled with a VA health plan) the care and services authorized under that chapter in accordance with the terms and conditions applicable to that veteran and that care under such chapter.

"(b) VETERANS WHO ARE NOT ELIGIBLE TO ENROLL UNDER GUARANTEED HEALTH INSURANCE ACT OF 1994.—In the case of a veteran who is not an eligible individual within the meaning of section 1001 of the Guaranteed Health Insurance Act of 1994, the Secretary shall provide to the veteran the care and services that may be provided under chapter 17 of this title through any facility of the department, whether or not the facility is operating as or within a VA health plan.

"(c) PRESERVATION OF SPECIALIZED DVA TREATMENT CAPACITIES.—In carrying out subsection (a), the Secretary shall ensure that the Department maintains the capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans (including veterans with spinal cord dysfunction, blindness, and mental illness) within distinct programs or facilities of the Department that are dedicated to the specialized needs of those veterans in a manner that affords those veterans reasonable access to care and services for those specialized needs. The Secretary shall ensure that overall capacity of the Department to provide such specialized services is not reduced below the capacity of the Department, nationwide, to provide those services, as of the date of the enactment of this chapter. Nothing in this subsection precludes the Secretary from expanding the number or type of facilities or programs that provide treatment and rehabilitation services for the specialized needs of such veterans, including provision of specialized services on an outpatient basis.

"(d) ANNUAL REPORT.—Not later than March 1 of each year, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report describing the actions the Secretary has taken to carry out subsection (c) during the preceding fiscal year. Each such report shall include a statement of the number of veterans to whom the Department provided specialized services that are covered by the report and the expense of providing those services, and a description of the alternatives available in the private sector for the provision of those services to veterans.

"§ 1823. Supplemental benefits packages and policies

"The Secretary may offer supplemental health benefits packages consistent with the requirements of title V of the Guaranteed Health Insurance Act of 1994. However, the Secretary may not offer a supplemental health benefits package to a veteran that provides coverage for services that the Department is required to provide to that veteran under chapter 17 of this title. To the extent that supplemental health benefits packages and supplemental cost sharing policies are offered and accepted, benefits under such packages and policies shall be entitlements for each enrolled individual.

"§ 1824. Limitation regarding veterans enrolled with health plans outside Department

"(a) REIMBURSEMENT REQUIRED.—After December 31, 1998, a veteran who is enrolled in a health plan other than a GHIA-qualified VA health plan may be provided the items and services in the guaranteed national benefit package by a VA health plan operating in that area only if (except as provided in subsection (b)) the plan is reimbursed for the cost of the care provided.

(b) EXCEPTION.—The Secretary may not impose on or collect from a veteran described in subsection (a) a cost-share charge of any kind in the case of treatment for a service-connected disability that (as determined by the Secretary) requires a specialized treatment capacity for which the Department has particular expertise.

"SUBCHAPTER IV—FINANCIAL MATTERS

"§ 1831. Premiums, copayments, etc.

"(a) EXEMPTION OF CERTAIN VETERANS.—(1) In the case of a veteran described in subsection (b) who is a VA enrollee, there may not be imposed or collected from the veteran a cost-share charge of any kind (whether a premium, copayment, deductible, coinsurance charge, or other charge) for items and services in the guaranteed national benefit package that are provided to the veteran by the Secretary within a VA plan provider network.

"(2) In the case of a veteran described in subsection (b) who is enrolled in a GHIA-qualified VA health plan and has a premium certificate issued under part A of title XXII of the Social Security

Act, the Secretary may require the veteran to tender the certificate to the Secretary and the Secretary may accept the certificate.

"(3) The Secretary shall make such arrangements as necessary with the appropriate health insurance purchasing cooperative or with appropriate Federal, State, or other officials in order to carry out this subsection.

"(b) VETERANS EXEMPT FROM CHARGES.—The veterans referred to in subsection (a) are the following:

"(1) Any veteran with a service-connected disability.

"(2) Any veteran whose discharge or release from the active military, naval or air service was for a disability incurred or aggravated in the line of duty.

"(3) Any veteran who is in receipt of, or who, but for a suspension pursuant to section 1151 of this title (or both such a suspension and the receipt of retired pay), would be entitled to disability compensation, but only to the extent that such a veteran's continuing eligibility for such care is provided for in the judgment or settlement provided for in such section.

"(4) Any veteran who is a former prisoner of war.

"(5) Any veteran of the Mexican border period or World War I.

"(6) Any veteran who is unable to defray the expenses of necessary care as determined under section 1722(a) of this title.

"(c) ESTABLISHMENT OF PREMIUM RATES.—(1) In the case of a transitional VA health plan, the Secretary shall establish premium rates for enrollees in the plan (other than for veterans described in subsection (b) and enrollees described in paragraph (3)) in accordance with regulations to be prescribed by the Secretary.

"(2) In the case of a GHIA-qualified VA health plan, premium rates (other than for veterans described in subsection (b) and enrollees described in paragraph (3)) shall be established in accordance with regulations prescribed by the Secretary of Health and Human Services under title V of the Guaranteed Health Insurance Act of 1994.

"(3) The Secretary may not collect a premium from an enrollee in the case of—

"(A) an individual who is enrolled in a VA health plan by reason of eligibility under section 1812 of this title; or

"(B) an individual who is enrolled in a VA health plan by reason of eligibility under section 1813 of this title and who is described in paragraph (1) of section 1713(a) of this title.

"(d) COST-SHARE CHARGES.—(1) In the case of a transitional VA health plan, the Secretary may establish cost-sharing charges (including copayments, deductibles, and other coinsurance amounts) for enrollees in the plan (other than for veterans described in subsection (b)) in accordance with regulations to be prescribed by the Secretary.

"(2) In the case of a GHIA-qualified VA health plan, cost-sharing charges (including copayments, deductibles, and other coinsurance amounts) for enrollees in the plan (other than for veterans described in subsection (b)) shall be established in accordance with regulations prescribed by the Secretary of Health and Human Services under title V of the Guaranteed Health Insurance Act of 1994.

"(3) The Secretary may not charge or collect a copayment, deductible, or other coinsurance amount in the case of care for any disease covered under section 1710(e)(1) of this title.

"§ 1832. Recovery of cost of certain care and services

"(a) RECOVERY FROM THIRD PARTIES.—In the case of an individual provided care or services through a VA health plan who is covered under a supplemental health insurance policy under the Guaranteed Health Insurance Act of 1994, a Medicare supplemental health insurance plan (as defined in the Guaranteed Health Insurance Act of 1994), or any other plan or policy designed to supplement health insurance coverage, the Secretary has the right to

recover or collect charges for care or services (as determined by the Secretary, but not including care or services for a service-connected disability) from the party providing that coverage to the extent that the individual (or the provider of the care or services) would be eligible to receive payment for such care or services from such party if the care or services had not been furnished by a department or agency of the United States.

"(b) PROCEDURES.—The provisions of subsections (b) through (f) of section 1729 of this title shall apply with respect to claims by the United States under subsection (a) in the same manner as they apply to claims under subsection (a) of that section.

"§ 1833. Health Plan Fund

"(a) ESTABLISHMENT OF FUND.—There is hereby established in the Treasury a revolving fund to be known as the 'Department of Veterans Affairs Health Plan Fund'.

"(b) CREDITING OF AMOUNTS TO FUND.—There shall be credited to the revolving fund any amount received by the Department by reason of the furnishing of health care by a VA health plan and any amount received by the Department by reason of the enrollment of an individual with a VA health plan (including amounts received as premiums, premium discount payments, copayments or coinsurance, and deductibles), any amount received as a third-party reimbursement, and any amount received as a reimbursement from another health plan for care furnished to one of its enrollees.

"(c) CREDITING TO TREASURY.—Any amounts deposited to the revolving fund that are attributable to amounts received by the Department as a premium by reason of the enrollment with a VA health plan of a veteran described in section 1831(b) of this title shall be covered into the General Fund of the Treasury.

"(d) AVAILABILITY OF FUNDS.—Amounts in the revolving fund are hereby authorized to be appropriated for all expenses, both direct and indirect, related to the delivery by a VA health plan of the items and services in the guaranteed national benefit package and any supplemental benefits package or policy offered by the Secretary. The appropriations authorized by this subsection shall be considered mandatory appropriations for all purposes, including for purposes of the Balanced Budget and Emergency Deficit Control Act of 1985 and the Congressional Budget Act of 1974.

"§ 1834. Guaranteed funding of Government costs

"(a) REQUIRED DEPOSITS FROM TREASURY.—The Secretary of the Treasury shall deposit into the Department of Veterans Affairs Health Plan Fund on the first day of each fiscal year quarter, from amounts not otherwise appropriated, the amount certified to the Secretary under subsection (b) with respect to the fiscal year quarter beginning on that date.

"(b) CERTIFICATION OF AMOUNT.—Not later than 30 days before the beginning of each fiscal year quarter, the Secretary of Veterans Affairs shall certify to the Secretary of the Treasury the amount determined for that quarter under subsection (c).

"(c) DETERMINATION OF AMOUNT.—(1) The amount to be certified to the Secretary of the Treasury under subsection (b) for any fiscal year quarter is the product of—

"(A) the projected number of VA enrollees described in section 1831(b) of this title as of the beginning of that fiscal year quarter, and

"(B) the capitated enrollment amount for that fiscal year determined under subsection (d).

"(2) The Secretary shall adjust future certifications under this subsection to take account of—

"(A) differences between the actual number of veterans described in section 1831(b) of this title enrolled for a fiscal year quarter and the projected number used in the certification for that quarter pursuant to paragraph (1); and

"(B) any information that the Secretary finds would produce a more accurate capitated enrollment amount by enabling the Secretary to estimate more accurately the costs that the Department will incur during the period covered by any such certification in providing those services that are specified to be included in the guaranteed national benefit package.

"(d) CAPITATED ENROLLMENT AMOUNT.—(1) The Secretary shall determine the capitated enrollment amount for purposes of subsection (c). The initial capitated enrollment amount shall be determined as the amount equal to—

"(A) the annual full cost (as defined in OMB Circular A–25, issued on July 8, 1993) that has been incurred by the Department in providing those services that are specified to be included in the guaranteed national benefit package, based upon the most recent cost data available as of the time of the determination, adjusted for inflation to the date of the determination based upon the medical care consumer price index calculated by the Bureau of Labor Statistics, divided by

"(B) the total number of veterans described in section 1831(b) of this title who received those services.

"(2) The Secretary shall include in the total annual cost for purposes of paragraph (1)(A) the amount appropriated for fiscal year 1994 for medical and prosthetic research by the Veterans Health Administration.

"(3) The Secretary shall develop the methodology for determining the initial capitated enrollment amount under paragraph (1) in consultation with the Comptroller General of the United States. If the Comptroller General disagrees with the methodology proposed to be used by the Secretary, the Comptroller General shall promptly notify the Committees on Veterans' Affairs of the Senate and House of Representatives. The determination of that amount shall be made not later than June 1, 1995.

"(4) The initial capitated enrollment amount, as adjusted annually for inflation based upon the medical care consumer price index calculated by the Bureau of Labor Statistics, shall apply through the fifth fiscal year during which the Secretary operates a GHIA-qualified VA health plan.

"(5)(A) Not later than the end of the third fiscal year during which the Secretary operates a GHIA-qualified VA health plan, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on what actions, if any, would be necessary in order for the Department to change the annual capitated enrollment amount by the end of the fifth such year from the initial amount determined under paragraph (1) to an amount determined using the method described in subparagraph (B), or to amounts determined using some other methodology, without a reduction in quality of care.

"(B) The method for determining the annual capitated enrollment amount for purposes of the study under this paragraph is to determine the average premium that would be payable under the Guaranteed Health Insurance Act of 1994 for individuals enrolled in health plans other than a GHIA-qualified VA health plans which have enrollment populations with disproportionate numbers of persons with similar demographic and patient-risk characteristics to the population of VA enrollees.".

(2) CLERICAL AMENDMENT.—The tables of chapters at the beginning of title 38, United States Code, and at the beginning of part II of such title, are amended by inserting after the item relating to chapter 17 the following new item:

"18. Eligibility and Benefits Under Enrollment-Based System ..... 1801".

(b) PRESERVATION OF EXISTING BENEFITS FOR FACILITIES NOT OPERATING AS HEALTH PLANS.—(1) Chapter 17 of title 38, United States Code, is amended by inserting after section 1704 the following new section:

"§ 1705. Facilities not operating within health plans; veterans not eligible to enroll in health plans

"The provisions of this chapter shall apply with respect to the furnishing of care and services—

"(1) by any facility of the Department that (A) is not operating as or within a GHIA-qualified VA health plan, and (B) is not located in a State (or portion of a State) that is described in section 7342(a) of this title; and

"(2) by any facility of the Department (whether or not operating as or within a GHIA-qualified VA health plan) in the case of a veteran who is not an eligible individual with the meaning of section 1001 of the Guaranteed Health Insurance Act of 1994.".

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1704 the following new item:

"1705. Facilities not operating within health plans; veterans not eligible to enroll in health plans."

SEC. 15002. ORGANIZATION OF DEPARTMENT OF VETERANS AFFAIRS FACILITIES AS HEALTH PLANS.

(a) IN GENERAL.—Chapter 73 of title 38, United States Code, is amended—

(1) by redesignating subchapter IV as subchapter V; and

(2) by inserting after subchapter III the following new subchapter:

"SUBCHAPTER IV—PARTICIPATION AS PART OF NATIONAL HEALTH CARE REFORM

"§ 7341. Organization of health care facilities as health plans

"(a)(1) The Secretary shall organize health plans and operate Department facilities as or within such health plans. The Secretary shall establish standards for the organization and operation of Department health care facilities as or within health plans.

"(2) Health plans organized and operated by the Secretary shall be known as 'VA health plans'. Such plans shall be known during the period before January 1, 1999, as 'transitional VA health plans'.

"(3) With respect to the operation of such plans after December 31, 1998, standards established under paragraph (1) shall be consistent with the regulations prescribed by the Secretary of Health and Human Services pursuant to title V of the Guaranteed Health Insurance Act of 1994.

"(4) The Secretary shall seek to ensure that each health plan organized by the Secretary before January 1, 1999, is certified as a qualified health benefit plan under title V of the Guaranteed Health Insurance Act of 1994, as provided in subsection (b).

"(5) The Secretary may not operate a VA health plan after December 31, 1998, unless the plan is certified as provided in subsection (b).

"(b)(1) A health plan established under subsection (a) may be certified as a qualified health benefit plan for purposes of the Guaranteed Health Insurance Act of 1994 in accordance with regulations prescribed by the Secretary of Health and Human Services pursuant to title V of the Guaranteed Health Insurance Act of 1994.

"(2) A health plan established by the Secretary under subsection (a) that is certified as provided in paragraph (2) may be referred to as a 'GHIA-qualified VA health plan'.

"(c) Within a geographic area or region, health care facilities of the Department located within that area or region may be organized to operate as a single health plan encompassing all Department facilities within that area or region or may be organized to operate as several health plans.

"(d) The Secretary shall ensure that each health plan established by the Secretary that is certified as a qualified health benefit plan under title V of the Guaranteed Health Insurance Act of 1994 is operated (except as specifically otherwise provided in chapter 18 of this title or in this subchapter) in accordance with the provisions of the Guaranteed Health Insurance Act of 1994 (and the amendments made by the Guaranteed Health Insurance Act of 1994).

"(e)(1) In establishing and operating health plans, the Secretary (in consultation with the Comptroller General) shall take appropriate steps to ensure the financial solvency and stability of each VA health plan and of contractors and subcontractors providing services pursuant to section 7343 of this title.

"(2) In carrying out paragraph (1), the Secretary may purchase from commercial sources insurance to insure the United States against the financial risks involved in the operation of any VA health plan.

"§ 7342. Operation of health care facilities within States operating single payer programs or pure managed competition programs

"(a) In a State (or portion of a State) that under the Guaranteed Health Insurance Act of 1994 is operating as a single payer program or that uses a pure managed competition program, the Secretary shall seek to achieve the maximum participation of Department health care facilities or GHIA-qualified VA health plans, as the case may be, in that State (or portion of a State) that is permitted under applicable provisions of law.

"(b) To the extent that the Secretary determines that applicable provisions of law do not permit adequate participation by GHIA-qualified VA health plans or Department health care facilities in such a State (or portion of a State), the Secretary shall submit to Congress a report containing such legislative recommendations as the Secretary considers appropriate. Any such report shall be prepared in coordination with the Secretary of Health and Human Services.

"§ 7343. Health care resource agreements

"(a)(1) In accordance with policies established under subsection (b), an official specified in paragraph (2) may, without regard to any law or regulation specified in paragraph (3), enter into agreements with health care plans, with insurers, and with health care providers, and with any other entity or individual, to furnish or obtain any health-care resource.

"(2) An official specified in this paragraph is any of the following:

"(A) The head of a VA health plan.

"(B) The director of a Department health care facility that is operating as or within a VA health plan.

"(C) The director of a Department health care facility that is operating in a State (or portion of a State) that is described in section 7342(a) of this title.

"(3) A law or regulation specified in this paragraph is any of the following:

"(A) Section 1703 of this title.

"(B) Any other law or regulation pertaining to—

"(i) competitive procedures;

"(ii) acquisition procedures or policies (other than contract dispute settlement procedures); or

"(iii) bid protests.

"(4) For purposes of this subsection, the term 'health-care resource' has the meaning given that term in section 8152 of this title.

"(b) Policies established by the Secretary under subsection (a) shall include appropriate provisions to ensure that procurements under that subsection are carried out in a manner consistent with

(1) Federal acquisition policies regarding nondiscrimination, equal opportunity, business integrity, and safeguarding against fraud and abuse; and (2) the goal of a streamlined process for the acquisition of health-care resources.

"(c) Any proceeds to the Government received from an agreement under subsection (a) shall be credited to the Department of Veterans Affairs Health Plan Fund established under section 1834 of this title and to funds that have been allotted to the facility that furnished the resource involved.

"§ 7344. Administrative and personnel flexibility

"(a) In order to carry out this subchapter, the Secretary may—

"(1) subject to section 1822(c) of this title, carry out administrative reorganizations of the Department without regard to those provisions of section 510 of this title following subsection (a) of that section; and

"(2) when the Secretary finds it is cost-effective or necessary in order to provide health care services in a timely manner—

"(A) enter into contracts for procurement of any commercially available item at a cost of under $100,000 without regard to any provision of law or regulation (i) requiring competitive procedures; (ii) mandating or giving priority to any source of supply; or (iii) pertaining to protests; and

"(B) enter into contracts without regard to section 8110(c) of this title for the performance of services previously performed by employees of the Department.

"(b)(1) Whenever the Secretary considers such action necessary for the operation of a VA health plan, the Secretary may establish alternative personnel systems or procedures for personnel at facilities operating as or within VA health plans or for personnel at facilities operating in a State (or portion of a State) that is described in section 7342(a) of this title, except that the Secretary shall provide for preference eligibles (as defined in section 2108 of title 5) in a manner comparable to the preference for such eligibles under subchapter I of chapter 33, and subchapter I of chapter 35, of such title.

"(2) In establishing alternative personnel systems or procedures under this subsection, the Secretary shall include the following:

"(A) A system that ensures that applicants for employment and employees are appointed, promoted, and assigned on the basis of merit and fitness.

"(B) An equal employment opportunity program.

"(C) Compensation systems which will be used to set rates of pay that are competitive with rates of pay paid by health-care providers other than the Department and that take into consideration the difficulty, responsibility, and qualification requirements of the work performed.

"(D) A formal performance appraisal system.

"(E) A system to address unacceptable conduct and performance by employees, including a general statement of violations, sanctions, and procedures which shall be made known to all employees, and a dispute resolution procedure.

"(F) A formal policy regarding the accrual and use of sick leave and annual leave.

"(c) The Secretary may carry out appropriate promotional, advertising, and marketing activities to inform individuals of the availability of facilities of the Department operating as or within VA health plans.

"§ 7345. Veterans Health Care Transition Fund

"(a) For each of fiscal years 1995, 1996, and 1997, the Secretary of the Treasury shall credit to a special fund (in this section referred to as the 'Fund') of the Treasury an amount equal to—

"(1) $1,250,000,000 for fiscal year 1995;
"(2) $850,000,000 for fiscal year 1996; and
"(3) $1,950,000,000 for fiscal year 1997.

"(b) Amounts in the Fund shall be available to the Secretary only for the VA health plans authorized under this chapter. Such amounts are available without fiscal year limitation for costs of commencing operation of VA health plans, including consulting services, equipment, marketing, and other costs, minor construction, and (subject to section 8104 of this title) major construction.

"(c) The Secretary shall submit to Congress, no later than March 1, 1997, a report concerning the operation of the Department of Veterans Affairs health care system during fiscal years 1995 and 1996 in preparing for commencement of operations as VA health plans. The report shall include a discussion of—

"(1) the adequacy of amounts in the Fund for the operation of VA health plans;
"(2) the quality of care provided by such plans;
"(3) the ability of such plans to attract patients; and
"(4) the need (if any) for additional funds for the Fund in fiscal years after fiscal year 1997.

"§ 7346. Funding provisions: grants and other sources of assistance

"The Secretary may apply for and accept, if awarded, any grant or other source of funding that is intended to meet the needs of special populations if funds obtained through the grant or other source of funding will be used through a facility of the Department operating as or within a health plan.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 73 is amended by striking out the item relating to the heading for subchapter IV and inserting in lieu thereof the following:

"SUBCHAPTER IV—PARTICIPATION AS PART OF NATIONAL HEALTH CARE REFORM

"7341. Organization of health care facilities as health plans.
"7342. Operation of health care facilities within States operating single payer programs or pure managed competition programs.
"7343. Health care resource agreements.
"7344. Administrative and personnel flexibility.
"7345. Veterans Health Care Transition Fund.
"7346. Funding provisions: grants and other sources of assistance.

"SUBCHAPTER V—RESEARCH CORPORATIONS".

SEC. 15003. ELIGIBILITY FOR CHAPTER 17 CARE.

(a) NURSING HOME CARE.—Section 1710(a)(1) of title 38, United States Code, is amended by inserting "(or, in the case of a veteran described in subparagraph (A) or (D) below, shall furnish nursing home care)" after "may furnish nursing home care".

(b) OUTPATIENT CARE FOR ENROLLED VETERANS.—Paragraph (1) of section 1712(a) of such title is amended—

(1) by striking out "and" at the end of subparagraph (C);
(2) by striking out the period at the end of subparagraph (D) and inserting in lieu thereof a semicolon; and
(3) by adding at the end the following:

"(E) to any veteran described in section 1831(b) of this title who is enrolled under section 1811 of this title and the Guaranteed Health Insurance Act of 1994 with a VA health plan (as defined in section 1801 of this title), for any disability to the extent that care and treatment of that disability is not included within the guaranteed national benefit package (as defined in section 1801 of this title);".

(c) OBVIATE-THE-NEED OUTPATIENT CARE.—(1) Paragraph (2) of such section is amended by striking out "The Secretary" and all the follows through "this subsection—," and inserting in lieu thereof "Except as provided in subsection (b) of this section, the Secretary

shall furnish on an ambulatory or outpatient basis such medical services as the Secretary determines are needed—".

(2) Paragraph (4) of such section is amended by striking out "medical services for a purpose described in paragraph (5) of this subsection" and inserting in lieu thereof ", to the extent that facilities are available, such medical services as the Secretary determines are needed".

(3) Such section is further amended—

(A) by striking out paragraph (5); and

(B) by redesignating paragraphs (6) and (7) as paragraphs (5) and (6), respectively.

(d) CONFORMING AMENDMENTS.—(1) Section 1701(6)(A)(i) of such title is amended by striking out "(except under the conditions described in section 1712(a)(5)(A) of this title)".

(2) Section 1701(6)(B)(i)(II) of such title is amended by striking "section 1712(a)(5)(B)" and inserting in lieu thereof "section 1712".

(3) Section 1703(a)(2)(B) of such title is amended by striking out "for a purpose described in section 1712(a)(5)(B) of this title" and inserting in lieu thereof "to complete treatment incident to hospital, nursing home, or domiciliary care that has been provided by the Department".

(4) Section 1712A(b)(1) of such title is amended by striking out "section 1712(a)(5)(B)" and inserting in lieu thereof "section 1703(a)(2)(B)".

SEC. 15004. AUTHORITY TO PROVIDE HEALTH CARE FOR HERBICIDE AND RADIATION EXPOSURE.

(a) AUTHORIZED INPATIENT CARE.—Section 1710(e) of title 38, United States Code, is amended to read as follows:

"(e)(1)(A) Subject to paragraph (4), a herbicide-exposed veteran is eligible for hospital care and nursing home care under subsection (a)(1)(G) for any disease specified in subparagraph (B).

"(B) The diseases referred to in subparagraph (A) are those for which the National Academy of Sciences, in a report issued in accordance with section 2 of the Agent Orange Act of 1991, has determined—

"(i) that there is sufficient evidence to conclude that there is a positive association between occurrence of the disease in humans and exposure to a herbicide agent;

"(ii) that there is evidence which is suggestive of an association between occurrence of the disease in humans and exposure to a herbicide agent, but such evidence is limited in nature; or

"(iii) that available studies are insufficient to permit a conclusion about the presence or absence of an association between occurrence of the disease in humans and exposure to a herbicide agent.

"(2) A radiation-exposed veteran is eligible for hospital care and nursing home care under subsection (a)(1)(G) for—

"(A) any disease listed in section 1112(c)(2) of this title; and

"(B) any other disease for which the Secretary, based on the advice of the Advisory Committee on Environmental Hazards, determines that there is credible evidence of a positive association between occurrence of the disease in humans and exposure to ionizing radiation.

"(3) Subject to paragraph (4), a veteran who the Secretary finds may have been exposed while serving on active duty in the Southwest Asia theater of operations during the Persian Gulf War to a toxic substance or environmental hazard is eligible for hospital care and nursing home care under subsection (a)(1)(G) of this section for any disability which becomes manifest before October 1, 1996, notwithstanding that there is insufficient medical evidence to conclude that such disability may be associated with such exposure.

"(4) Hospital and nursing home care may not be provided under or by virtue of paragraph (1) after September 30, 1996, or,

in the case of a veteran described in paragraph (3), after September 30, 1998.

"(5) For purposes of this subsection and section 1712 of this title—

"(A) the term 'herbicide-exposed veteran' means a veteran (i) who served on active duty in the Republic of Vietnam during the Vietnam era, and (ii) who the Secretary finds may have been exposed during such service to a herbicide agent;

"(B) the term 'herbicide agent' has the meaning given that term in section 1116(a)(4) of this title; and

"(C) the term 'radiation-exposed veteran' has the meaning given that term in section 1112(c)(4) of this title.".

(b) AUTHORIZED OUTPATIENT CARE.—Section 1712 of such title is amended—

(1) in subsection (a)(1) (as amended by section 15003(b)), by adding at the end the following:

"(F) during the period before October 1, 1996, to any herbicide-exposed veteran for any disease listed in section 1710(e)(1)(B) of this title; and

"(G) to any radiation-exposed veteran for any disease covered under section 1710(e)(1)(C) of this title."; and

(2) in subsection (i)(3)—

(A) by striking out "(A)"; and

(B) by striking out ", or (B)" and all that follows through "title".

(c) SAVINGS PROVISION.—The provisions of sections 1710(e) and 1712(a) of title 38, United States Code, as in effect on the day before the date of the enactment of this Act, shall apply with respect to hospital care, nursing home care, and medical services in the case of any veteran furnished care or services before such date of enactment on the basis of presumed exposure to a substance or radiation under the authority of those provisions.

SEC. 15005. EXTENSION OF AUTHORITY TO PROVIDE PRIORITY OUTPATIENT HEALTH CARE FOR EXPOSURE TO ENVIRONMENTAL HAZARDS.

Section 1712(a)(1)(D) of title 38, United States Code, is amended by striking out "December 31, 1994, for any disability" and inserting in lieu thereof "October 1, 1998, for any disability which becomes manifest before October 1, 1996,".

SEC. 15006. CONFIDENTIALITY OF MEDICAL RECORDS.

Subsection (a) of section 5701 of title 38, United States Code, is amended to read as follows:

"(a)(1) Except for medical records protected by the Guaranteed Health Insurance Act of 1994, records described in paragraph (2) shall be confidential and privileged, and no disclosure of such records shall be made except as provided in this section.

"(2) Paragraph (1) applies to the following records in the possession of the Department:

"(A) All records pertaining to any claim under the laws administered by the Secretary.

"(B) All records of the names and addresses of present or former members of the Armed Forces, and their dependents, contained in records pertaining to any such claim or derived from records pertaining to any such claim.

"(3) For purposes of this paragraph, the term 'records' includes files, reports, and other papers and documents."

SEC. 15007. REPORT ON WAIVING COST-SHARING FOR CERTAIN MEDICAL CARE FOR DEPENDENTS OF PERSIAN GULF VETERANS WHO MAY HAVE BEEN EXPOSED TO ENVIRONMENTAL HAZARDS.

(a) REPORT.—The Secretary of Veterans Affairs shall submit to Congress a report on the desirability and the feasibility of waiving any requirement for cost-sharing in the case of medical care described in subsection (b) that is provided by a VA health plan under chapter 18 of title 38, United States Code (as added by sec-

tion 15001), to an individual who is a VA enrollee enrolled under family-member eligibility under section 1813 of that chapter.

(b) PERSIAN GULF WAR ILLNESS.—Medical care referred to in subsection (a) is medical care provided to a family member of a veteran described in subparagraph (C) of section 1710(e)(1) of title 38, United States Code, for any disease or disability occurring in that family member which the Secretary finds may be related to the service of the veteran in the Southwest Asia theater of operations during the Persian Gulf War.

(c) MATTERS TO BE CONSIDERED.—In preparing the report under subsection (a), the Secretary shall consider relevant studies, including those that have been (or that are being) conducted by the Department of Veterans Affairs, the Department of Defense, the National Institutes of Health, the National Academy of Sciences, and private health care providers.

(d) SUBMISSION OF REPORT.—The report under subsection (a) shall be submitted not later than 60 days after the date of the enactment of this Act.

SEC. 15008. STUDY OF THE EFFECT OF TELEMEDICINE ON THE DELIVERY OF VA HEALTH CARE SERVICES.

(a) IN GENERAL.—During each of fiscal years 1995 through 1997, the Secretary of Veterans Affairs shall carry out a study of the effect of telemedicine on the delivery, accessibility, and quality of health care services available to individuals who are eligible for enrollment in a Department of Veterans Affairs health care plan.

(b) REPORTS.—Not later than 120 days after the date of the enactment of this Act and annually thereafter through 1998, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report, including descriptions of the telemedicine applications benefiting veterans, relating to the study conducted under subsection (a).

(c) CONSULTATION.—Each study under subsection (a) shall be carried out in consultation with the Secretary of Health and Human Services, the Secretary of Defense, the Chair of the White House Information Infrastructure Task Force, and the Director of High Performance Computing and Communications in the Executive Office of the President.

SEC. 15009. CONFORMING REDUCTION IN DISCRETIONARY SPENDING LIMITS.

(a) REDUCTION IN LIMITS.—To reflect the change in certain veterans' health activities from discretionary to mandatory, the spending limits for the discretionary category set forth in section 601(a)(2) of the Congressional Budget Act of 1974 (as adjusted in conformance with section 251 of the Balanced Budget and Emergency Deficit Control Act of 1985) are hereby reduced as follows:

(1) for fiscal year 1996, $2,170,000,000 in new budget authority and in outlays;

(2) for fiscal year 1997, $6,020,000,000 in new budget authority and in outlays; and

(3) for fiscal year 1998, $15,650,000,000 in new budget authority and in outlays.

(b) DEFICIT REDUCTION INCLUDED ON PAY-AS-YOU-GO SCORECARD.—The reduction in the discretionary outlay limits under subsection (a) shall be considered a reduction in pay-as-you-go outlays for purposes of estimates made for this Act under section 252(d) of the Balanced Budget and Emergency Deficit Control Act of 1985 (in addition to any other pay-as-you-go amount estimated for purposes of that section as a result of the enactment of this Act).

SEC. 15010. EFFECTIVE DATES.

(a) CHAPTER 18.—The provisions of chapter 18 of title 38, United States Code, as added by section 15001, shall take effect on October 1, 1996.

(b) CHAPTER 17 ELIGIBILITY REFORM.—The amendments made by section 15003 shall take effect on October 1, 1996.

(c) ADMINISTRATIVE MATTERS.—The provisions of sections 7343 and 7344 of title 38, United States Code, as added by 15002(a), shall take effect on the date of the enactment of this Act.

(d) EARLY ENROLLMENT.—The Secretary of Veterans Affairs may commence enrollment under chapter 18 of title 38, United States Code, as added by section 15001, and otherwise carry out activities related to preparation for the conduct of health care activities in the form of health plans effective as of the date of the enactment of this Act.

TITLE XVI—INDIAN HEALTH SERVICE

SEC. 16001. POLICY.

Section 3(a) of the Indian Health Care Improvement Act (25 U.S.C. 1602(a)) is amended to read as follows:

"(a) The Congress hereby declares that it is the policy of this Nation, in fulfillment of its unique trust responsibility and legal obligation to the American Indian and Alaska Native people—

"(1) to assure the highest possible health status for American Indians and Alaska Natives,

"(2) to raise the quality of health care delivery to American Indians and Alaska Natives to the highest possible level,

"(3) to provide health care services in a culturally appropriate manner which is consistent with the policies of Indian self-determination and tribal self-governance, and

"(4) to provide all resources necessary to effect paragraphs (1) through (3).".

SEC. 16002. HEALTH SECURITY FOR INDIANS.

The Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.) is amended by adding at the end the following new title:

"TITLE IX—HEALTH SECURITY FOR INDIANS

"SEC. 901. DEFINITIONS.

"For the purposes of this title:

"(1) GUARANTEED NATIONAL BENEFIT PACKAGE.—The term 'guaranteed national benefit package' has the meaning given such term in section 2(5) of the Guaranteed Health Insurance Act of 1994.

"(2) HEALTH PROGRAM OF THE SERVICE.—The term 'health program of the Service' means a facility or plan which provides or arranges for the provision of health services through one or more programs operated by the Service, by a health program of an Indian tribe, or by an urban Indian program operated pursuant to title V.

"(3) HEALTH PROGRAM OF AN INDIAN TRIBE.—The term 'health program of an Indian tribe' means a program which provides or arranges for the provision of health services and is operated by an Indian tribe, tribal organization, or group of Indian tribes or tribal organizations.

"(4) FAMILY.—The term 'family' has the meaning given such term in section 3 of the Guaranteed Health Insurance Act of 1994.

"(5) CERTIFIED HEALTH PLAN.—The term 'certified health plan' has the meaning given such term in section 2(2) of the Guaranteed Health Insurance Act of 1994.

"SEC. 902. ELIGIBILITY AND HEALTH SERVICE COVERAGE OF INDIANS.

"(a) ELIGIBILITY.—

"(1) IN GENERAL.—An eligible individual (as defined in section 1001(c) of the Guaranteed Health Insurance Act of 1994) is eligible to enroll in a health program of the Service if the individual is—

"(A) eligible to receive services pursuant to sections 36.1—36.14 of title 42, Code of Federal Regulations (1986);

"(B) an urban Indian; or

"(C) an Indian described in section 809(b).

"(2) ELECTION TO ENROLL OTHER TRIBAL MEMBERS.—In addition to those individuals made eligible to enroll in a health program of the Service under paragraph (1), a tribe, which operates a health program directly or through a tribal organization, may elect to offer enrollment in a health program of the Service to members of the tribe, regardless of their residency or domicile.

"(b) ENROLLMENT.—

"(1) AUTOMATIC ENROLLMENT IN HEALTH PROGRAM OF THE SERVICE.—The Service shall enroll an individual described in subsection (a)(1) in the health program of the Service in which the individual was last an active user unless the individual elects to enroll in—

"(A) another certified health plan,

"(B) another health program of the Service, or

"(C) medicare part C program (established under title XXI of the Social Security Act).

"(2) ELECTIVE ENROLLMENT IN HEALTH PROGRAM OF THE SERVICE.—The Service shall permit an individual described in subsection (a) who is not an active user to enroll in a health program of the Service.

"(3) CONSTRUCTION.—Nothing in paragraph (1) shall prevent an individual referred to in such paragraph from disenrolling from the health plan of the Service in order to enroll in another certified health plan or to become a medicare part C eligible individual.

"(c) LIMITATION ON CHARGES.—An individual who is eligible under subsection (a) and who enrolls in a health program of the Service shall not be subject to any charge for health insurance premiums, deductibles, copayments, coinsurance, or any other cost for health services provided under such program.

"SEC. 903. PROVISION OF HEALTH SERVICES TO NON-ENROLLEES AND NON-INDIANS.

"(a) PROVISION OF HEALTH SERVICES TO NON-INDIAN FAMILY MEMBERS OF INDIANS.—

"(1) IN GENERAL.—A health program of the Service may provide health services to family members of individuals described in section 902(a) if the tribe, tribes, or urban Indian organization served by the program authorizes the provision of services to such family members.

"(2) ENROLLMENT IN A HEALTH PROGRAM OF THE SERVICE.—

"(A) ELECTION.—If a health program of the Service opens enrollment pursuant to paragraph (1) to family members of individuals described in section 902(a), such program shall permit such individuals to elect family enrollment in such program.

"(B) ENROLLMENT.—

"(i) IN GENERAL.—An individual who elects family enrollment under subparagraph (A) in a health program of the Service shall enroll in such program.

"(ii) APPLICABLE INDIVIDUAL CHARGES.—The individual who enrolls in such program under clause (i) is not subject to any charge for health insurance premiums, deductibles, copayments, coinsurance, or any other cost for health services provided under such program attributable to the individual, but the family members who are not eligible for a health program of the Service under section 902(a) are subject to all such charges.

(b) CONTRACTS WITH CERTIFIED HEALTH PLANS.—A health program of the Service may enter into a contract with a certified health plan that is not a health program of the Service for the provision of health care services to individuals enrolled in such certified health plan if the tribe, tribes, or urban Indian organization served by the health program of the Service—

"(1) authorizes serving non-Indians, and

"(2) determines that allowing such services to non-Indians will not result in a denial or diminution of health services to any individual described in section 902(a) who is enrolled in a health program of the Service.

"(c) PROVISION OF HEALTH SERVICES AS AN ESSENTIAL COMMUNITY PROVIDER.—A health program of the Service may elect to provide services as an essential community provider under section

5012 of the Guaranteed Health Insurance Act of 1994 if the authorization and determination specified in paragraphs (1) and (2) of subsection (b) are made.

"(d) PROVISION OF HEALTH SERVICES AS A CERTIFIED HEALTH PLAN.—A health program of the Service may elect to offer the guaranteed national benefit package to individuals not described in subsection (a) of this section or section 902(a), or as a certified health plan under title V of the Guaranteed Health Insurance Act of 1994, if the authorization and determination specified in paragraphs (1) and (2) of subsection (b) are made.

"(e) PROVISION OF HEALTH SERVICES AS A PROGRAM OTHER THAN A CERTIFIED HEALTH PLAN OR AN ESSENTIAL COMMUNITY PROVIDER.—A health program of the Service that is not a certified health plan under title V of the Guaranteed Health Insurance Act of 1994 may provide health services to individuals who are not described in subsection (a) of this section or section 902(a) if the authorization and determination specified in paragraphs (1) and (2) of subsection (b) are made.

"SEC. 904. PROVISION OF GUARANTEED NATIONAL BENEFIT PACKAGE.

"Effective January 1, 1999, the Secretary shall ensure that all health programs of the Service provide or arrange for the provision of the guaranteed national benefit package to individuals described in section 902(a).

"SEC. 905. ADMINISTRATIVE PROVISIONS.

"(a) REIMBURSEMENT FOR SERVICES PROVIDED TO INDIANS ENROLLED IN OTHER HEALTH PROGRAMS OF THE SERVICE.—A health program of the Service shall reimburse another health program of the Service for services provided to its enrollees in accordance with such reimbursement provisions as the Secretary determines to be appropriate.

"(b) RETENTION OF RECEIPTS.—

"(1) IN GENERAL.—Amounts received by a health program of the Service pursuant to this title, the Guaranteed Health Insurance Act of 1994, or an amendment made by the Guaranteed Health Insurance Act of 1994 for the delivery of health services shall remain with and may be expended by the health program of the Service.

"(2) AVAILABILITY OF FUNDS FOR EXPENDITURE BY A HEALTH PROGRAM OF THE SERVICE.—Amounts available to a health program of the Service pursuant to this subsection shall be available without further appropriation and shall remain available until expended, first for payments for the delivery of the items and services in the guaranteed national benefit package and then for other services offered by the health program of the Service, including supplemental Indian health care benefits described in section 905(g).

"(c) RISK SHARING.—

"(1) AGGREGATION OF RECEIPTS.—Health programs of the Service may aggregate fund receipts (including from contracts and subcontracts) for the purposes of retaining risk on a partial or full risk basis.

"(2) REINSURANCE POOLS.—The Secretary may establish reinsurance pools on a local, regional, or national basis—

"(A) for health programs of the Service operated by the Service,

"(B) for health programs of an Indian tribe or an urban Indian organization, at the request of the tribe, tribes, tribal organization, or urban Indian organizations concerned, or

"(C) any combination thereof, if authorized by the tribe, tribes, tribal organization, or urban Indian organizations concerned.

"(d) PAYMENT FOR SERVICES PROVIDED BY CONTRACTORS.—Nothing in this title, the Guaranteed Health Insurance Act of 1994,

or an amendment made by the Guaranteed Health Insurance Act of 1994 shall be construed as—

"(1) affecting any other provision of law, regulation, or judicial or administrative interpretation of law or policy concerning the status of the Service as the payor of last resort (as defined in part 36 of title 42, Code of Federal Regulations) for Indians eligible for contract health services under a health program of the Service; or

"(2) amending or modifying section 206 of this Act (relating to reimbursement from certain third parties of costs of health services).

"(e) HEALTH PROFESSIONAL SERVICES.—With respect to any individual enrolled in a health program of the Service, in applying the guaranteed national benefit package the term 'health professional services' includes health services provided by a traditional Indian healer.

"(f) DISPOSITION OF SUBSIDIES AND EMPLOYER PREMIUMS TRANSFERRED FROM THE SECRETARY OF THE TREASURY.—With respect to amounts paid to the Secretary under section 2124(c)(2)(C) of the Social Security Act, the Secretary shall promptly provide for the appropriate distribution of such amounts to such health programs of the Service as provide services to employees and family members with respect to which such payments are made. The Secretary may not offset or limit the amount of funds obligated to any health program of the Service because of receipt of funds under this section.

"(g) FACILITATION OF APPLICATION FOR PREMIUM CERTIFICATES.—The Service shall take such actions as may be necessary to facilitate the application for premium certificates under part A of title XXII of the Social Security Act by individuals described in section 902(a).

"(h) SUPPLEMENTAL INDIAN HEALTH CARE BENEFITS.—All individuals described in section 902(a) remain eligible for all services provided under the laws administered by the Service which supplement the guaranteed national benefit package. The individual shall not be subject to any charge or any other cost for such benefits.

"(i) MEDICAL RESIDENCY TRAINING PROGRAMS.—Consistent with the provisions of subtitle A of title VII of the Guaranteed Health Insurance Act of 1994, the Secretary shall develop training sites for medical residency training programs in primary care in health programs of the Service.

"SEC. 906. LONG-TERM CARE FOR HOME AND COMMUNITY-BASED SERVICES.

"(a) DISTRIBUTION OF SET-ASIDE FOR HOME AND COMMUNITY-BASED SERVICES TO CERTAIN INDIVIDUALS.—The Service shall provide for the fair and equitable distribution of funds received under section 10006(c) of the Guaranteed Health Insurance Act of 1994 to Indian tribes and tribal organizations for the provision of home and community-based services to individuals described in section 902(a) and enrolled family members under section 903(a) of this title with severe disabilities (as defined in section 10002 of the Guaranteed Health Insurance Act of 1994).

"(b) FEDERAL QUALITY STANDARDS.—

"(1) IN GENERAL.—Except as provided in paragraph (2), an Indian tribe or tribal organization may receive funds under subsection (a) if the tribe or tribal organization meets the quality standards prescribed by the Secretary under title X of the Guaranteed Health Insurance Act of 1994 for the provision of home and community-based services for individuals with severe disabilities.

"(2) EXCEPTION.—No Indian or family member of an Indian served through a health program of the Service shall be required to participate in cost sharing for services provided under this section.

"SEC. 907. CAPITAL INVESTMENT AND TRANSITIONAL ASSISTANCE.

"(a) CAPITAL FINANCING.—

"(1) ESTABLISHMENT OF PROGRAM.—There is established in the Service a revolving loan program. Under the program, the Secretary, acting through the Service, shall provide guaranteed loans from the amounts appropriated pursuant to paragraph (5) to health programs of an Indian tribe and urban Indian organizations.

"(2) USE OF FUNDS.—Loans made under paragraph (1) may be used for the construction and renovation of hospitals, health centers, health stations, and other facilities of the Service, tribes, tribal organizations, and urban Indian organizations for the purpose of improving and expanding such facilities to enable the delivery of the full array of items and services guaranteed in the guaranteed national benefit package.

"(3) TERMS AND CONDITIONS.—Guaranteed loans under paragraph (1) shall be subject to such terms and conditions as the Secretary may prescribe, to assure that funds are used in a manner consistent with paragraph (2).

"(4) ELIGIBILITY FOR OTHER FUNDING.—Receipt of a guaranteed loan under paragraph (1) shall not prevent such health programs from obtaining loans or loan guarantees pursuant to section 2802(a)(2)(A) of the Public Health Service Act.

"(5) AGGREGATE CAPITAL FINANCING FUNDING LEVELS.—For purposes of paragraph (1), there is authorized to be appropriated $500,000,000 for each of the fiscal years 1995 through 1997.

"(b) TRANSITIONAL ASSISTANCE.—

"(1) IN GENERAL.—There is authorized to be appropriated $200,000,000 for each of the fiscal years 1995 through 2000 to provide transitional assistance to the Service and to Indian tribes, tribal organizations, and urban Indian organizations to provide the guaranteed national benefit package.

"(2) GRANTS TO TRIBES AND TRIBAL ORGANIZATIONS.—Subject to the availability of appropriations under paragraph (1), the Service shall make grants to assist Indian tribes, tribal organizations, and urban Indian organizations, under such terms and conditions as the Secretary determines, in developing the capacity (including the establishment of computerized information and billing systems) to deliver or arrange for the delivery of services under the guaranteed national benefit package.

"SEC. 908. TREATMENT OF INDIANS ENTITLED TO VETERANS BENEFITS.

"(a) IN GENERAL.—In the case of an individual described in section 902(a) who is enrolled in a health program of the Service and is a veteran who receives items and services in the guaranteed national benefit package through the Secretary of Veterans' Affairs, the Service shall not be required to provide reimbursement to such Secretary for such items and services.

"(b) COOPERATIVE AGREEMENTS.—The Secretary shall enter into a cooperative service and payment agreement with the Secretary of Veterans' Affairs to assure that veterans who are described in section 902(a) and also eligible for enrollment in a health plan operated by the Department of Veterans' Affairs are entitled to fully participate in either health plan without payment premiums, copayments, deductibles, or coinsurance.

"(c) SURVEY OF HEALTH SERVICES AVAILABLE TO INDIAN VETERANS.—

"(1) IN GENERAL.—The Secretary, in consultation with the Secretary of Veterans Affairs, Indian tribes and tribal organizations, shall conduct a survey to assess the availability and accessibility of health care services for Indian veterans residing on Indian reservations.

"(2) REPORT.—Not later than 180 days after the date of enactment of this title, the Secretary shall submit a report to the Congress, including recommendations, concerning the survey conducted under paragraph (1).".

SEC. 16003. TREATMENT OF PAYMENTS UNDER MEDICARE AND MEDICAID PROGRAMS.

(a) HEALTH CARE FACILITIES.—

(1) MEDICARE.—Section 401(a) of the Indian Health Care Improvement Act (25 U.S.C. 1641) is amended by striking "facility of the Service (whether operated by the Service or by an Indian tribe or tribal organization pursuant to a contract under the Indian Self-Determination Act)" and inserting "of a health program of the Service (as defined in section 901(2))".

(2) MEDICAID.—Section 402 of the Indian Health Care Improvement Act (25 U.S.C. 1642) is amended—

(A) in the first sentence of subsection (a)—

(i) by striking "facility of the Service" and inserting "health program of the Service (as defined in section 901(2))"; and

(ii) by striking "such Service" and inserting "such health programs of the Service";

(B) in the second sentence of subsection (a), by striking "the facilities of the Service" and inserting "such health programs of the Service"; and

(C) in subsection (b), by striking "such facility" and inserting "such health program of the Service".

SEC. 16004. ANNUAL CONSULTATION CONCERNING HEALTH CARE INITIATIVES.

Title VI of the Indian Health Care Improvement Act (25 U.S.C. 1661 et seq.) is amended—

(1) redesignating section 603 as section 604; and

(2) by inserting after section 602 the following:

"ANNUAL CONSULTATION AND NATIONAL INDIAN HEALTH ADVISORY GROUP

"SEC. 603. (a) The Secretary shall consult annually with representatives of Indian tribes, tribal organizations, and urban Indian organizations concerning health care initiatives that affect Indian communities and concerning policy, funding, and administration of health programs of the Service (as defined in section 901(2)). The Secretary shall solicit and consider the views and recommendations provided by Indian tribes, tribal organizations, and urban Indian organizations in making determinations that affect Indians and Indian tribes.

"(b)(1) The Secretary shall establish a national Indian advisory group to assess and advise the Secretary on all aspects of the administration of health programs of the Service (as defined in section 901(2)), including development of the budget for such programs.

"(2) The advisory group shall be composed of not less than one representative from each Service area, to be appointed by the Secretary from nominees of tribes and tribal organizations in the respective areas and such other appointees as the Secretary determines appropriate, except that a majority of the members must have been nominated by a tribe or tribal organization.

"(3) The advisory group shall submit such reports as may be necessary to the Congress.".

SEC. 16005. PREEMPTION OF STATE REGULATORY AUTHORITY.

A State (or an entity of a State) may not impose any standard or requirement on a health program of the Service (as defined in section 901(2) of the Indian Health Care Improvement Act) that is inconsistent with this Act or any regulation prescribed under this Act or the Indian Health Care Improvement Act regarding the operation of any such health program of the Service.

SEC. 16006. RULES OF CONSTRUCTION.

Unless otherwise provided by this Act or an amendment made by this Act, no part of this Act or any such amendment shall be construed to rescind or otherwise modify any obligations, findings, or purposes contained in the Indian Health Care Improvement Act

(25 U.S.C. 1601 et seq.) and in the Indian Self-Determination and Education Assistance Act.

SEC. 16007. PROHIBITION ON REDUCTIONS OF FULL-TIME EQUIVALENT POSITIONS IN THE INDIAN HEALTH SERVICE.

(a) PROHIBITION.—Notwithstanding any other provision of law and until January 1, 1999, no reduction may be made in the number of full-time equivalent positions in the Indian Health Service from the number of such positions on September 30, 1994.

(b) EXEMPTION.—During the period that the prohibition specified in subsection (a) is effective, no restriction imposed by law on hiring by executive agencies for the purpose of achieving workforce reductions shall apply to the Indian Health Service, including section 5 of the Federal Workforce Restructuring Act of 1994 (5 U.S.C. 3101 note).

(c) RULE OF CONSTRUCTION.—No law may be construed as suspending or modifying this section unless such law specifically refers to or amends this section.

TITLE XVII—MEDICAL MALPRACTICE AND ANTITRUST REFORMS

Subtitle A—Medical Malpractice

PART 1—LIABILITY REFORM

SEC. 17001. DEFINITIONS.

In this subtitle, the following definitions apply:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM.—The term "alternative dispute resolution system" means a system that provides for the resolution of medical malpractice claims in a manner other than through medical malpractice liability actions.

(2) ARBITRATION.—The term "arbitration" means a nonjury, adversarial dispute resolution process that may result in a final decision as to fact, law, liability, or damages.

(3) CLAIMANT.—The term "claimant" means any person who alleges a medical malpractice claim, and any person on whose behalf such a claim is alleged, including the decedent in the case of an action brought through or on behalf of an estate.

(4) CONTINGENCY FEE.—The term "contingency fee" means any fee for professional legal services which is, in whole or in part, contingent upon the recovery of any amount of damages, whether through judgment or settlement.

(5) FUTURE DAMAGES.—The term "future damages" means damages for economic or noneconomic loss incurred after the time of judgment.

(6) HEALTH CARE PROFESSIONAL.—The term "health care professional" means any individual who provides health care services in a State and who is required by the laws or regulations of the State to be licensed or certified by the State to provide such services in the State.

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

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

(9) MANDATORY.—The term "mandatory" means required to be used by the parties to attempt to resolve a medical malpractice claim notwithstanding any other provision of an agreement, State law, or Federal law.

(10) MEDIATION.—The term "mediation" means a settlement process coordinated by a neutral third party and without the ultimate rendering of a formal opinion as to factual or legal findings.

(11) MEDICAL MALPRACTICE CLAIM.—The term "medical malpractice claim" means a claim against a health care provider, a health care professional, or a blood or tissue bank licensed or registered by the Food and Drug Administration in which a claimant alleges that injury was caused by the provision of (or the failure to provide) health care services, except that such term does not include—

(A) any claim based on an allegation of an intentional tort;

(B) any claim based on an allegation that a product is defective or unreasonably dangerous, or fails to contain an adequate warning; or

(C) any claim brought pursuant to subtitle D of title IX.

(12) MEDICAL MALPRACTICE LIABILITY ACTION.—The term "medical malpractice liability action" means a civil action brought in a State or Federal court against a health care provider, a health care professional, or a blood or tissue bank licensed or registered by the Food and Drug Administration in which the plaintiff alleges a medical malpractice claim.

SEC. 17002. FEDERAL TORT REFORM.

(a) IN GENERAL.—Except as provided in section 17003, this part shall apply with respect to any medical malpractice liability action brought in any State or Federal court, except that this part shall not apply to a claim or action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the claim or action.

(b) PREEMPTION.—The provisions of this part shall preempt any State law to the extent such law is inconsistent with such provisions.

(c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in this part shall be construed to—

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

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

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

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

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

(d) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—Nothing in this part shall be construed to establish any jurisdiction in the district courts of the United States over medical malpractice liability actions on the basis of section 1331 or 1337 of title 28, United States Code.

SEC. 17003. ALTERNATIVE DISPUTE RESOLUTION METHODS.

(a) APPLICATION TO MALPRACTICE CLAIMS.—In any medical malpractice liability action, the alternative dispute resolution systems adopted under subsection (b) shall be available to the claimant. Participation in any of such systems shall be in lieu of any alternative dispute resolution method required by any other law or by any contractual arrangement made by or on behalf of the parties before the commencement of the action.

(b) STATE ADOPTION OF ALTERNATIVE DISPUTE RESOLUTION METHODS—Each State shall—

(1) adopt at least one of the alternative dispute resolution methods specified under subsection (c) for the resolution, subject to subsection (d), of medical malpractice claims;

(2) disclose to residents of the State the availability and procedures for resolution of consumer grievances regarding the provision of (or failure to provide) health care services, including the alternative dispute resolution methods applicable under paragraph (1); and

(3) provide that the alternative dispute resolution process may begin before or after, at the option of the claimant, the commencement of a medical malpractice liability action.

(c) SPECIFICATION OF PERMISSIBLE ALTERNATIVE DISPUTE RESOLUTION METHODS.—

(1) IN GENERAL.—The Attorney General, in consultation with the Secretary, shall, by regulation, develop requirements with respect to the following alternative dispute resolution methods for the adoption by States:

(A) MANDATORY MEDIATION.—Mandatory mediation conducted by one or more mediators who are selected by agreement of the parties or, if the parties do not agree,

who are qualified under applicable State law and selected by the court.

(B) ARBITRATION.—Arbitration entered into by agreement of the parties.

(2) STANDARDS FOR ESTABLISHING METHODS.—In developing alternative dispute resolution methods under paragraph (1), the Attorney General, in consultation with the Secretary, shall ensure that the methods promote the resolution of medical malpractice claims in a manner that—

(A) is affordable for the parties involved;

(B) encourages timely resolution of claims;

(C) encourages the consistent and fair resolution of claims;

(D) provides for reasonably convenient access to dispute resolution; and

(E) in the case of arbitration, provides rules for limiting the use of experts, for expediting discovery, and for waiving applicable rules of evidence.

(d) FURTHER REDRESS AND ADMISSIBILITY.—Any party dissatisfied with a determination reached with respect to a medical malpractice claim as a result of an alternative dispute resolution method applied under this section shall not be bound by such determination. The results of any alternative dispute resolution method applied under this section, and all statements, offers, and communications that originate during the application of such method, shall be inadmissible for purposes of adjudicating the claim.

SEC. 17004. REQUIREMENT FOR AFFIDAVIT OF MERIT.

(a) REQUIRING SUBMISSION WITH COMPLAINT.—No medical malpractice liability action may be brought by any individual unless, at the time the individual brings the action (except as provided in subsection (b)(1)), the individual (or the individual's attorney) submits an affidavit declaring that—

(1) the individual (or the individual's attorney) has consulted and reviewed the facts of the action with a qualified specialist;

(2) the individual (or the individual's attorney) has obtained a written report by a qualified specialist that clearly identifies the individual and that includes the specialist's statement of belief that, based on a review of the available medical record and other relevant material, there is a reasonable and meritorious cause for the filing of the action against the defendant; and

(3) on the basis of the qualified specialist's review and consultation, that the individual (or the individual's attorney) has concluded that there is a reasonable and meritorious cause for the filing of the action.

(b) EXTENSION IN CERTAIN INSTANCES.—

(1) IN GENERAL.—Subject to paragraph (2), subsection (a) shall not apply with respect to an individual who brings a medical malpractice liability action without submitting an affidavit described in such subsection if—

(A) the individual is unable to obtain the affidavit before the expiration of the applicable statute of limitations;

(B) as of the time the individual brings the action, the individual has been unable to obtain adequate medical records or other information necessary to prepare the affidavit; or

(C) other good cause exists for failing to submit the affidavit.

(2) DEADLINE FOR SUBMISSION WHERE EXTENSION APPLIES.—In the case of an individual who brings an action for which paragraph (1) applies, the action shall be dismissed unless the individual (or the individual's attorney) submits the affidavit described in subsection (a) not later than—

(A) in the case of an action for which subparagraph (A) of paragraph (1) applies, 90 days after bringing the action;

(B) in the case of an action for which subparagraph (B) of paragraph (1) applies, 90 days after obtaining the information described in such subparagraph; or

(C) in the case of an action for which subparagraph (C) of paragraph (1) applies, 90 days after the good cause involved ceases to exist.

(c) QUALIFIED SPECIALIST DEFINED.—In subsection (a), a "qualified specialist" means, with respect to a medical malpractice liability action, a health care professional who is reasonably believed by the individual bringing the action (or the individual's attorney)—

(1) to be knowledgeable in the relevant issues involved in the action, and

(2) to practice (or to have practiced) or to teach (or to have taught) in the same, or a substantially similar, area of health care or medicine that is at issue in the action.

(d) SANCTIONS FOR SUBMITTING FALSE ALLEGATIONS.—Upon the motion of any party or its own initiative, the court in a medical malpractice liability action may impose a sanction on a party or the party's attorney (or both), including a requirement that the party reimburse the other party to the action for costs and a reasonable attorney's fee, if an affidavit described in subsection (a) is submitted without reasonable cause and is found to be untrue.

(e) CONFIDENTIALITY OF SPECIALIST.—Upon a showing of good cause by a defendant, the court may ascertain the identity of a specialist referred to in subsection (a) while preserving confidentiality.

SEC. 17005. LIMITATION ON AMOUNT OF ATTORNEYS' CONTINGENCY FEES.

(a) IN GENERAL.—

(1) AUTHORITY TO ENTER INTO CONTINGENCY FEE AGREEMENTS.—Notwithstanding any State law, an individual who intends to bring a medical malpractice liability action and an attorney may enter into an agreement for the payment of—

(A) a fee, on a contingency fee basis for services in connection with the resolution of the action, up to 33 ⅓ percent of the total amount recovered (exclusive of costs) by judgment or settlement; and

(B) an additional reasonable fee, subject to the approval of the court, for services in connection with any appeal of a judgment in the action.

(2) EXCLUSION OF OTHER FEES.—An attorney who represents, on a contingency fee basis, a plaintiff in a medical malpractice liability action may not charge, demand, receive, or collect for services rendered in connection with the action any fee in excess of the maximum fee payable under paragraph (1).

(b) CALCULATION IN CASE OF PERIODIC PAYMENTS.—For purposes of computing under subsection (a) the limitation on contingency fees, the value of future damages recovered in a judgment or settlement and to be paid on a periodic basis shall be based on the present value of such payments calculated according to an appropriate discount rate. The balance of the judgment or settlement shall then be paid in accordance with the schedule determined under section 17006.

SEC. 17006. PERIODIC PAYMENT OF AWARDS.

(a) AUTHORITY TO PERMIT PERIODIC PAYMENTS.—The court may instruct the trier of fact to find, or may otherwise order that, part or all of future damages that exceed $250,000 be paid on an appropriate periodic basis. The court shall ensure that the amount and present value of periodic payments constitute full recovery of the damages awarded for the claimant's injury and that the payment schedule is found to be in the best interests of all the parties to the action.

(b) BOND OR SECURITY FOR FUTURE DAMAGES.—If future damages are awarded on a periodic basis, the court shall require the defendant to post security or a bond, or otherwise ensure the full payment of such damages.

(c) MODIFICATION OF PAYMENT SCHEDULE.—Except where the parties agree otherwise, in a medical malpractice liability action, the court shall retain authority to modify, on the basis of changed circumstances, the payment schedule of any periodic payments of future damages awarded in the action.

(d) DEATH OF PLAINTIFF.—Except where the parties agree otherwise, if a plaintiff to whom future damages are awarded in a medical malpractice liability action and made payable on a periodic basis dies before completion of the payment of such damages, the court shall order the payment of any remaining portion of such damages be paid to the estate of the plaintiff.

PART 2—OTHER PROVISIONS RELATING TO MEDICAL MALPRACTICE LIABILITY

SEC. 17011. PILOT PROGRAM APPLYING PRACTICE GUIDELINES TO MEDICAL MALPRACTICE LIABILITY ACTIONS.

(a) ESTABLISHMENT.—Not later than 1 year after the Secretary determines that appropriate practice guidelines are available (including clinical practice guidelines developed under title IX of the Public Health Service Act) and were developed with the input of health care providers, legal professionals, and consumer representatives, the Secretary, in consultation with the Attorney General, shall establish a pilot program under which the Secretary shall provide funds (in such amount as the Secretary considers appropriate) to one or more eligible States to determine the effect of applying practice guidelines in the resolution of medical malpractice liability actions.

(b) ELIGIBILITY OF STATE.—A State is eligible to participate in the pilot program established under subsection (a) if the State submits an application to the Secretary (at such time and in such form as the Secretary may require) containing—

(1) assurances that, under the law of the State, in the resolution of any medical malpractice liability action based on conduct addressed by an appropriate practice guideline, that—

(A) compliance with the guideline shall be admissible by any party in a medical malpractice liability action and shall be sufficient to establish a rebuttable presumption that there is no liability for medical malpractice for conduct that is within the scope of the guideline; and

(B) noncompliance with the guideline shall be admissible by any party in a medical malpractice liability action and shall be sufficient to establish a rebuttable presumption that there is liability for medical malpractice for conduct that is within the scope of the guideline; and

(2) such other information and assurances as the Secretary may require.

(c) SELECTION OF PARTICIPATING STATES.—In selecting a State to participate in the pilot project established under subsection (a), the Secretary shall determine whether the practice guideline described in the application submitted under subsection (b)—

(1) is appropriate for purposes of resolving medical malpractice liability actions based on conduct addressed by such guideline; and

(2) was developed with the input of health care providers, legal professionals, and consumer representatives.

(d) REPORTS TO CONGRESS.—Not later than 3 months after the last day of each year throughout which the pilot program established under subsection (a) is in effect, the Secretary shall submit, to the Speaker of the House of Representatives and the President pro tempore of the Senate, a report describing the operation of the program during the previous year and containing such recommendations as the Secretary considers appropriate, including recommendations relating to revisions to the laws governing medical malpractice liability.

SEC. 17012. FEDERAL STUDY ON MEDICAL MALPRACTICE.

(a) STUDY.—In order to improve the level of empirical data on the incidence and effect of medical malpractice in the United States, the Secretary, in consultation with the Attorney General, shall carry out a nationwide interdisciplinary study of medical malpractice, including an evaluation of—

(1) the incidence of injuries resulting from medical treatment and the percentage of such injuries that resulted from the medical malpractice by a health care provider or health care professional;

(2) the costs of medical expenses and lost wages to the victims of medical malpractice and their families, and their compensation for such losses under current law;

(3) the costs of legal expenses associated with medical malpractice liability actions, including attorneys' fees that are not paid on a contingency fee basis;

(4) the number of medical malpractice claims brought and their impact on the legal system;

(5) methods to reduce the incidence and costs of medical malpractice;

(6) the cost of medical malpractice insurance and methods for reducing such cost; and

(7) methods to promote the efficient and fair resolution of legal claims stemming from the incidence of medical malpractice, including methods of resolving small medical malpractice claims in a more efficient and less costly basis.

(b) REPORT TO CONGRESS.—Not later than 3 years after the date of the enactment of this Act, the Secretary shall submit, to the Speaker of the House of Representatives and the President pro tempore of the Senate, a report describing the results of the evaluation required by subsection (a).

Subtitle B—McCarran-Ferguson Reform

SEC. 17101. SHORT TITLE.

This subtitle may be cited as the "Insurance Competitive Pricing Act of 1994".

SEC. 17102. RULES OF CONSTRUCTION.

The amendments made by this subtitle preserve—

(1) the provisions relating to State taxing and regulatory authority in section 2 of the Act of March 9, 1945 (59 Stat. 34; 15 U.S.C. 1012), commonly known as the McCarran-Ferguson Act;

(2) the availability, to persons engaged in the business of insurance, of the defense of State action in the same manner and to the same extent as such defense is available to other persons;

(3) the availability, to persons engaged in the business of insurance, of any antitrust immunity or defense that may be applicable under law other than the McCarran-Ferguson Act;

(4) the legal standards applicable under the McCarran-Ferguson Act, as in effect before such Act is amended by this subtitle, to all conduct described in the safe harbors found in subparagraphs (B), (C), (D), and (E) of section 2(b)(1) of the McCarran-Ferguson Act, as amended by this subtitle; and

(5) the provisions relating to boycott, coercion, or intimidation in section 3(b) of the McCarran-Ferguson Act.

SEC. 17103. AMENDMENTS.

Section 2 of the Act of March 9, 1945 (59 Stat. 34; 15 U.S.C. 1012), commonly known as the McCarran-Ferguson Act, is amended—

(1) in subsection (b)—

(A) by striking ": *Provided*," and all that follows through "law." and inserting the following:

"except as follows:

"(1)(A) The antitrust laws shall be applicable to the business of insurance except as provided in subparagraphs (B), (C), (D), and (E).

"(B) The antitrust laws shall not be applicable to conduct that consists of making an agreement or engaging in joint conduct—

"(i)(I) to collect, compile, classify, or disseminate historical data;

"(II) to develop procedures to collect, compile, classify, or disseminate historical data; or

"(III) to verify that historical data is accurate and complete;

"(ii) to determine, using standard actuarial techniques, or disseminate, a loss development factor or developed losses;

"(iii) to develop or disseminate a standard insurance policy form (including a standard addendum to an insurance policy form and standard terminology in an insurance policy form) if such agreement or joint conduct does not include an agreement to adhere to such standard form, or to require adherence to such standard form, except that the fact that 2 or more persons engaged in the business of insurance use such standard form—

"(I) shall not be sufficient in itself to support a finding that an agreement to adhere, or to require adherence, to such standard form exists; and

"(II) may be used only for the purpose of supplementing or explaining direct evidence of the existence of an agreement to adhere, or to require adherence, to such standard form;

"(iv) to develop or disseminate, for use in providing insurance in a State, a manual that is filed, before dissemination, with the State entity that regulates the business of insurance under State law, if such manual includes only—

"(I) information and conduct described in clauses (i), (ii), and (iii), including relativity factors;

"(II) during the transition period, a trend factor or information to which a trend factor has been applied, to the extent permitted under subparagraph (C); and

"(III) explanations and instructions for using the manual (or any of the information contained in the manual), if such agreement or joint conduct does not include an agreement among competitors to adhere, or to require adherence, to any of such explanations or instructions;

"(v) to provide insurance pursuant to a public necessity market mechanism;

"(vi) to provide insurance as a historical underwriting capacity risk pool;

"(vii) to administer a public necessity market mechanism in a State, pursuant to the authorization of and under the supervision of such State, if all persons who provide insurance in such State pursuant to such mechanism, and all persons seeking to obtain insurance through such mechanism, have a reasonable opportunity to appeal determinations affecting them to a governmental entity;

"(viii) to develop or participate in a program to inspect commercial buildings and fire protection facilities, and evaluate government building code requirements and enforcement of such requirements, to determine the likelihood and potential extent of loss due to fire, wind, hail, earthquake, flood, or tidal wave, pursuant to a State law that provides procedures for making such a determination and provides a reasonable opportunity for an affected person to appeal such a determination to a governmental entity; or

"(ix) to develop or participate in a program, pursuant to a workers' compensation insurance plan filed with the State entity that regulates the business of insurance under State law, to measure an employer's experience with respect to occupational accidents and illnesses for which such employer is liable, against the comparable experience of other employers, and to make a modification for an individual employer based on such comparisons, if an affected employer has a reasonable opportunity to appeal a determination under such program to a governmental entity;

to the extent that such conduct is regulated by State law.

"(C) During the transition period, the antitrust laws shall not be applicable to conduct that consists of making an agreement or engaging in joint conduct to determine or disseminate a trend factor, to the extent that such conduct is regulated by State law.

"(D) The antitrust laws shall not be applicable to conduct by a director, officer, or employee of a national trade association representing insurance agents, or of a State trade association representing insurance agents that is affiliated with such national trade association, acting within the scope of the authority vested in such director, officer, or employee by the trade association involved, that consists of preparing, disseminating, or discussing a report or comment (including describing, evaluating, and suggesting possible responses for members of the association whose directors, officers, or employees prepared such report or such comment to consider) with respect to any insurer practice affecting the relationship between insurers and insurance agents, if—

"(i) such report or such comment includes a conspicuous statement that each insurance agent is expected to make his or her own decision regarding matters contained in such report or such comment and that anticompetitive agreements among insurance agents with respect to any response to such practice are illegal under the antitrust laws;

"(ii) such conduct does not involve—

"(I) monitoring or policing the extent to which any insurance agent follows, or pressuring any insurance agent to follow, any of such responses;

"(II) initiating any communication (including a mailing, association publication, or association meeting) with any member of any such association with respect to such report or such comment (including any of such responses), other than by a means designed to reach all members, or all directors and officers, of such association;

"(III) referring to any of such responses in any discussion unless the discussion emphasizes that each insurance agent is expected to make his or her own decision regarding matters contained in such report or such comment and that anticompetitive agreements among insurance agents with respect to any response to such practice are illegal under the antitrust laws; or

"(IV) the formal endorsement of such report or such comment (including any of such responses) by any part of the membership of any such association, other than a statement that dissemination of such report or such comment has been approved by the directors or officers of the association whose directors, officers, or employees prepared such report or such comment; and

"(iii) the number of directors and officers of any such association who are involved in preparing, disseminating, or discussing such report or such comment (including any of such responses) does not substantially exceed the num-

ber of directors and officers of such association serving on April 30, 1994;

and if the business of insurance is regulated by State law.

"(E) The antitrust laws shall not be applicable to conduct of an insurance agent that is a member of an association referred to in subparagraph (D) that consists of independently initiating a communication, in an issue of a regularly scheduled association publication or at a regularly scheduled association meeting, to members of a local trade association representing insurance agents of which such agent is a member, that describes or summarizes all or part of the contents of a report or comment described in such subparagraph provided to such agent by such association described in such subsection and that is made only by a means designed to reach all such members, if—

"(i) such conduct does not involve—

"(I) monitoring or policing the extent to which any insurance agent follows, or pressuring any insurance agent to follow, any of the possible responses contained in such report or such comment;

"(II) referring to any of such responses unless the references emphasizes that each insurance agent is expected to make his or her own decision regarding matters contained in such report or such comment and that anticompetitive agreements among insurance agents with respect to any response to an insurance practice discussed in such report or such comment are illegal under the antitrust laws; or

"(III) the formal endorsement of such report or such comment (including any of such responses); and

"(ii) the primary purpose of such meeting, or of such issue of such publication, is not the discussion of such report or such comment (including any of such responses);

and if the business of insurance is regulated by State law.

"(2) Subsequent to the transition period, the independent purchase of a trend factor by a person engaged in the business of insurance from a person not engaged in providing insurance (and not affiliated with a person engaged in providing insurance) shall be presumed not to violate the antitrust laws.

"(3) The Federal Trade Commission Act shall be applicable to the business of insurance to the extent that such business is not regulated by State law, except that, with respect to enforcement of the antitrust laws, section 17105 of such Act shall be applicable to the business of insurance to the same extent as the other antitrust laws.", and

(2) by adding at the end the following:

"(c) For purposes of subsection (b)—

"(1) the term 'antitrust laws' has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) as such section 5 applies to conduct that constitutes a violation of the Sherman Act or the Clayton Act;

"(2) the term 'developed losses' means aggregate paid losses and aggregate reserves held for received claims, as adjusted by a loss development factor;

"(3) the term 'historical underwriting capacity risk pool' means an underwriting capacity risk pool established prior to April 30, 1994—

"(A) the purpose of which is to provide insurance for a commercial risk relating to—

"(i) an airport, aviation, or aerospace activity;

"(ii) a large commercial or industrial property (including machinery, boilers, and pressure vessels);

"(iii) a grain elevator or feed mill;

"(iv) an oil, gas, or chemical peril;

"(v) the construction or operation of a nuclear energy facility;

"(vi) an inland marine peril or an ocean marine enterprise;

"(vii) a natural disaster;

"(viii) an occupational accident or illness;

"(ix) transportation of currency, mail, securities, bullion, or other valuables by a person with fiduciary responsibility for their safe transport;

"(x) foreign commercial activities undertaken in cooperation with the United States Export-Import Bank; or

"(xi) a war, rebellion, riot, or similar civil commotion;

"(B) whose conduct has not materially changed from the conduct described in accordance with subparagraph (C)(ii) in which such pool—

"(i) was authorized to engage under its charter, bylaws, or other documents of organization or governance filed in accordance with subparagraph (C)(iii); and

"(ii) did engage as so authorized;

prior to April 30, 1994; and

"(C) that, before the effective date of the Insurance Competitive Pricing Act of 1994, filed with the Attorney General of the United States, in accordance with such rules as the Attorney General may have issued, a notification—

"(i) disclosing the identities of the members of such pool on April 30, 1994;

"(ii) describing the nature and scope of the activities of such pool, and the lines of insurance in which such pool was engaged, prior to April 30, 1994; and

"(iii) containing the charter, bylaws, and other documents of organization or governance of such pool in effect on or before April 30, 1994;

"(4) the term 'historical data' means information respecting—

"(A) losses paid by, claims received by, reserves for such claims set aside by, or units of exposure to loss in insurance policies sold by any person engaged in the business of insurance; or

"(B) insurance premiums received by any person engaged in the business of insurance, if such information is not disseminated in a form from which information respecting premiums received by any separately identifiable person engaged in the business of insurance may be derived;

"(5) the term 'insurance agent' means a person that is—

"(A) engaged as an independent contractor in the business of selling insurance;

"(B) licensed under the law of a State as an insurance agent or insurance broker; and

"(C) neither an insurer in any State in which such person is so engaged, nor an employee of an insurer;

"(6) the term 'insurance policy' means a contract under which insurance is sold to an insured;

"(7) the term 'insurer' means a person that is—

"(A) engaged in the business of providing insurance; and

"(B) obligated to pay losses under the insurance policies under which it provides insurance;

"(8) the term 'loss' means an amount paid or to be paid by a person engaged in the business of insurance to (or for the benefit of) a claimant to satisfy a claim on an insurance policy, and includes any attorney, investigatory, or litigation expenses

that are separately incurred, identified, and allocated by such person with respect to that particular claim;

"(9) the term 'loss development factor' means an adjustment to be made to the aggregate of losses incurred during a prior period of time that have been paid or for which claims have been received and reserves are being held, in order to estimate the aggregate of the losses incurred during such period that will ultimately be paid;

"(10) the term 'loss incurred' means a loss for which the event has occurred that ultimately gives rise to liability on a claim on an insurance policy, without regard to whether a claim based on such event has been received;

"(11) the term 'public necessity market mechanism' means a plan established by State law or by the State entity that regulates the business of insurance under State law—

"(A) for providing a type of insurance in a State;

"(B) in which the persons providing such type of insurance pursuant to such mechanism represent a substantial number of the persons engaged in the business of providing such type of insurance in such State and are either required by State law, or formally requested or ordered by such State entity to participate;

"(C) the purpose of which is to make such type of insurance available to persons who would not otherwise be able to obtain such type of insurance at affordable cost; and

"(D) in which the rate for such type of insurance is subject to the approval or disapproval of such State;

"(12) the term 'relativity factor' means a ratio comparing one classification of historical data to another such classification, or comparing developed losses in one such classification to developed losses in another such classification;

"(13) the term 'transition period' means the 2-year period beginning on the effective date of the Insurance Competitive Pricing Act of 1994;

"(14) the term 'trend factor' means an adjustment to be made to developed losses in order to account for any change that is anticipated to affect losses; and

"(15) the term 'underwriting capacity risk pool' means a business arrangement or association—

"(A) whose members consist of 2 or more persons engaged in the business of insurance; and

"(B) that operates for the purpose of providing insurance under which the liability for paying losses is spread among such members."

SEC. 17104. PUBLICATION AND AVAILABILITY OF HISTORICAL UNDERWRITING CAPACITY RISK POOL NOTIFICATIONS.

The Attorney General shall, not later than 30 days after receiving a notification filed in accordance with section 2(c)(3)(C) of the Act of March 9, 1945 (59 Stat. 34; 15 U.S.C. 1012), commonly known as the McCarran-Ferguson Act—

(1) publish in the Federal Register—

(A) a summary of such notification; and

(B) notice that such notification is available to the public; and

(2) make such notification available to the public.

SEC. 17105. BUSINESS REVIEW.

If a person engaged in the business of insurance submits a written request to the Attorney General in accordance with section 50.6 of title 28 of the Code of Federal Regulations (July 1, 1992), as amended from time to time, for a business review letter with respect to the application of the antitrust laws to specified activities of an underwriting capacity risk pool (as defined in section 2(c)(15) of the Act of March 9, 1945, commonly known as the McCarran-Ferguson Act) of which such person is, or intends to become, a

member, then the Attorney General shall issue such letter in accordance with such section.

SEC. 17106. STUDY AND REPORT.

(a) STUDY.—During the 5-year period beginning on the effective date of this Act, the Attorney General shall conduct a study to determine the effect of this subtitle, and the amendments made by this subtitle, on the business of insurance.

(b) REPORT.—Not later than 1 year after the expiration of the 5-year period referred to in subsection (a), the Attorney General shall submit, to the Speaker of the House of Representatives and the President pro tempore of the Senate, a report summarizing the results of the study required by subsection (a).

SEC. 17107. EFFECTIVE DATES.

(a) GENERAL EFFECTIVE DATE.—Except as provided in subsection (b), this subtitle shall take effect 1 year after the date of the enactment of this Act.

(b) EFFECTIVE DATE OF SECTIONS 17104 AND 17105.—Sections 17104 and 17105 shall take effect on the date of the enactment of this Act.