104TH CONGRESS
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HOUSE OF REPRESENTATIVES
REPT. 104–496
Part 1

HEALTH COVERAGE AVAILABILITY AND AFFORDABILITY ACT OF 1996

MARCH 25, 1996.—Ordered to be printed

Mr. ARCHER, from the Committee on Ways and Means, submitted the following

R E P O R T

together with

DISSENTING VIEWS

[To accompany H.R. 3103]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 3103) to amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, to simplify the administration of health insurance, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment is as follows:

Strike out all after the enacting clause and insert in lieu thereof the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Health Coverage Availability and Affordability Act of 1996".

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

TITLE I—IMPROVED AVAILABILITY AND PORTABILITY OF HEALTH INSURANCE COVERAGE

SUBTITLE A—COVERAGE UNDER GROUP HEALTH PLANS

SEC. 101. PORTABILITY OF COVERAGE FOR PREVIOUSLY COVERED INDIVIDUALS.

(a) CREDITING PERIODS OF PREVIOUS COVERAGE TOWARD PREEXISTING CONDITION RESTRICTIONS.—Subject to the succeeding provisions of this section, a group health plan, and an insurer or health maintenance organization offering health insurance coverage in connection with a group health plan, shall provide that any preexisting condition limitation period (as defined in subsection (b)(2)) is reduced by the length of the aggregate period of qualified prior coverage (if any, as defined in subsection (b)(3)) applicable to the participant or beneficiary as of the date of commencement of coverage under the plan.

(b) DEFINITIONS AND OTHER PROVISIONS RELATING TO PREEXISTING CONDITIONS.—

(1) PREEXISTING CONDITION.—

(A) IN GENERAL.—For purposes of this subtitle, subject to subparagraph (B), the term "preexisting condition" means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the day before—

(i) the effective date of the coverage of such participant or beneficiary, or

(ii) the earliest date upon which such coverage could have been effective if there were no waiting period applicable,

whichever is earlier.

(B) TREATMENT OF GENETIC INFORMATION.—For purposes of this section, genetic information shall not be considered to be a preexisting condition, so

long as treatment of the condition to which the information is applicable has not been sought during the 6-month period described in subparagraph (A).

(2) PREEXISTING CONDITION LIMITATION PERIOD.—For purposes of this subtitle, the term ''preexisting condition limitation period'' means, with respect to coverage of an individual under a group health plan or under health insurance coverage, the period during which benefits with respect to treatment of a condition of such individual are not provided based on the fact that the condition is a preexisting condition.

(3) AGGREGATE PERIOD OF QUALIFIED PRIOR COVERAGE.—

(A) IN GENERAL.—For purposes of this section, the term ''aggregate period of qualified prior coverage'' means, with respect to commencement of coverage of an individual under a group health plan or health insurance coverage offered in connection with a group health plan, the aggregate of the qualified coverage periods (as defined in subparagraph (B)) of such individual occurring before the date of such commencement. Such period shall be treated as zero if there is more than a 60-day break in coverage under a group health plan (or health insurance coverage offered in connection with such a plan) between the date the most recent qualified coverage period ends and the date of such commencement.

(B) QUALIFIED COVERAGE PERIOD.—

(i) IN GENERAL.—For purposes of this paragraph, subject to subsection (c), the term ''qualified coverage period'' means, with respect to an individual, any period of coverage of the individual under a group health plan, health insurance coverage, under title XVIII or XIX of the Social Security Act, coverage under the TRICARE program under chapter 55 of title 10, United States Code, a program of the Indian Health Service, and State health insurance coverage or risk pool, and includes coverage under a health plan offered under chapter 89 of title 5, United States Code.

(ii) DISREGARDING PERIODS BEFORE BREAKS IN COVERAGE.—Such term does not include any period occurring before any 60-day break in coverage described in subparagraph (A).

(C) WAITING PERIOD NOT TREATED AS A BREAK IN COVERAGE.—For purposes of subparagraphs (A) and (B), any period that is in a waiting period for any coverage under a group health plan (or for health insurance coverage offered in connection with a group health plan) shall not be considered to be a break in coverage described in subparagraph (B)(ii).

(D) ESTABLISHMENT OF PERIOD.—A qualified coverage period with respect to an individual shall be established through presentation of certifications described in subsection (c) or in such other manner as may be specified in regulations to carry out this section.

(c) CERTIFICATIONS OF COVERAGE; CONFORMING COVERAGE.—

(1) IN GENERAL.—The plan administrator of a group health plan, or the insurer or HMO offering health insurance coverage in connection with a group health plan, shall, on request made on behalf of an individual covered (or previously covered within the previous 18 months) under the plan or coverage, provide for a certification of the period of coverage of the individual under such plan or coverage and of the waiting period (if any) imposed with respect to the individual for any coverage under the plan.

(2) STANDARD METHOD.—Subject to paragraph (3), a group health plan, or insurer or HMO offering health insurance coverage in connection with a group health plan, shall determine qualified coverage periods under subsection (b)(3)(B) by including all periods described in such subsection, without regard to the specific benefits offered during such a period.

(3) ALTERNATIVE METHOD.—Such a plan, insurer, or HMO may elect to make such determination on a benefit-specific basis for all participants and beneficiaries and not to include as a qualified coverage period with respect to a specific benefit coverage during a previous period unless such previous coverage for that benefit was included at the end of the most recent period of coverage. In the case of such an election—

(A) the plan, insurer, or HMO shall prominently state in any disclosure statements concerning the plan or coverage and to each enrollee at the time of enrollment under the plan (or at the time the health insurance coverage is offered for sale in the group health market) that the plan or coverage has made such election and shall include a description of the effect of this election; and

(B) upon the request of the plan, insurer, or HMO, the entity providing a certification under paragraph (1)—

(i) shall promptly disclose to the requesting plan, insurer, or HMO the plan statement (insofar as it relates to health benefits under the plan) or other detailed benefit information on the benefits available under the previous plan or coverage, and

(ii) may charge for the reasonable cost of providing such information.

SEC. 102. LIMITATION ON PREEXISTING CONDITION EXCLUSIONS; NO APPLICATION TO CERTAIN NEWBORNS, ADOPTED CHILDREN, AND PREGNANCY.

(a) LIMITATION OF PERIOD.—

(1) IN GENERAL.—Subject to the succeeding provisions of this section, a group health plan, and an insurer or HMO offering health insurance coverage in connection with a group health plan, shall provide that any preexisting condition limitation period (as defined in section 101(b)(2)) does not exceed 12 months, counting from the effective date of coverage.

(2) EXTENSION OF PERIOD IN THE CASE OF LATE ENROLLMENT.—In the case of a participant or beneficiary whose initial coverage commences after the date the participant or beneficiary first becomes eligible for coverage under the group health plan, the reference in paragraph (1) to "12 months" is deemed a reference to "18 months".

(b) EXCLUSION NOT APPLICABLE TO CERTAIN NEWBORNS AND CERTAIN ADOPTIONS.—

(1) IN GENERAL.—Subject to paragraph (2), a group health plan, and an insurer or HMO offering health insurance coverage in connection with a group health plan, may not provide any limitation on benefits based on the existence of a preexisting condition in the case of—

(A) an individual who within the 30-day period beginning with the date of birth, or

(B) an adopted child or a child placed for adoption beginning at the time of adoption or placement if the individual, within the 30-day period beginning on the date of adoption or placement,

becomes covered under a group health plan or otherwise becomes covered under health insurance coverage (or covered for medical assistance under title XIX of the Social Security Act).

(2) LOSS IF BREAK IN COVERAGE.—Paragraph (1) shall no longer apply to an individual if the individual does not have any coverage described in section 101(b)(3)(B)(i) for a continuous period of 60 days, not counting in such period any days that are in a waiting period for any coverage under a group health plan.

(3) PLACED FOR ADOPTION DEFINED.—In this subsection and section 103(d), the term "placement", or being "placed", for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

(c) EXCLUSION NOT APPLICABLE TO PREGNANCY.—For purposes of this section, pregnancy shall not be treated as a preexisting condition.

(d) ELIGIBILITY PERIOD IMPOSED BY HEALTH MAINTENANCE ORGANIZATIONS AS ALTERNATIVE TO PREEXISTING CONDITION LIMITATION.—A health maintenance organization which offers health insurance coverage in connection with a group health plan and which does not use the preexisting condition limitations allowed under this section and section 101 with respect to any particular coverage option may impose an eligibility period for such coverage option, but only if such period does not exceed—

(1) 60 days, in the case of a participant or beneficiary whose initial coverage commences at the time such participant or beneficiary first becomes eligible for coverage under the plan, or

(2) 90 days, in the case of a participant or beneficiary whose initial coverage commences after the date on which such participant or beneficiary first becomes eligible for coverage.

Such an HMO may use alternative methods, from those described in the previous sentence, to address adverse selection as approved by the applicable State authority. For purposes of this subsection, the term "eligibility period" means a period which, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. Any such eligibility period shall be treated for purposes of this subtitle as a waiting

period under the plan and shall run concurrently with any other applicable waiting period under the plan.

SEC. 103. PROHIBITING EXCLUSIONS BASED ON HEALTH STATUS AND PROVIDING FOR ENROLLMENT PERIODS.

(a) PROHIBITION OF EXCLUSION OF PARTICIPANTS OR BENEFICIARIES BASED ON HEALTH STATUS.—

(1) IN GENERAL.—A group health plan, and an insurer or HMO offering health insurance coverage in connection with a group health plan, may not exclude an employee or his or her beneficiary from being (or continuing to be) a participant or beneficiary under the terms of such plan or coverage based on health status (as defined in section 191(c)(6)).

(2) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the establishment of preexisting condition limitations and restrictions to the extent consistent with the provisions of this subtitle.

(b) ENROLLMENT OF ELIGIBLE INDIVIDUALS WHO LOSE OTHER COVERAGE.—A group health plan shall permit an uncovered employee who is otherwise eligible for coverage under the terms of the plan (or an uncovered dependent, as defined under the terms of the plan, of such an employee, if family coverage is available) to enroll for coverage under the plan under at least one benefit option if each of the following conditions is met:

(1) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or individual.

(2) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment.

(3) The employee or dependent lost coverage under a group health plan or health insurance coverage (as a result of loss of eligibility for the coverage, termination of employment, or reduction in the number of hours of employment).

(4) The employee requests such enrollment within 30 days after the date of termination of such coverage.

(c) DEPENDENT BENEFICIARIES.—

(1) IN GENERAL.—If a group health plan makes family coverage available, the plan may not require, as a condition of coverage of an individual as a dependent (as defined under the terms of the plan) of a participant in the plan, a waiting period applicable to the coverage of a dependent who—

(A) is a newborn,

(B) is an adopted child or child placed for adoption (within the meaning of section 102(b)(3)), at the time of adoption or placement, or

(C) is a spouse, at the time of marriage,

if the participant has met any waiting period applicable to that participant.

(2) TIMELY ENROLLMENT.—

(A) IN GENERAL.—Enrollment of a participant's beneficiary described in paragraph (1) shall be considered to be timely if a request for enrollment is made within 30 days of the date family coverage is first made available or, in the case described in—

(i) paragraph (1)(A), within 30 days of the date of the birth,

(ii) paragraph (1)(B), within 30 days of the date of the adoption or placement for adoption, or

(iii) paragraph (1)(C), within 30 days of the date of the marriage with such a beneficiary who is the spouse of the participant,

if family coverage is available as of such date.

(B) COVERAGE.—If available coverage includes family coverage and enrollment is made under such coverage on a timely basis under subparagraph (A), the coverage shall become effective not later than the first day of the first month beginning 15 days after the date the completed request for enrollment is received.

SEC. 104. ENFORCEMENT.

(a) ENFORCEMENT THROUGH COBRA PROVISIONS IN INTERNAL REVENUE CODE.—

(1) APPLICATION OF COBRA SANCTIONS.—Subsection (a) of section 4980B of the Internal Revenue Code of 1986 is amended by striking "the requirements of" and all that follows and inserting "the requirements of—

"(1) subsection (f) with respect to any qualified beneficiary, or

"(2) subject to subsection (h)—

"(A) section 101 or 102 of the Health Coverage Availability and Affordability Act of 1996 with respect to any individual covered under the group health plan, or

"(B) section 103 of such Act with respect to any individual.".

(2) NOTICE REQUIREMENT.—Section 4980B(f)(6)(A) of such Code is amended by inserting before the period the following: "and subtitle A of title I of the Health Coverage Availability and Affordability Act of 1996".

(3) SPECIAL RULES.—Section 4980B of such Code is amended by adding at the end the following:

"(h) SPECIAL RULES.—For purposes of applying this section in the case of requirements described in subsection (a)(2) relating to section 101, section 102, or section 103 of the Health Coverage Availability and Affordability Act of 1996—

"(1) IN GENERAL.—

"(A) DEFINITION OF GROUP HEALTH PLAN.—The term 'group health plan' has the meaning given such term in section 191(a) of the Health Coverage Availability and Affordability Act of 1996.

"(B) QUALIFIED BENEFICIARY.—Subsections (b), (c), and (e) shall be applied by substituting the term 'individual' for the term 'qualified beneficiary' each place it appears.

"(C) NONCOMPLIANCE PERIOD.—Clause (ii) of subsection (b)(2)(B) and the second sentence of subsection (b)(2) shall not apply.

"(D) LIMITATION ON TAX.—Subparagraph (B) of subsection (c)(3) shall not apply.

"(E) LIABILITY FOR TAX.—Paragraph (2) of subsection (e) shall not apply.

"(2) DEFERRAL TO STATE REGULATION.—No tax shall be imposed by this section on any failure to meet the requirements of such section by any entity which offers health insurance coverage and which is an insurer or health maintenance organization (as defined in section 191(c) of the Health Coverage Availability and Affordability Act of 1996) regulated by a State unless the Secretary of Health and Human Services has made the determination described in section 104(c)(2) of such Act with respect to such State, section, and entity.

"(3) LIMITATION FOR INSURED PLANS.—In the case of a group health plan of a small employer (as defined in section 191 of the Health Coverage Availability and Affordability Act of 1996) that provides health care benefits solely through a contract with an insurer or health maintenance organization (as defined in such section), no tax shall be imposed by this section upon the employer on a failure to meet such requirements if the failure is solely because of the product offered by the insurer or organization under such contract.

"(4) LIMITATION ON IMPOSITION OF TAX.—In no case shall a tax be imposed by this section for a failure to meet such a requirement if—

"(A) a civil money penalty has been imposed by the Secretary of Labor under part 5 of subtitle A of title I of the Employee Retirement Income Security Act of 1974 with respect to such failure, or

"(B) a civil money penalty has been imposed by the Secretary of Health and Human Services under section 104(c) of the Health Coverage Availability and Affordability Act of 1996 with respect to such failure.".

(b) ENFORCEMENT THROUGH ERISA SANCTIONS FOR CERTAIN GROUP HEALTH PLANS.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, sections 101 through 103 of this subtitle shall be deemed to be provisions of title I of the Employee Retirement Income Security Act of 1974 for purposes of applying such title.

(2) FEDERAL ENFORCEMENT ONLY IF NO ENFORCEMENT THROUGH STATE.—The Secretary of Labor shall enforce each section referred to in paragraph (1) with respect to any entity which is an insurer or health maintenance organization regulated by a State only if the Secretary of Labor determines that such State has not provided for enforcement of State laws which govern the same matters as are governed by such section and which require compliance by such entity with at least the same requirements as those provided under such section.

(3) LIMITATIONS ON LIABILITY.—

(A) NO APPLICATION WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No liability shall be imposed under this subsection on the basis of any failure during any period for which it is established to the satisfaction of the Secretary of Labor that none of the persons against whom the liability would be imposed knew, or exercising reasonable diligence would have known, that such failure existed.

(B) NO APPLICATION WHERE FAILURE CORRECTED WITHIN 30 DAYS.—No liability shall be imposed under this subsection on the basis of any failure if such failure was due to reasonable cause and not to willful neglect, and such failure is corrected during the 30-day period beginning on the first day any of the persons against whom the liability would be imposed knew, or

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

(4) AVOIDING DUPLICATION OF CERTAIN PENALTIES.—In no case shall a civil money penalty be imposed under the authority provided under paragraph (1) for a violation of this subtitle for which an excise tax has been imposed under section 4980B of the Internal Revenue Code of 1986 or a civil money penalty imposed under subsection (c).

(c) ENFORCEMENT THROUGH CIVIL MONEY PENALTIES.—

(1) IMPOSITION.—

(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, any group health plan, insurer, or organization that fails to meet a requirement of this subtitle is subject to a civil money penalty under this section.

(B) LIABILITY FOR PENALTY.—Rules similar to the rules described in section 4980B(e) of the Internal Revenue Code of 1986 for liability for a tax imposed under section 4980B(a) of such Code shall apply to liability for a penalty imposed under subparagraph (A).

(C) AMOUNT OF PENALTY.—

(i) IN GENERAL.—The maximum amount of penalty imposed under this paragraph is $100 for each day for each individual with respect to which such a failure occurs.

(ii) CONSIDERATIONS IN IMPOSITION.—In determining the amount of any penalty to be assessed under this paragraph, the Secretary of Health and Human Services shall take into account the previous record of compliance of the person being assessed with the applicable requirements of this subtitle, the gravity of the violation, and the overall limitations for unintentional failures provided under section 4980B(c)(4) of the Internal Revenue Code of 1986.

(iii) LIMITATIONS.—

(I) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No civil money penalty shall be imposed under this paragraph on any failure during any period for which it is established to the satisfaction of the Secretary that none of the persons against whom the penalty would be imposed knew, or exercising reasonable diligence would have known, that such failure existed.

(II) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No civil money penalty shall be imposed under this paragraph on any failure if such failure was due to reasonable cause and not to willful neglect, and such failure is corrected during the 30-day period beginning on the first day any of the persons against whom the penalty would be imposed knew, or exercising reasonable diligence would have known, that such failure existed.

(D) ADMINISTRATIVE REVIEW.—

(i) OPPORTUNITY FOR HEARING.—The person assessed shall be afforded an opportunity for hearing by the Secretary upon request made within 30 days after the date of the issuance of a notice of assessment. In such hearing the decision shall be made on the record pursuant to section 554 of title 5, United States Code. If no hearing is requested, the assessment shall constitute a final and unappealable order.

(ii) HEARING PROCEDURE.—If a hearing is requested, the initial agency decision shall be made by an administrative law judge, and such decision shall become the final order unless the Secretary modifies or vacates the decision. Notice of intent to modify or vacate the decision of the administrative law judge shall be issued to the parties within 30 days after the date of the decision of the judge. A final order which takes effect under this paragraph shall be subject to review only as provided under subparagraph (D).

(E) JUDICIAL REVIEW.—

(i) FILING OF ACTION FOR REVIEW.—Any person against whom an order imposing a civil money penalty has been entered after an agency hearing under this paragraph may obtain review by the United States district court for any district in which such person is located or the United States District Court for the District of Columbia by filing a notice of appeal in such court within 30 days from the date of such order, and simultaneously sending a copy of such notice be registered mail to the Secretary.

(ii) CERTIFICATION OF ADMINISTRATIVE RECORD.—The Secretary shall promptly certify and file in such court the record upon which the penalty was imposed.

(iii) STANDARD FOR REVIEW.—The findings of the Secretary shall be set aside only if found to be unsupported by substantial evidence as provided by section 706(2)(E) of title 5, United States Code.

(iv) APPEAL.—Any final decision, order, or judgment of such district court concerning such review shall be subject to appeal as provided in chapter 83 of title 28 of such Code.

(F) FAILURE TO PAY ASSESSMENT; MAINTENANCE OF ACTION.—

(i) FAILURE TO PAY ASSESSMENT.—If any person fails to pay an assessment after it has become a final and unappealable order, or after the court has entered final judgment in favor of the Secretary, the Secretary shall refer the matter to the Attorney General who shall recover the amount assessed by action in the appropriate United States district court.

(ii) NONREVIEWABILITY.—In such action the validity and appropriateness of the final order imposing the penalty shall not be subject to review.

(G) PAYMENT OF PENALTIES.—Except as otherwise provided, penalties collected under this paragraph shall be paid to the Secretary (or other officer) imposing the penalty and shall be available without appropriation and until expended for the purpose of enforcing the provisions with respect to which the penalty was imposed.

(2) FEDERAL ENFORCEMENT ONLY IF NO ENFORCEMENT THROUGH STATE.—Paragraph (1) shall apply to enforcement of the requirements of section 101, 102, or 103 with respect to any entity which offers health insurance coverage and which is an insurer or HMO regulated by a State only if the Secretary of Health and Human Services has determined that such State has not provided for enforcement of State laws which govern the same matters as are governed by such section and which require compliance by such entity with at least the same requirements as those provided under such section.

(3) NONDUPLICATION OF SANCTIONS.—In no case shall a civil money penalty be imposed under this subsection for a violation of this subtitle for which an excise tax has been imposed under section 4980B of the Internal Revenue Code of 1986 or for which a civil money penalty has been imposed under the authority provided under subsection (b).

(d) COORDINATION IN ADMINISTRATION.—The Secretaries of the Treasury, Labor, and Health and Human Services shall issue regulations that are nonduplicative to carry out this subtitle. Such regulations shall be issued in a manner that assures coordination and nonduplication in their activities under this subtitle.

Subtitle B—Definitions; General Provisions

SEC. 191. DEFINITIONS; SCOPE OF COVERAGE.

(a) GROUP HEALTH PLAN.—

(1) DEFINITION.—Subject to the succeeding provisions of this subsection and subsection (d)(1), the term ''group health plan'' means an employee welfare benefit plan to the extent that the plan provides medical care (as defined in subsection (c)(9)) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise, and includes a group health plan (within the meaning of section 5000(b)(1) of the Internal Revenue Code of 1986).

(2) LIMITATION OF REQUIREMENTS TO PLANS WITH 2 OR MORE EMPLOYEE PARTICIPANTS.—The requirements of subtitle Ashall apply in the case of a group health plan for any plan year, or for health insurance coverage offered in connection with a group health plan for a year, only if the group health plan has two or more participants as current employees on the first day of the plan year.

(3) EXCLUSION OF PLANS WITH LIMITED COVERAGE.—An employee welfare benefit plan shall be treated as a group health plan under this title only with respect to medical care which is provided under the plan and which does not consist of coverage excluded from the definition of health insurance coverage under subsection (c)(4)(B).

(4) TREATMENT OF CHURCH PLANS.—

(A) EXCLUSION.—The requirements of this title insofar as they apply to group health plans shall not apply to church plans.

(B) OPTIONAL DISREGARD IN DETERMINING PERIOD OF COVERAGE.—For purposes of applying section 101(b)(3)(B)(i), a group health plan may elect to disregard periods of coverage of an individual under a church plan that, pursuant to subparagraph (A), is not subject to the requirements of this title.

(5) TREATMENT OF GOVERNMENTAL PLANS.—

(A) ELECTION TO BE EXCLUDED.—If the plan sponsor of a governmental plan which is a group health plan to which the provisions of this subtitle otherwise apply makes an election under this paragraph for any specified period (in such form and manner as the Secretary of Health and Human Services may by regulations prescribe), then the requirements of this title insofar as they apply to group health plans shall not apply to such governmental plans for such period.

(B) OPTIONAL DISREGARD IN DETERMINING PERIOD OF COVERAGE IF ELECTION MADE.—For purposes of applying section 101(b)(3)(B)(i), a group health plan may elect to disregard periods of coverage of an individual under a governmental plan that, under an election under subparagraph (A), is not subject to the requirements of this title.

(6) TREATMENT OF MEDICAID PLAN AS GROUP HEALTH PLAN.—A State plan under title XIX of the Social Security Act shall be treated as a group health plan for purposes of applying section 101(c), unless the State elects not to be so treated.

(7) TREATMENT OF MEDICARE AS GROUP HEALTH PLAN.—Title XVIII of the Social Security Act shall be treated as a group health plan for purposes of applying section 101(c).

(b) INCORPORATION OF CERTAIN DEFINITIONS IN EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—Except as provided in this section, the terms "beneficiary", "church plan", "employee", "employee welfare benefit plan", "employer", "governmental plan", "multiemployer plan", "multiple employer welfare arrangement", "participant", "plan sponsor", and "State" have the meanings given such terms in section 3 of the Employee Retirement Income Security Act of 1974.

(c) OTHER DEFINITIONS.—For purposes of this title:

(1) APPLICABLE STATE AUTHORITY.—The term "applicable State authority" means, with respect to an insurer or health maintenance organization in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of this title for the State involved with respect to such insurer or organization.

(2) BONA FIDE ASSOCIATION.—The term "bona fide association" means an association which—

(A) has been actively in existence for at least 5 years,

(B) has been formed and maintained in good faith for purposes other than obtaining insurance,

(C) does not condition membership in the association on health status,

(D) makes health insurance coverage offered through the association available to all members regardless of health status,

(E) does not make health insurance coverage offered through the association available to any individual who is not a member (or dependent of a member) of the association at the time the coverage is initially issued,

(F) does not impose preexisting condition exclusions except in a manner consistent with the requirements of sections 101 and 102 as they relate to group health plans, and

(G) provides for renewal and continuation of health insurance coverage in a manner consistent with the requirements of section 132 as they relate to the renewal and continuation in force of coverage in a group market.

(3) COBRA CONTINUATION PROVISION.—The term "COBRA continuation provision" means any of the following:

(A) Section 4980B of the Internal Revenue Code of 1986, other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines.

(B) Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.), other than section 609.

(C) Title XXII of the Public Health Service Act.

(4) HEALTH INSURANCE COVERAGE.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the term "health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization group contract offered by an insurer or a health maintenance organization.

(B) EXCEPTION.—Such term does not include coverage under any separate policy, certificate, or contract only for one or more of any of the following:

(i) Coverage for accident, credit-only, vision, disability income, long-term care, nursing home care, community-based care dental, on-site medical clinics, or employee assistance programs, or any combination thereof.

(ii) Medicare supplemental health insurance (within the meaning of section 1882(g)(1) of the Social Security Act (42 U.S.C. 1395ss(g)(1))) and similar supplemental coverage provided under a group health plan.

(iii) Coverage issued as a supplement to liability insurance.

(iv) Liability insurance, including general liability insurance and automobile liability insurance.

(v) Workers' compensation or similar insurance.

(vi) Automobile medical-payment insurance.

(vii) Coverage consisting of benefit payments made on a periodic basis for a specified disease or illness or period of hospitalization, without regard to the costs incurred or services rendered during the period to which the payments relate.

(viii) Short-term limited duration insurance.

(ix) Such other coverage, comparable to that described in previous clauses, as may be specified in regulations prescribed under this title.

(5) HEALTH MAINTENANCE ORGANIZATION; HMO.—The terms "health maintenance organization" and "HMO" mean—

(A) a Federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act (42 U.S.C. 300e(a))),

(B) an organization recognized under State law as a health maintenance organization, or

(C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization,

if it is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974).

(6) HEALTH STATUS.—The term "health status" includes, with respect to an individual, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), or disability.

(7) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The term "individual health insurance coverage" means health insurance coverage offered to individuals if the coverage is not offered in connection with a group health plan (other than such a plan that has fewer than two participants as current employees on the first day of the plan year).

(8) INSURER.—The term "insurer" means an insurance company, insurance service, or insurance organization which is licensed to engage in the business of insurance in a State and which is regulated by a State (within the meaning of section 514(b)(2)(A) of the Employee Retirement Income Security Act of 1974).

(9) MEDICAL CARE.—The term "medical care" means—

(A) amounts paid for, or items or services in the form of, the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for, or items or services provided for, the purpose of affecting any structure or function of the body,

(B) amounts paid for, or services in the form of, transportation primarily for and essential to medical care referred to in subparagraph (A), and

(C) amounts paid for insurance covering medical care referred to in subparagraphs (A) and (B).

(10) NETWORK PLAN.—The term "network plan" means, with respect to health insurance coverage, an arrangement of an insurer or a health maintenance organization under which the financing and delivery of medical care are provided, in whole or in part, through a defined set of providers under contract with the insurer or health maintenance organization.

(11) WAITING PERIOD.—The term "waiting period" means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the minimum period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the plan.

(d) TREATMENT OF PARTNERSHIPS.—

(1) TREATMENT AS A GROUP HEALTH PLAN.—Any plan, fund, or program which would not be (but for this paragraph) an employee welfare benefit plan and which is established or maintained by a partnership, to the extent that such plan, fund, or program provides medical care to present or former partners in

the partnership or to their dependents (as defined under the terms of the plan, fund, or program), directly or through insurance, reimbursement, or otherwise, shall be treated (subject to paragraph (1)) as an employee welfare benefit plan which is a group health plan.

(2) TREATMENT OF PARTNERSHIP AND PARTNERS AND EMPLOYER AND PARTICIPANTS.—In the case of a group health plan—

(A) the term "employer" includes the partnership in relation to any partner; and

(B) the term "participant" includes—

(i) in connection with a group health plan maintained by a partnership, an individual who is a partner in relation to the partnership, or

(ii) in connection with a group health plan maintained by a self-employed individual (under which one or more employees are participants), the self-employed individual,

if such individual is or may become eligible to receive a benefit under the plan or such individual's beneficiaries may be eligible to receive any such benefit.

(e) DEFINITIONS RELATING TO MARKETS AND SMALL EMPLOYERS.—As used in this title:

(1) INDIVIDUAL MARKET.—The term "individual market" means the market for health insurance coverage offered to individuals and not to employers or in connection with a group health plan and does not include the market for such coverage issued only by an insurer or HMO that makes such coverage available only on the basis of affiliation with a bona fide association (as defined in subsection (c)(2)).

(2) LARGE GROUP MARKET.—The term "large group market" means the market for health insurance coverage offered to employers (other than small employers) on behalf of their employees (and their dependents) and does not include health insurance coverage available solely in connection with a bona fide association (as defined in subsection (c)(2)).

(3) SMALL EMPLOYER.—The term "small employer" means, in connection with a group health plan with respect to a calendar year, an employer who employs at least 2 but fewer than 51 employees on a typical business day in the year. All persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 shall be treated as a single employer for purposes of this title.

(4) SMALL GROUP MARKET.—The term "small group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) on the basis of employment or other relationship with respect to a small employer and does not include health insurance coverage available solely in connection with a bona fide association (as defined in subsection (c)(2)).

SEC. 192. STATE FLEXIBILITY TO PROVIDE GREATER PROTECTION.

(a) STATE FLEXIBILITY TO PROVIDE GREATER PROTECTION.—Subject to subsection (b), nothing in this title shall be construed to preempt State laws that require insurers or HMOs—

(1) to impose a limitation or exclusion of benefits relating to the treatment of a preexisting condition for a period that is shorter than the applicable period provided for under this title;

(2) to allow individuals, participants, and beneficiaries to be considered to be in a period of previous qualifying coverage if such individual, participant, or beneficiary experiences a lapse in coverage that is greater than the 60-day periods provided for under sections 101(b)(3)(A), 101(b)(3)(B)(ii), and 102(b)(2); or

(3) require insurers or HMOs, in defining pre-existing condition, to have a look-back period that is shorter than the 6-month period described in section 101(b)(1)(A).

(b) NO OVERRIDE OF ERISA PREEMPTION.—Nothing in this Act shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144).

SEC. 193. EFFECTIVE DATE.

(a) IN GENERAL.—Except as otherwise provided for in this title, the provisions of this title shall apply with respect to—

(1) group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning on or after January 1, 1998, and

(2) individual health insurance coverage issued, renewed, in effect, or operated on or after July 1, 1998.

(b) CONSIDERATION OF PREVIOUS COVERAGE.—The Secretaries of Health and Human Services, Treasury, and Labor shall jointly establish rules regarding the treatment (in determining qualified coverage periods under sections 102(b) and 141(b)) of coverage before the applicable effective date specified in subsection (a).

(c) TIMELY ISSUANCE OF REGULATIONS.—The Secretaries of Health and Human Services, the Treasury, and Labor shall issue such regulations on a timely basis as may be required to carry out this title.

SEC. 194. RULE OF CONSTRUCTION.

Nothing in this title or any amendment made thereby may be construed to require the coverage of any specific procedure, treatment, or service as part of a group health plan or health insurance coverage under this title or through regulation.

TITLE II—PREVENTING HEALTH CARE FRAUD AND ABUSE; ADMINISTRATIVE SIMPLIFICATION

SEC. 200. REFERENCES IN TITLE.

Except as otherwise specifically provided, whenever in this title an amendment 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 that section or other provision of the Social Security Act.

Subtitle A—Fraud and Abuse Control Program

SEC. 201. FRAUD AND ABUSE CONTROL PROGRAM.

(a) ESTABLISHMENT OF PROGRAM.—Title XI (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128B the following new section:

"FRAUD AND ABUSE CONTROL PROGRAM

"SEC. 1128C. (a) ESTABLISHMENT OF PROGRAM.—

"(1) IN GENERAL.—Not later than January 1, 1997, the Secretary, acting through the Office of the Inspector General of the Department of Health and Human Services, and the Attorney General shall establish a program—

"(A) to coordinate Federal, State, and local law enforcement programs to control fraud and abuse with respect to health plans,

"(B) to conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care in the United States,

"(C) to facilitate the enforcement of the provisions of sections 1128, 1128A, and 1128B and other statutes applicable to health care fraud and abuse,

"(D) to provide for the modification and establishment of safe harbors and to issue advisory opinions and special fraud alerts pursuant to section 1128D, and

"(E) to provide for the reporting and disclosure of certain final adverse actions against health care providers, suppliers, or practitioners pursuant to the data collection system established under section 1128E.

"(2) COORDINATION WITH HEALTH PLANS.—In carrying out the program established under paragraph (1), the Secretary and the Attorney General shall consult with, and arrange for the sharing of data with representatives of health plans.

"(3) GUIDELINES.—

"(A) IN GENERAL.—The Secretary and the Attorney General shall issue guidelines to carry out the program under paragraph (1). The provisions of sections 553, 556, and 557 of title 5, United States Code, shall not apply in the issuance of such guidelines.

"(B) INFORMATION GUIDELINES.—

"(i) IN GENERAL.—Such guidelines shall include guidelines relating to the furnishing of information by health plans, providers, and others to enable the Secretary and the Attorney General to carry out the program (including coordination with health plans under paragraph (2)).

"(ii) CONFIDENTIALITY.—Such guidelines shall include procedures to assure that such information is provided and utilized in a manner that

appropriately protects the confidentiality of the information and the privacy of individuals receiving health care services and items.

"(iii) QUALIFIED IMMUNITY FOR PROVIDING INFORMATION.—The provisions of section 1157(a) (relating to limitation on liability) shall apply to a person providing information to the Secretary or the Attorney General in conjunction with their performance of duties under this section.

"(4) ENSURING ACCESS TO DOCUMENTATION.—The Inspector General of the Department of Health and Human Services is authorized to exercise such authority described in paragraphs (3) through (9) of section 6 of the Inspector General Act of 1978 (5 U.S.C. App.) as necessary with respect to the activities under the fraud and abuse control program established under this subsection.

"(5) AUTHORITY OF INSPECTOR GENERAL.—Nothing in this Act shall be construed to diminish the authority of any Inspector General, including such authority as provided in the Inspector General Act of 1978 (5 U.S.C. App.).

"(b) ADDITIONAL USE OF FUNDS BY INSPECTOR GENERAL.—

"(1) REIMBURSEMENTS FOR INVESTIGATIONS.—The Inspector General of the Department of Health and Human Services is authorized to receive and retain for current use reimbursement for the costs of conducting investigations and audits and for monitoring compliance plans when such costs are ordered by a court, voluntarily agreed to by the payor, or otherwise.

"(2) CREDITING.—Funds received by the Inspector General under paragraph (1) as reimbursement for costs of conducting investigations shall be deposited to the credit of the appropriation from which initially paid, or to appropriations for similar purposes currently available at the time of deposit, and shall remain available for obligation for 1 year from the date of the deposit of such funds.

"(c) HEALTH PLAN DEFINED.—For purposes of this section, the term 'health plan' means a plan or program that provides health benefits, whether directly, through insurance, or otherwise, and includes—

"(1) a policy of health insurance;

"(2) a contract of a service benefit organization; and

"(3) a membership agreement with a health maintenance organization or other prepaid health plan.".

(b) ESTABLISHMENT OF HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT IN FEDERAL HOSPITAL INSURANCE TRUST FUND.—Section 1817 (42 U.S.C. 1395i) is amended by adding at the end the following new subsection:

"(k) HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.—

"(1) ESTABLISHMENT.—There is hereby established in the Trust Fund an expenditure account to be known as the 'Health Care Fraud and Abuse Control Account' (in this subsection referred to as the 'Account').

"(2) APPROPRIATED AMOUNTS TO TRUST FUND.—

"(A) IN GENERAL.—There are hereby appropriated to the Trust Fund—

"(i) such gifts and bequests as may be made as provided in subparagraph (B);

"(ii) such amounts as may be deposited in the Trust Fund as provided in sections 242(b) and 249(c) of the Health Coverage Availability and Affordability Act of 1996, and title XI; and

"(iii) such amounts as are transferred to the Trust Fund under subparagraph (C).

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

"(C) TRANSFER OF AMOUNTS.—The Managing Trustee shall transfer to the Trust Fund, under rules similar to the rules in section 9601 of the Internal Revenue Code of 1986, an amount equal to the sum of the following:

"(i) Criminal fines recovered in cases involving a Federal health care offense (as defined in section 982(a)(6)(B) of title 18, United States Code).

"(ii) Civil monetary penalties and assessments imposed in health care cases, including amounts recovered under titles XI, XVIII, and XIX, and chapter 38 of title 31, United States Code (except as otherwise provided by law).

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

"(iv) Penalties and damages obtained and otherwise creditable to miscellaneous receipts of the general fund of the Treasury obtained under sections 3729 through 3733 of title 31, United States Code (known as the False Claims Act), in cases involving claims related to the provision

of health care items and services (other than funds awarded to a relator, for restitution or otherwise authorized by law).

"(3) APPROPRIATED AMOUNTS TO ACCOUNT FOR FRAUD AND ABUSE CONTROL PROGRAM, ETC.—

"(A) DEPARTMENTS OF HEALTH AND HUMAN SERVICES AND JUSTICE.—

"(i) IN GENERAL.—There are hereby appropriated to the Account from the Trust Fund such sums as the Secretary and the Attorney General certify are necessary to carry out the purposes described in subparagraph (C), to be available without further appropriation, in an amount not to exceed—

"(I) for fiscal year 1997, $104,000,000,

"(II) for each of the fiscal years 1998 through 2003, the limit for the preceding fiscal year, increased by 15 percent; and

"(III) for each fiscal year after fiscal year 2003, the limit for fiscal year 2003.

"(ii) MEDICARE AND MEDICAID ACTIVITIES.—For each fiscal year, of the amount appropriated in clause (i), the following amounts shall be available only for the purposes of the activities of the Office of the Inspector General of the Department of Health and Human Services with respect to the medicare and medicaid programs—

"(I) for fiscal year 1997, not less than $60,000,000 and not more than $70,000,000;

"(II) for fiscal year 1998, not less than $80,000,000 and not more than $90,000,000;

"(III) for fiscal year 1999, not less than $90,000,000 and not more than $100,000,000;

"(IV) for fiscal year 2000, not less than $110,000,000 and not more than $120,000,000;

"(V) for fiscal year 2001, not less than $120,000,000 and not more than $130,000,000;

"(VI) for fiscal year 2002, not less than $140,000,000 and not more than $150,000,000; and

"(VII) for each fiscal year after fiscal year 2002, not less than $150,000,000 and not more than $160,000,000.

"(B) FEDERAL BUREAU OF INVESTIGATION.—There are hereby appropriated from the general fund of the United States Treasury and hereby appropriated to the Account for transfer to the Federal Bureau of Investigation to carry out the purposes described in subparagraph (C), to be available without further appropriation—

"(i) for fiscal year 1997, $47,000,000;

"(ii) for fiscal year 1998, $56,000,000;

"(iii) for fiscal year 1999, $66,000,000;

"(iv) for fiscal year 2000, $76,000,000;

"(v) for fiscal year 2001, $88,000,000;

"(vi) for fiscal year 2002, $101,000,000; and

"(vii) for each fiscal year after fiscal year 2002, $114,000,000.

"(C) USE OF FUNDS.—The purposes described in this subparagraph are to cover the costs (including equipment, salaries and benefits, and travel and training) of the administration and operation of the health care fraud and abuse control program established under section 1128C(a), including the costs of—

"(i) prosecuting health care matters (through criminal, civil, and administrative proceedings);

"(ii) investigations;

"(iii) financial and performance audits of health care programs and operations;

"(iv) inspections and other evaluations; and

"(v) provider and consumer education regarding compliance with the provisions of title XI.

"(4) APPROPRIATED AMOUNTS TO ACCOUNT FOR MEDICARE INTEGRITY PROGRAM.—

"(A) IN GENERAL.—There are hereby appropriated to the Account from the Trust Fund for each fiscal year such amounts as are necessary to carry out the Medicare Integrity Program under section 1893, subject to subparagraph (B) and to be available without further appropriation.

"(B) AMOUNTS SPECIFIED.—The amount appropriated under subparagraph (A) for a fiscal year is as follows:

"(i) For fiscal year 1997, such amount shall be not less than $430,000,000 and not more than $440,000,000.

"(ii) For fiscal year 1998, such amount shall be not less than $490,000,000 and not more than $500,000,000.

"(iii) For fiscal year 1999, such amount shall be not less than $550,000,000 and not more than $560,000,000.

"(iv) For fiscal year 2000, such amount shall be not less than $620,000,000 and not more than $630,000,000.

"(v) For fiscal year 2001, such amount shall be not less than $670,000,000 and not more than $680,000,000.

"(vi) For fiscal year 2002, such amount shall be not less than $690,000,000 and not more than $700,000,000.

"(vii) For each fiscal year after fiscal year 2002, such amount shall be not less than $710,000,000 and not more than $720,000,000.

"(5) ANNUAL REPORT.—The Secretary and the Attorney General shall submit jointly an annual report to Congress on the amount of revenue which is generated and disbursed, and the justification for such disbursements, by the Account in each fiscal year.".

SEC. 202. MEDICARE INTEGRITY PROGRAM.

(a) ESTABLISHMENT OF MEDICARE INTEGRITY PROGRAM.—Title XVIII is amended by adding at the end the following new section:

"MEDICARE INTEGRITY PROGRAM

"SEC. 1893. (a) ESTABLISHMENT OF PROGRAM.—There is hereby established the Medicare Integrity Program (in this section referred to as the 'Program') under which the Secretary shall promote the integrity of the medicare program by entering into contracts in accordance with this section with eligible private entities to carry out the activities described in subsection (b).

"(b) ACTIVITIES DESCRIBED.—The activities described in this subsection are as follows:

"(1) Review of activities of providers of services or other individuals and entities furnishing items and services for which payment may be made under this title (including skilled nursing facilities and home health agencies), including medical and utilization review and fraud review (employing similar standards, processes, and technologies used by private health plans, including equipment and software technologies which surpass the capability of the equipment and technologies used in the review of claims under this title as of the date of the enactment of this section).

"(2) Audit of cost reports.

"(3) Determinations as to whether payment should not be, or should not have been, made under this title by reason of section 1862(b), and recovery of payments that should not have been made.

"(4) Education of providers of services, beneficiaries, and other persons with respect to payment integrity and benefit quality assurance issues.

"(5) Developing (and periodically updating) a list of items of durable medical equipment in accordance with section 1834(a)(15) which are subject to prior authorization under such section.

"(c) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract under the Program to carry out any of the activities described in subsection (b) if—

"(1) the entity has demonstrated capability to carry out such activities;

"(2) in carrying out such activities, the entity agrees to cooperate with the Inspector General of the Department of Health and Human Services, the Attorney General of the United States, and other law enforcement agencies, as appropriate, in the investigation and deterrence of fraud and abuse in relation to this title and in other cases arising out of such activities;

"(3) the entity demonstrates to the Secretary that the entity's financial holdings, interests, or relationships will not interfere with its ability to perform the functions to be required by the contract in an effective and impartial manner; and

"(4) the entity meets such other requirements as the Secretary may impose.

In the case of the activity described in subsection (b)(5), an entity shall be deemed to be eligible to enter into a contract under the Program to carry out the activity if the entity is a carrier with a contract in effect under section 1842.

"(d) PROCESS FOR ENTERING INTO CONTRACTS.—The Secretary shall enter into contracts under the Program in accordance with such procedures as the Secretary shall by regulation establish, except that such procedures shall include the following:

"(1) The Secretary shall determine the appropriate number of separate contracts which are necessary to carry out the Program and the appropriate times at which the Secretary shall enter into such contracts.

"(2)(A) Except as provided in subparagraph (B), the provisions of section 1153(e)(1) shall apply to contracts and contracting authority under this section.

"(B) Competitive procedures must be used when entering into new contracts under this section, or at any other time considered appropriate by the Secretary, except that the Secretary may contract with entities that are carrying out the activities described in this section pursuant to agreements under section 1816 or contracts under section 1842 in effect on the date of the enactment of this section.

"(3) A contract under this section may be renewed without regard to any provision of law requiring competition if the contractor has met or exceeded the performance requirements established in the current contract.

"(e) LIMITATION ON CONTRACTOR LIABILITY.—The Secretary shall by regulation provide for the limitation of a contractor's liability for actions taken to carry out a contract under the Program, and such regulation shall, to the extent the Secretary finds appropriate, employ the same or comparable standards and other substantive and procedural provisions as are contained in section 1157.".

(b) ELIMINATION OF FI AND CARRIER RESPONSIBILITY FOR CARRYING OUT ACTIVITIES SUBJECT TO PROGRAM.—

(1) RESPONSIBILITIES OF FISCAL INTERMEDIARIES UNDER PART A.—Section 1816 (42 U.S.C. 1395h) is amended by adding at the end the following new subsection:

"(l) No agency or organization may carry out (or receive payment for carrying out) any activity pursuant to an agreement under this section to the extent that the activity is carried out pursuant to a contract under the Medicare Integrity Program under section 1893.".

(2) RESPONSIBILITIES OF CARRIERS UNDER PART B.—Section 1842(c) (42 U.S.C. 1395u(c)) is amended by adding at the end the following new paragraph:

"(6) No carrier may carry out (or receive payment for carrying out) any activity pursuant to a contract under this subsection to the extent that the activity is carried out pursuant to a contract under the Medicare Integrity Program under section 1893. The previous sentence shall not apply with respect to the activity described in section 1893(b)(5) (relating to prior authorization of certain items of durable medical equipment under section 1834(a)(15)).".

SEC. 203. BENEFICIARY INCENTIVE PROGRAMS.

(a) CLARIFICATION OF REQUIREMENT TO PROVIDE EXPLANATION OF MEDICARE BENEFITS.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall provide an explanation of benefits under the medicare program under title XVIII of the Social Security Act with respect to each item or service for which payment may be made under the program which is furnished to an individual, without regard to whether or not a deductible or coinsurance may be imposed against the individual with respect to the item or service.

(b) PROGRAM TO COLLECT INFORMATION ON FRAUD AND ABUSE.—

(1) ESTABLISHMENT OF PROGRAM.—Not later than 3 months after the date of the enactment of this Act, the Secretary shall establish a program under which the Secretary shall encourage individuals to report to the Secretary information on individuals and entities who are engaging or who have engaged in acts or omissions which constitute grounds for the imposition of a sanction under section 1128, section 1128A, or section 1128B of the Social Security Act, or who have otherwise engaged in fraud and abuse against the medicare program for which there is a sanction provided under law. The program shall discourage provision of, and not consider, information which is frivolous or otherwise not relevant or material to the imposition of such a sanction.

(2) PAYMENT OF PORTION OF AMOUNTS COLLECTED.—If an individual reports information to the Secretary under the program established under paragraph (1) which serves as the basis for the collection by the Secretary or the Attorney General of any amount of at least $100 (other than any amount paid as a penalty under section 1128B of the Social Security Act), the Secretary may pay a portion of the amount collected to the individual (under procedures similar to those applicable under section 7623 of the Internal Revenue Code of 1986 to payments to individuals providing information on violations of such Code).

(c) PROGRAM TO COLLECT INFORMATION ON PROGRAM EFFICIENCY.—

(1) ESTABLISHMENT OF PROGRAM.—Not later than 3 months after the date of the enactment of this Act, the Secretary shall establish a program under which

the Secretary shall encourage individuals to submit to the Secretary suggestions on methods to improve the efficiency of the medicare program.

(2) PAYMENT OF PORTION OF PROGRAM SAVINGS.—If an individual submits a suggestion to the Secretary under the program established under paragraph (1) which is adopted by the Secretary and which results in savings to the program, the Secretary may make a payment to the individual of such amount as the Secretary considers appropriate.

SEC. 204. APPLICATION OF CERTAIN HEALTH ANTI-FRAUD AND ABUSE SANCTIONS TO FRAUD AND ABUSE AGAINST FEDERAL HEALTH CARE PROGRAMS.

(a) IN GENERAL.—Section 1128B (42 U.S.C. 1320a–7b) is amended as follows:

(1) In the heading, by striking "MEDICARE OR STATE HEALTH CARE PROGRAMS" and inserting "FEDERAL HEALTH CARE PROGRAMS".

(2) In subsection (a)(1), by striking "a program under title XVIII or a State health care program (as defined in section 1128(h))" and inserting "a Federal health care program".

(3) In subsection (a)(5), by striking "a program under title XVIII or a State health care program" and inserting "a Federal health care program".

(4) In the second sentence of subsection (a)—

(A) by striking "a State plan approved under title XIX" and inserting "a Federal health care program", and

(B) by striking "the State may at its option (notwithstanding any other provision of that title or of such plan)" and inserting "the administrator of such program may at its option (notwithstanding any other provision of such program)".

(5) In subsection (b), by striking "title XVIII or a State health care program" each place it appears and inserting "a Federal health care program".

(6) In subsection (c), by inserting "(as defined in section 1128(h))" after "a State health care program".

(7) By adding at the end the following new subsection:

"(f) For purposes of this section, the term 'Federal health care program' means—

"(1) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the health insurance program under chapter 89 of title 5, United States Code); or

"(2) any State health care program, as defined in section 1128(h).".

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1997.

SEC. 205. GUIDANCE REGARDING APPLICATION OF HEALTH CARE FRAUD AND ABUSE SANCTIONS.

Title XI (42 U.S.C. 1301 et seq.), as amended by section 201, is amended by inserting after section 1128C the following new section:

"GUIDANCE REGARDING APPLICATION OF HEALTH CARE FRAUD AND ABUSE SANCTIONS

"SEC. 1128D. (a) SOLICITATION AND PUBLICATION OF MODIFICATIONS TO EXISTING SAFE HARBORS AND NEW SAFE HARBORS.—

"(1) IN GENERAL.—

"(A) SOLICITATION OF PROPOSALS FOR SAFE HARBORS.—Not later than January 1, 1997, and not less than annually thereafter, the Secretary shall publish a notice in the Federal Register soliciting proposals, which will be accepted during a 60-day period, for—

"(i) modifications to existing safe harbors issued pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987 (42 U.S.C. 1320a–7b note);

"(ii) additional safe harbors specifying payment practices that shall not be treated as a criminal offense under section 1128B(b) and shall not serve as the basis for an exclusion under section 1128(b)(7);

"(iii) advisory opinions to be issued pursuant to subsection (b); and

"(iv) special fraud alerts to be issued pursuant to subsection (c).

"(B) PUBLICATION OF PROPOSED MODIFICATIONS AND PROPOSED ADDITIONAL SAFE HARBORS.—After considering the proposals described in clauses (i) and (ii) of subparagraph (A), the Secretary, in consultation with the Attorney General, shall publish in the Federal Register proposed modifications to existing safe harbors and proposed additional safe harbors, if appropriate, with a 60-day comment period. After considering any public comments received during this period, the Secretary shall issue final rules modifying the existing safe harbors and establishing new safe harbors, as appropriate.

"(C) REPORT.—The Inspector General of the Department of Health and Human Services (in this section referred to as the 'Inspector General') shall, in an annual report to Congress or as part of the year-end semiannual report required by section 5 of the Inspector General Act of 1978 (5 U.S.C. App.), describe the proposals received under clauses (i) and (ii) of subparagraph (A) and explain which proposals were included in the publication described in subparagraph (B), which proposals were not included in that publication, and the reasons for the rejection of the proposals that were not included.

"(2) CRITERIA FOR MODIFYING AND ESTABLISHING SAFE HARBORS.—In modifying and establishing safe harbors under paragraph (1)(B), the Secretary may consider the extent to which providing a safe harbor for the specified payment practice may result in any of the following:

"(A) An increase or decrease in access to health care services.

"(B) An increase or decrease in the quality of health care services.

"(C) An increase or decrease in patient freedom of choice among health care providers.

"(D) An increase or decrease in competition among health care providers.

"(E) An increase or decrease in the ability of health care facilities to provide services in medically underserved areas or to medically underserved populations.

"(F) An increase or decrease in the cost to Federal health care programs (as defined in section 1128B(f)).

"(G) An increase or decrease in the potential overutilization of health care services.

"(H) The existence or nonexistence of any potential financial benefit to a health care professional or provider which may vary based on their decisions of—

"(i) whether to order a health care item or service; or

"(ii) whether to arrange for a referral of health care items or services to a particular practitioner or provider.

"(I) Any other factors the Secretary deems appropriate in the interest of preventing fraud and abuse in Federal health care programs (as so defined).

"(b) ADVISORY OPINIONS.—

"(1) ISSUANCE OF ADVISORY OPINIONS.—The Secretary shall issue written advisory opinions as provided in this subsection.

"(2) MATTERS SUBJECT TO ADVISORY OPINIONS.—The Secretary shall issue advisory opinions as to the following matters:

"(A) What constitutes prohibited remuneration within the meaning of section 1128B(b).

"(B) Whether an arrangement or proposed arrangement satisfies the criteria set forth in section 1128B(b)(3) for activities which do not result in prohibited remuneration.

"(C) Whether an arrangement or proposed arrangement satisfies the criteria which the Secretary has established, or shall establish by regulation for activities which do not result in prohibited remuneration.

"(D) What constitutes an inducement to reduce or limit services to individuals entitled to benefits under title XVIII or title XIX or title XXI within the meaning of section 1128B(b).

"(E) Whether any activity or proposed activity constitutes grounds for the imposition of a sanction under section 1128, 1128A, or 1128B.

"(3) MATTERS NOT SUBJECT TO ADVISORY OPINIONS.—Such advisory opinions shall not address the following matters:

"(A) Whether the fair market value shall be, or was paid or received for any goods, services or property.

"(B) Whether an individual is a bona fide employee within the requirements of section 3121(d)(2) of the Internal Revenue Code of 1986.

"(4) EFFECT OF ADVISORY OPINIONS.—

"(A) BINDING AS TO SECRETARY AND PARTIES INVOLVED.—Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion.

"(B) FAILURE TO SEEK OPINION.—The failure of a party to seek an advisory opinion may not be introduced into evidence to prove that the party intended to violate the provisions of sections 1128, 1128A, or 1128B.

"(5) REGULATIONS.—

"(A) IN GENERAL.—Not later than 180 days after the date of the enactment of this section, the Secretary shall issue regulations to carry out this section. Such regulations shall provide for—

"(i) the procedure to be followed by a party applying for an advisory opinion;

"(ii) the procedure to be followed by the Secretary in responding to a request for an advisory opinion;

"(iii) the interval in which the Secretary shall respond;

"(iv) the reasonable fee to be charged to the party requesting an advisory opinion; and

"(v) the manner in which advisory opinions will be made available to the public.

"(B) SPECIFIC CONTENTS.—Under the regulations promulgated pursuant to subparagraph (A)—

"(i) the Secretary shall be required to respond to a party requesting an advisory opinion by not later than 30 days after the request is received; and

"(ii) the fee charged to the party requesting an advisory opinion shall be equal to the costs incurred by the Secretary in responding to the request.

"(c) SPECIAL FRAUD ALERTS.—

"(1) IN GENERAL.—

"(A) REQUEST FOR SPECIAL FRAUD ALERTS.—Any person may present, at any time, a request to the Inspector General for a notice which informs the public of practices which the Inspector General considers to be suspect or of particular concern under the medicare program or a State health care program, as defined in section 1128(h) (in this subsection referred to as a 'special fraud alert').

"(B) ISSUANCE AND PUBLICATION OF SPECIAL FRAUD ALERTS.—Upon receipt of a request described in subparagraph (A), the Inspector General shall investigate the subject matter of the request to determine whether a special fraud alert should be issued. If appropriate, the Inspector General shall issue a special fraud alert in response to the request. All special fraud alerts issued pursuant to this subparagraph shall be published in the Federal Register.

"(2) CRITERIA FOR SPECIAL FRAUD ALERTS.—In determining whether to issue a special fraud alert upon a request described in paragraph (1), the Inspector General may consider—

"(A) whether and to what extent the practices that would be identified in the special fraud alert may result in any of the consequences described in subsection (a)(2); and

"(B) the volume and frequency of the conduct that would be identified in the special fraud alert.".

Subtitle B—Revisions to Current Sanctions for Fraud and Abuse

SEC. 211. MANDATORY EXCLUSION FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS.

(a) INDIVIDUAL CONVICTED OF FELONY RELATING TO HEALTH CARE FRAUD.—

(1) IN GENERAL.—Section 1128(a) (42 U.S.C. 1320a–7(a)) is amended by adding at the end the following new paragraph:

"(3) FELONY CONVICTION RELATING TO HEALTH CARE FRAUD.—Any individual or entity that has been convicted after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program (other than those specifically described in paragraph (1)) operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.".

(2) CONFORMING AMENDMENT.—Paragraph (1) of section 1128(b) (42 U.S.C. 1320a–7(b)) is amended to read as follows:

"(1) CONVICTION RELATING TO FRAUD.—Any individual or entity that has been convicted after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, under Federal or State law—

"(A) of a criminal offense consisting of a misdemeanor relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct—

"(i) in connection with the delivery of a health care item or service, or

"(ii) with respect to any act or omission in a health care program (other than those specifically described in subsection (a)(1)) operated by or financed in whole or in part by any Federal, State, or local government agency; or

"(B) of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct with respect to any act or omission in a program (other than a health care program) operated by or financed in whole or in part by any Federal, State, or local government agency.".

(b) INDIVIDUAL CONVICTED OF FELONY RELATING TO CONTROLLED SUBSTANCE.—

(1) IN GENERAL.—Section 1128(a) (42 U.S.C. 1320a–7(a)), as amended by subsection (a), is amended by adding at the end the following new paragraph:

"(4) FELONY CONVICTION RELATING TO CONTROLLED SUBSTANCE.—Any individual or entity that has been convicted after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.".

(2) CONFORMING AMENDMENT.—Section 1128(b)(3) (42 U.S.C. 1320a–7(b)(3)) is amended—

(A) in the heading, by striking "CONVICTION" and inserting "MISDEMEANOR CONVICTION"; and

(B) by striking "criminal offense" and inserting "criminal offense consisting of a misdemeanor".

SEC. 212. ESTABLISHMENT OF MINIMUM PERIOD OF EXCLUSION FOR CERTAIN INDIVIDUALS AND ENTITIES SUBJECT TO PERMISSIVE EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS.

Section 1128(c)(3) (42 U.S.C. 1320a–7(c)(3)) is amended by adding at the end the following new subparagraphs:

"(D) In the case of an exclusion of an individual or entity under paragraph (1), (2), or (3) of subsection (b), the period of the exclusion shall be 3 years, unless the Secretary determines in accordance with published regulations that a shorter period is appropriate because of mitigating circumstances or that a longer period is appropriate because of aggravating circumstances.

"(E) In the case of an exclusion of an individual or entity under subsection (b)(4) or (b)(5), the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended, or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

"(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B), the period of the exclusion shall be not less than 1 year.".

SEC. 213. PERMISSIVE EXCLUSION OF INDIVIDUALS WITH OWNERSHIP OR CONTROL INTEREST IN SANCTIONED ENTITIES.

Section 1128(b) (42 U.S.C. 1320a–7(b)) is amended by adding at the end the following new paragraph:

"(15) INDIVIDUALS CONTROLLING A SANCTIONED ENTITY.—(A) Any individual—

"(i) who has a direct or indirect ownership or control interest in a sanctioned entity and who knows or should know (as defined in section 1128A(i)(6)) of the action constituting the basis for the conviction or exclusion described in subparagraph (B); or

"(ii) who is an officer or managing employee (as defined in section 1126(b)) of such an entity.

"(B) For purposes of subparagraph (A), the term 'sanctioned entity' means an entity—

"(i) that has been convicted of any offense described in subsection (a) or in paragraph (1), (2), or (3) of this subsection; or

"(ii) that has been excluded from participation under a program under title XVIII or under a State health care program.".

SEC. 214. SANCTIONS AGAINST PRACTITIONERS AND PERSONS FOR FAILURE TO COMPLY WITH STATUTORY OBLIGATIONS.

(a) MINIMUM PERIOD OF EXCLUSION FOR PRACTITIONERS AND PERSONS FAILING TO MEET STATUTORY OBLIGATIONS.—

(1) IN GENERAL.—The second sentence of section 1156(b)(1) (42 U.S.C. 1320c–5(b)(1)) is amended by striking "may prescribe)" and inserting "may prescribe, except that such period may not be less than 1 year)".

(2) CONFORMING AMENDMENT.—Section 1156(b)(2) (42 U.S.C. 1320c–5(b)(2)) is amended by striking "shall remain" and inserting "shall (subject to the minimum period specified in the second sentence of paragraph (1)) remain".

(b) REPEAL OF "UNWILLING OR UNABLE" CONDITION FOR IMPOSITION OF SANCTION.—Section 1156(b)(1) (42 U.S.C. 1320c–5(b)(1)) is amended—

(1) in the second sentence, by striking "and determines" and all that follows through "such obligations,"; and

(2) by striking the third sentence.

SEC. 215. INTERMEDIATE SANCTIONS FOR MEDICARE HEALTH MAINTENANCE ORGANIZATIONS.

(a) APPLICATION OF INTERMEDIATE SANCTIONS FOR ANY PROGRAM VIOLATIONS.—

(1) IN GENERAL.—Section 1876(i)(1) (42 U.S.C. 1395mm(i)(1)) is amended by striking "the Secretary may terminate" and all that follows and inserting "in accordance with procedures established under paragraph (9), the Secretary may at any time terminate any such contract or may impose the intermediate sanctions described in paragraph (6)(B) or (6)(C) (whichever is applicable) on the eligible organization if the Secretary determines that the organization—

"(A) has failed substantially to carry out the contract;

"(B) is carrying out the contract in a manner substantially inconsistent with the efficient and effective administration of this section; or

"(C) no longer substantially meets the applicable conditions of subsections (b), (c), (e), and (f).".

(2) OTHER INTERMEDIATE SANCTIONS FOR MISCELLANEOUS PROGRAM VIOLATIONS.—Section 1876(i)(6) (42 U.S.C. 1395mm(i)(6)) is amended by adding at the end the following new subparagraph:

"(C) In the case of an eligible organization for which the Secretary makes a determination under paragraph (1) the basis of which is not described in subparagraph (A), the Secretary may apply the following intermediate sanctions:

"(i) Civil money penalties of not more than $25,000 for each determination under paragraph (1) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract.

"(ii) Civil money penalties of not more than $10,000 for each week beginning after the initiation of procedures by the Secretary under paragraph (9) during which the deficiency that is the basis of a determination under paragraph (1) exists.

"(iii) Suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.".

(3) PROCEDURES FOR IMPOSING SANCTIONS.—Section 1876(i) (42 U.S.C. 1395mm(i)) is amended by adding at the end the following new paragraph:

"(9) The Secretary may terminate a contract with an eligible organization under this section or may impose the intermediate sanctions described in paragraph (6) on the organization in accordance with formal investigation and compliance procedures established by the Secretary under which—

"(A) the Secretary first provides the organization with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under paragraph (1) and the organization fails to develop or implement such a plan;

"(B) in deciding whether to impose sanctions, the Secretary considers aggravating factors such as whether an organization has a history of deficiencies or has not taken action to correct deficiencies the Secretary has brought to the organization's attention;

"(C) there are no unreasonable or unnecessary delays between the finding of a deficiency and the imposition of sanctions; and

"(D) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before imposing any sanction or terminating the contract.".

(4) CONFORMING AMENDMENTS.—Section 1876(i)(6)(B) (42 U.S.C. 1395mm(i)(6)(B)) is amended by striking the second sentence.

(b) AGREEMENTS WITH PEER REVIEW ORGANIZATIONS.—Section 1876(i)(7)(A) (42 U.S.C. 1395mm(i)(7)(A)) is amended by striking "an agreement" and inserting "a written agreement".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to contract years beginning on or after January 1, 1996.

SEC. 216. ADDITIONAL EXCEPTION TO ANTI-KICKBACK PENALTIES FOR DISCOUNTING AND MANAGED CARE ARRANGEMENTS.

(a) IN GENERAL.—Section 1128B(b)(3) (42 U.S.C. 1320a–7b(b)(3)) is amended—

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

(2) by striking the period at the end of subparagraph (E) and inserting "; and"; and

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

"(F) any remuneration between an organization and an individual or entity providing items or services, or a combination thereof, pursuant to a written agreement between the organization and the individual or entity if the organization is an eligible organization under section 1876 or if the written agreement places the individual or entity at substantial financial risk for the cost or utilization of the items or services, or a combination thereof, which the individual or entity is obligated to provide, whether through a withhold, capitation, incentive pool, per diem payment, or any other similar risk arrangement which places the individual or entity at substantial financial risk.".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to written agreements entered into on or after January 1, 1997.

SEC. 217. CRIMINAL PENALTY FOR FRAUDULENT DISPOSITION OF ASSETS IN ORDER TO OBTAIN MEDICAID BENEFITS.

Section 1128B(a) (42 U.S.C. 1320a–7b(a)) is amended—

(1) by striking "or" at the end of paragraph (4);

(2) by adding "or" at the end of paragraph (5); and

(3) by inserting after paragraph (5) the following new paragraph:

"(6) knowingly and willfully disposes of assets (including by any transfer in trust) in order for an individual to become eligible for medical assistance under a State plan under title XIX, if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1917(c),".

SEC. 218. EFFECTIVE DATE.

Except as otherwise provided, the amendments made by this subtitle shall take effect January 1, 1997.

Subtitle C—Data Collection

SEC. 221. ESTABLISHMENT OF THE HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM.

(a) IN GENERAL.—Title XI (42 U.S.C. 1301 et seq.), as amended by sections 201 and 205, is amended by inserting after section 1128D the following new section:

"HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM

"SEC. 1128E. (a) GENERAL PURPOSE.—Not later than January 1, 1997, the Secretary shall establish a national health care fraud and abuse data collection program for the reporting of final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners as required by subsection (b), with access as set forth in subsection (c).

"(b) REPORTING OF INFORMATION.—

"(1) IN GENERAL.—Each Government agency and health plan shall report any final adverse action (not including settlements in which no findings of liability have been made) taken against a health care provider, supplier, or practitioner.

"(2) INFORMATION TO BE REPORTED.—The information to be reported under paragraph (1) includes:

"(A) The name and TIN (as defined in section 7701(a)(41) of the Internal Revenue Code of 1986) of any health care provider, supplier, or practitioner who is the subject of a final adverse action.

"(B) The name (if known) of any health care entity with which a health care provider, supplier, or practitioner is affiliated or associated.

"(C) The nature of the final adverse action and whether such action is on appeal.

"(D) A description of the acts or omissions and injuries upon which the final adverse action was based, and such other information as the Secretary determines by regulation is required for appropriate interpretation of information reported under this section.

"(3) CONFIDENTIALITY.—In determining what information is required, the Secretary shall include procedures to assure that the privacy of individuals receiving health care services is appropriately protected.

"(4) TIMING AND FORM OF REPORTING.—The information required to be reported under this subsection shall be reported regularly (but not less often than monthly) and in such form and manner as the Secretary prescribes. Such information shall first be required to be reported on a date specified by the Secretary.

"(5) TO WHOM REPORTED.—The information required to be reported under this subsection shall be reported to the Secretary.

"(c) DISCLOSURE AND CORRECTION OF INFORMATION.—

"(1) DISCLOSURE.—With respect to the information about final adverse actions (not including settlements in which no findings of liability have been made) reported to the Secretary under this section respecting a health care provider, supplier, or practitioner, the Secretary shall, by regulation, provide for—

"(A) disclosure of the information, upon request, to the health care provider, supplier, or licensed practitioner, and

"(B) procedures in the case of disputed accuracy of the information.

"(2) CORRECTIONS.—Each Government agency and health plan shall report corrections of information already reported about any final adverse action taken against a health care provider, supplier, or practitioner, in such form and manner that the Secretary prescribes by regulation.

"(d) ACCESS TO REPORTED INFORMATION.—

"(1) AVAILABILITY.—The information in this database shall be available to Federal and State government agencies and health plans pursuant to procedures that the Secretary shall provide by regulation.

"(2) FEES FOR DISCLOSURE.—The Secretary may establish or approve reasonable fees for the disclosure of information in this database (other than with respect to requests by Federal agencies). The amount of such a fee shall be sufficient to recover the full costs of operating the database. Such fees shall be available to the Secretary or, in the Secretary's discretion to the agency designated under this section to cover such costs.

"(e) PROTECTION FROM LIABILITY FOR REPORTING.—No person or entity, including the agency designated by the Secretary in subsection (b)(5) shall be held liable in any civil action with respect to any report made as required by this section, without knowledge of the falsity of the information contained in the report.

"(f) DEFINITIONS AND SPECIAL RULES.—For purposes of this section:

"(1) FINAL ADVERSE ACTION.—

"(A) IN GENERAL.—The term 'final adverse action' includes:

"(i) Civil judgments against a health care provider, supplier, or practitioner in Federal or State court related to the delivery of a health care item or service.

"(ii) Federal or State criminal convictions related to the delivery of a health care item or service.

"(iii) Actions by Federal or State agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners, including—

"(I) formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, censure or probation,

"(II) any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise, or

"(III) any other negative action or finding by such Federal or State agency that is publicly available information.

"(iv) Exclusion from participation in Federal or State health care programs.

"(v) Any other adjudicated actions or decisions that the Secretary shall establish by regulation.

"(B) EXCEPTION.—The term does not include any action with respect to a malpractice claim.

"(2) PRACTITIONER.—The terms 'licensed health care practitioner', 'licensed practitioner', and 'practitioner' mean, with respect to a State, an individual who is licensed or otherwise authorized by the State to provide health care services (or any individual who, without authority holds himself or herself out to be so licensed or authorized).

"(3) GOVERNMENT AGENCY.—The term 'Government agency' shall include:

"(A) The Department of Justice.

"(B) The Department of Health and Human Services.

"(C) Any other Federal agency that either administers or provides payment for the delivery of health care services, including, but not limited to the Department of Defense and the Veterans' Administration.

"(D) State law enforcement agencies.

"(E) State medicaid fraud control units.

"(F) Federal or State agencies responsible for the licensing and certification of health care providers and licensed health care practitioners.

"(4) HEALTH PLAN.—The term 'health plan' has the meaning given such term by section 1128C(c).

"(5) DETERMINATION OF CONVICTION.—For purposes of paragraph (1), the existence of a conviction shall be determined under paragraph (4) of section 1128(i).".

(b) IMPROVED PREVENTION IN ISSUANCE OF MEDICARE PROVIDER NUMBERS.—Section 1842(r) (42 U.S.C. 1395u(r)) is amended by adding at the end the following new sentence: "Under such system, the Secretary may impose appropriate fees on such physicians to cover the costs of investigation and recertification activities with respect to the issuance of the identifiers.".

Subtitle D—Civil Monetary Penalties

SEC. 231. SOCIAL SECURITY ACT CIVIL MONETARY PENALTIES.

(a) GENERAL CIVIL MONETARY PENALTIES.—Section 1128A (42 U.S.C. 1320a–7a) is amended as follows:

(1) In the third sentence of subsection (a), by striking "programs under title XVIII" and inserting "Federal health care programs (as defined in section 1128B(f)(1))".

(2) In subsection (f)—

(A) by redesignating paragraph (3) as paragraph (4); and

(B) by inserting after paragraph (2) the following new paragraph:

"(3) With respect to amounts recovered arising out of a claim under a Federal health care program (as defined in section 1128B(f)), the portion of such amounts as is determined to have been paid by the program shall be repaid to the program, and the portion of such amounts attributable to the amounts recovered under this section by reason of the amendments made by the Health Coverage Availability and Affordability Act of 1996 (as estimated by the Secretary) shall be deposited into the Federal Hospital Insurance Trust Fund pursuant to section 1817(k)(2)(C).".

(3) In subsection (i)—

(A) in paragraph (2), by striking "title V, XVIII, XIX, or XX of this Act" and inserting "a Federal health care program (as defined in section 1128B(f))",

(B) in paragraph (4), by striking "a health insurance or medical services program under title XVIII or XIX of this Act" and inserting "a Federal health care program (as so defined)", and

(C) in paragraph (5), by striking "title V, XVIII, XIX, or XX" and inserting "a Federal health care program (as so defined)".

(4) By adding at the end the following new subsection:

"(m)(1) For purposes of this section, with respect to a Federal health care program not contained in this Act, references to the Secretary in this section shall be deemed to be references to the Secretary or Administrator of the department or agency with jurisdiction over such program and references to the Inspector General of the Department of Health and Human Services in this section shall be deemed to be references to the Inspector General of the applicable department or agency.

"(2)(A) The Secretary and Administrator of the departments and agencies referred to in paragraph (1) may include in any action pursuant to this section, claims within the jurisdiction of other Federal departments or agencies as long as the following conditions are satisfied:

"(i) The case involves primarily claims submitted to the Federal health care programs of the department or agency initiating the action.

"(ii) The Secretary or Administrator of the department or agency initiating the action gives notice and an opportunity to participate in the investigation to the Inspector General of the department or agency with primary jurisdiction over the Federal health care programs to which the claims were submitted.

"(B) If the conditions specified in subparagraph (A) are fulfilled, the Inspector General of the department or agency initiating the action is authorized to exercise all powers granted under the Inspector General Act of 1978 with respect to the claims submitted to the other departments or agencies to the same manner and extent as provided in that Act with respect to claims submitted to such departments or agencies.".

(b) EXCLUDED INDIVIDUAL RETAINING OWNERSHIP OR CONTROL INTEREST IN PARTICIPATING ENTITY.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

(1) by striking "or" at the end of paragraph (1)(D);

(2) by striking ", or" at the end of paragraph (2) and inserting a semicolon;

(3) by striking the semicolon at the end of paragraph (3) and inserting "; or"; and

(4) by inserting after paragraph (3) the following new paragraph:

"(4) in the case of a person who is not an organization, agency, or other entity, is excluded from participating in a program under title XVIII or a State health care program in accordance with this subsection or under section 1128 and who, at the time of a violation of this subsection—

"(A) retains a direct or indirect ownership or control interest in an entity that is participating in a program under title XVIII or a State health care program, and who knows or should know of the action constituting the basis for the exclusion; or

"(B) is an officer or managing employee (as defined in section 1126(b)) of such an entity;".

(c) MODIFICATIONS OF AMOUNTS OF PENALTIES AND ASSESSMENTS.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)), as amended by subsection (b), is amended in the matter following paragraph (4)—

(1) by striking "$2,000" and inserting "$10,000";

(2) by inserting "; in cases under paragraph (4), $10,000 for each day the prohibited relationship occurs" after "false or misleading information was given"; and

(3) by striking "twice the amount" and inserting "3 times the amount".

(d) CLAIM FOR ITEM OR SERVICE BASED ON INCORRECT CODING OR MEDICALLY UNNECESSARY SERVICES.—Section 1128A(a)(1) (42 U.S.C. 1320a–7a(a)(1)) is amended—

(1) in subparagraph (A) by striking "claimed," and inserting "claimed, including any person who engages in a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a code that the person knows or should know will result in a greater payment to the person than the code the person knows or should know is applicable to the item or service actually provided,";

(2) in subparagraph (C), by striking "or" at the end; and

(3) by inserting after subparagraph (D) the following new subparagraph:

"(E) is for a medical or other item or service that a person knows or should know is not medically necessary; or".

(e) SANCTIONS AGAINST PRACTITIONERS AND PERSONS FOR FAILURE TO COMPLY WITH STATUTORY OBLIGATIONS.—Section 1156(b)(3) (42 U.S.C. 1320c–5(b)(3)) is amended by striking "the actual or estimated cost" and inserting "up to $10,000 for each instance".

(f) PROCEDURAL PROVISIONS.—Section 1876(i)(6) (42 U.S.C. 1395mm(i)(6)), as amended by section 215(a)(2), is amended by adding at the end the following new subparagraph:

"(D) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under subparagraph (B)(i) or (C)(i) in the same manner as such provisions apply to a civil money penalty or proceeding under section 1128A(a).".

(g) PROHIBITION AGAINST OFFERING INDUCEMENTS TO INDIVIDUALS ENROLLED UNDER PROGRAMS OR PLANS.—

(1) OFFER OF REMUNERATION.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)), as amended by subsection (b), is amended—

(A) by striking "or" at the end of paragraph (3);

(B) by striking the semicolon at the end of paragraph (4) and inserting "; or"; and

(D) by inserting after paragraph (4) the following new paragraph:

"(5) offers to or transfers remuneration to any individual eligible for benefits under title XVIII of this Act, or under a State health care program (as defined in section 1128(h)) that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under title XVIII, or a State health care program (as so defined);".

(2) REMUNERATION DEFINED.—Section 1128A(i) (42 U.S.C. 1320a–7a(i)) is amended by adding at the end the following new paragraph:

"(6) The term 'remuneration' includes the waiver of coinsurance and deductible amounts (or any part thereof), and transfers of items or services for free or for other than fair market value. The term 'remuneration' does not include—

"(A) the waiver of coinsurance and deductible amounts by a person, if—

"(i) the waiver is not offered as part of any advertisement or solicitation;

"(ii) the person does not routinely waive coinsurance or deductible amounts; and

"(iii) the person—

"(I) waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need;

"(II) fails to collect coinsurance or deductible amounts after making reasonable collection efforts; or

"(III) provides for any permissible waiver as specified in section 1128B(b)(3) or in regulations issued by the Secretary;

"(B) differentials in coinsurance and deductible amounts as part of a benefit plan design as long as the differentials have been disclosed in writing to all beneficiaries, third party payers, and providers, to whom claims are presented and as long as the differentials meet the standards as defined in regulations promulgated by the Secretary not later than 180 days after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996; or

"(C) incentives given to individuals to promote the delivery of preventive care as determined by the Secretary in regulations so promulgated.".

(h) EFFECTIVE DATE.—The amendments made by this section shall take effect January 1, 1997.

SEC. 232. CLARIFICATION OF LEVEL OF INTENT REQUIRED FOR IMPOSITION OF SANCTIONS.

(a) CLARIFICATION OF LEVEL OF KNOWLEDGE REQUIRED FOR IMPOSITION OF CIVIL MONETARY PENALTIES.—

(1) IN GENERAL.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

(A) in paragraphs (1) and (2), by inserting "knowingly" before "presents" each place it appears; and

(B) in paragraph (3), by striking "gives" and inserting "knowingly gives or causes to be given".

(2) DEFINITION OF STANDARD.—Section 1128A(i) (42 U.S.C. 1320a–7a(i)), as amended by section 231(g)(2), is amended by adding at the end the following new paragraph:

"(7) The term 'should know' means that a person, with respect to information—

"(A) acts in deliberate ignorance of the truth or falsity of the information; or

"(B) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to acts or omissions occurring on or after January 1, 1997.

SEC. 233. PENALTY FOR FALSE CERTIFICATION FOR HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1128A(b) (42 U.S.C. 1320a–7a(b)) is amended by adding at the end the following new paragraph:

"(3)(A) Any physician who executes a document described in subparagraph (B) with respect to an individual knowing that all of the requirements referred to in such subparagraph are not met with respect to the individual shall be subject to a civil monetary penalty of not more than the greater of—

"(i) $5,000, or

"(ii) three times the amount of the payments under title XVIII for home health services which are made pursuant to such certification.

"(B) A document described in this subparagraph is any document that certifies, for purposes of title XVIII, that an individual meets the requirements of section 1814(a)(2)(C) or 1835(a)(2)(A) in the case of home health services furnished to the individual.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to certifications made on or after the date of the enactment of this Act.

Subtitle E—Revisions to Criminal Law

SEC. 241. DEFINITION OF FEDERAL HEALTH CARE OFFENSE.

(a) IN GENERAL.—Chapter 1 of title 18, United States Code, is amended by adding at the end the following:

"§ 24. Definition of Federal health care offense

"(a) As used in this title, the term 'Federal health care offense' means a violation of, or a criminal conspiracy to violate—

"(1) section 669, 1035, or 1347 of this title; or

"(2) section 287, 371, 664, 666, 1001, 1027, 1341, 1343, or 1954 of this title, if the violation or conspiracy relates to a health care benefit program.

"(b) As used in this title, the term 'health care benefit program' has the meaning given such term in section 1347(b) of this title.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 2 of title 18, United States Code, is amended by inserting after the item relating to section 23 the following new item:

"24. Definition of Federal health care offense.".

SEC. 242. HEALTH CARE FRAUD.

(a) OFFENSE.—

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

"§ 1347. Health care fraud

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

"(1) to defraud any health care benefit program; or

"(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program,

in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 10 years, or both. If the violation results in serious bodily injury (as defined in section 1365 of this title), such person shall be fined under this title or imprisoned not more than 20 years, or both; and if the violation results in death, such person shall be fined under this title, or imprisoned for any term of years or for life, or both.

"(b) As used in this section, the term 'health care benefit program' means any public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract.".

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

"1347. Health care fraud.".

(b) CRIMINAL FINES DEPOSITED IN FEDERAL HOSPITAL INSURANCE TRUST FUND.—The Secretary of the Treasury shall deposit into the Federal Hospital Insurance Trust Fund pursuant to section 1817(k)(2)(C) of the Social Security Act (42 U.S.C. 1395i) an amount equal to the criminal fines imposed under section 1347 of title 18, United States Code (relating to health care fraud).

SEC. 243. THEFT OR EMBEZZLEMENT.

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

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

"(a) Whoever embezzles, steals, or otherwise without authority willfully and unlawfully converts to the use of any person other than the rightful owner, or intentionally misapplies any of the moneys, funds, securities, premiums, credits, property, or other assets of a health care benefit program, shall be fined under this title or imprisoned not more than 10 years, or both; but if the value of such property does not exceed the sum of $100 the defendant shall be fined under this title or imprisoned not more than one year, or both.

"(b) As used in this section, the term 'health care benefit program' has the meaning given such term in section 1347(b) of this title.".

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

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

SEC. 244. FALSE STATEMENTS.

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

"§ 1035. False statements relating to health care matters

"(a) Whoever, in any matter involving a health care benefit program, knowingly—

"(1) falsifies, conceals, or covers up by any trick, scheme, or device a material fact; or

"(2) makes any false, fictitious, or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry,

in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 5 years, or both.

"(b) As used in this section, the term 'health care benefit program' has the meaning given such term in section 1347(b) of this title.".

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

"1035. False statements relating to health care matters.".

SEC. 245. OBSTRUCTION OF CRIMINAL INVESTIGATIONS OF HEALTH CARE OFFENSES.

(a) IN GENERAL.—Chapter 73 of title 18, United States Code, is amended by adding at the end the following:

"§ 1518. Obstruction of criminal investigations of health care offenses

"(a) Whoever willfully prevents, obstructs, misleads, delays or attempts to prevent, obstruct, mislead, or delay the communication of information or records relating to a violation of a Federal health care offense to a criminal investigator shall be fined under this title or imprisoned not more than 5 years, or both.

"(b) As used in this section the term 'criminal investigator' means any individual duly authorized by a department, agency, or armed force of the United States to conduct or engage in investigations for prosecutions for violations of health care offenses.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 73 of title 18, United States Code, is amended by adding at the end the following new item:

"1518. Obstruction of criminal investigations of health care offenses.".

SEC. 246. LAUNDERING OF MONETARY INSTRUMENTS.

Section 1956(c)(7) of title 18, United States Code, is amended by adding at the end the following:

"(F) Any act or activity constituting an offense involving a Federal health care offense.".

SEC. 247. INJUNCTIVE RELIEF RELATING TO HEALTH CARE OFFENSES.

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

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

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

(3) by adding at the end the following:

"(C) committing or about to commit a Federal health care offense.".

(b) FREEZING OF ASSETS.—Section 1345(a)(2) of title 18, United States Code, is amended by inserting "or a Federal health care offense" after "title).".

SEC. 248. AUTHORIZED INVESTIGATIVE DEMAND PROCEDURES.

(a) IN GENERAL.—Chapter 223 of title 18, United States Code, is amended by adding after section 3485 the following:

"§ 3486. Authorized investigative demand procedures

"(a) AUTHORIZATION.—In any investigation relating to any act or activity involving a Federal health care offense, the Attorney General or the Attorney General's designee may issue in writing and cause to be served a subpoena requiring the production of any records (including any books, papers, documents, electronic media, or other objects or tangible things), which may be relevant to an authorized law en-

forcement inquiry, that a person or legal entity may possess or have care, custody, or control. A subpoena shall describe the objects required to be produced and prescribe a return date within a reasonable period of time within which the objects can be assembled and made available.

"(b) SERVICE.—A subpoena issued under this section may be served by any person designated in the subpoena to serve it. Service upon a natural person may be made by personal delivery of the subpoena to him. Service may be made upon a domestic or foreign corporation or upon a partnership or other unincorporated association which is subject to suit under a common name, by delivering the subpoena to an officer, to a managing or general agent, or to any other agent authorized by appointment or by law to receive service of process. The affidavit of the person serving the subpoena entered on a true copy thereof by the person serving it shall be proof of service.

"(c) ENFORCEMENT.—In the case of contumacy by or refusal to obey a subpoena issued to any person, the Attorney General may invoke the aid of any court of the United States within the jurisdiction of which the investigation is carried on or of which the subpoenaed person is an inhabitant, or in which he carries on business or may be found, to compel compliance with the subpoena. The court may issue an order requiring the subpoenaed person to appear before the Attorney General to produce records, if so ordered, or to give testimony touching the matter under investigation. Any failure to obey the order of the court may be punished by the court as a contempt thereof. All process in any such case may be served in any judicial district in which such person may be found.

"(d) IMMUNITY FROM CIVIL LIABILITY.—Notwithstanding any Federal, State, or local law, any person, including officers, agents, and employees, receiving a summons under this section, who complies in good faith with the summons and thus produces the materials sought, shall not be liable in any court of any State or the United States to any customer or other person for such production or for nondisclosure of that production to the customer.

"(e) LIMITATION ON USE.—(1) Health information about an individual that is disclosed under this section may not be used in, or disclosed to any person for use in, any administrative, civil, or criminal action or investigation directed against the individual who is the subject of the information unless the action or investigation arises out of and is directly related to receipt of health care or payment for health care or action involving a fraudulent claim related to health; or if authorized by an appropriate order of a court of competent jurisdiction, granted after application showing good cause therefor.

"(2) In assessing good cause, the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services.

"(3) Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 223 of title 18, United States Code, is amended by inserting after the item relating to section 3485 the following new item:

"3486. Authorized investigative demand procedures.".

(c) CONFORMING AMENDMENT.—Section 1510(b)(3)(B) of title 18, United States Code, is amended by inserting "or a Department of Justice subpoena (issued under section 3486 of title 18)," after "subpoena".

SEC. 249. FORFEITURES FOR FEDERAL HEALTH CARE OFFENSES.

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

"(6) The court, in imposing sentence on a person convicted of a Federal health care offense, shall order the person to forfeit property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense.".

(b) CONFORMING AMENDMENT.—Section 982(b)(1)(A) of title 18, United States Code, is amended by inserting "or (a)(6)" after "(a)(1)".

(c) PROPERTY FORFEITED DEPOSITED IN FEDERAL HOSPITAL INSURANCE TRUST FUND.—

(1) IN GENERAL.—After the payment of the costs of asset forfeiture has been made, and notwithstanding any other provision of law, the Secretary of the Treasury shall deposit into the Federal Hospital Insurance Trust Fund pursuant to section 1817(k)(2)(C) of the Social Security Act, as added by section 301(b), an amount equal to the net amount realized from the forfeiture of prop-

erty by reason of a Federal health care offense pursuant to section 982(a)(6) of title 18, United States Code.

(2) COSTS OF ASSET FORFEITURE.—For purposes of paragraph (1), the term ''payment of the costs of asset forfeiture'' means—

(A) the payment, at the discretion of the Attorney General, of any expenses necessary to seize, detain, inventory, safeguard, maintain, advertise, sell, or dispose of property under seizure, detention, or forfeited, or of any other necessary expenses incident to the seizure, detention, forfeiture, or disposal of such property, including payment for—

(i) contract services,

(ii) the employment of outside contractors to operate and manage properties or provide other specialized services necessary to dispose of such properties in an effort to maximize the return from such properties; and

(iii) reimbursement of any Federal, State, or local agency for any expenditures made to perform the functions described in this subparagraph;

(B) at the discretion of the Attorney General, the payment of awards for information or assistance leading to a civil or criminal forfeiture involving any Federal agency participating in the Health Care Fraud and Abuse Control Account;

(C) the compromise and payment of valid liens and mortgages against property that has been forfeited, subject to the discretion of the Attorney General to determine the validity of any such lien or mortgage and the amount of payment to be made, and the employment of attorneys and other personnel skilled in State real estate law as necessary;

(D) payment authorized in connection with remission or mitigation procedures relating to property forfeited; and

(E) the payment of State and local property taxes on forfeited real property that accrued between the date of the violation giving rise to the forfeiture and the date of the forfeiture order.

Subtitle F—Administrative Simplification

PART 1—GENERAL ADMINISTRATIVE SIMPLIFICATION

SEC. 251. PURPOSE.

It is the purpose of this part to improve the medicare program under title XVIII of the Social Security Act, the medicaid program under title XIX of such Act, and the efficiency and effectiveness of the health care system, by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information.

SEC. 252. ADMINISTRATIVE SIMPLIFICATION.

(a) IN GENERAL.—Title XI (42 U.S.C. 1301 et seq.) is amended by adding at the end the following:

''PART C—ADMINISTRATIVE SIMPLIFICATION

''SEC. 1171. DEFINITIONS.

''For purposes of this part:

''(1) CLEARINGHOUSE.—The term 'clearinghouse' means a public or private entity that—

''(A) processes or facilitates the processing of nonstandard data elements of health information into standard data elements; or

''(B) provides the means by which persons may meet the requirements of this part.

''(2) CODE SET.—The term 'code set' means any set of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes.

''(3) HEALTH CARE PROVIDER.—The term 'health care provider' includes a provider of services (as defined in section 1861(u)), a provider of medical or other health services (as defined in section 1861(s)), and any other person furnishing health care services or supplies.

"(4) HEALTH INFORMATION.—The term 'health information' means any information, whether oral or recorded in any form or medium that—

"(A) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or clearinghouse; and

"(B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

"(5) HEALTH PLAN.—The term 'health plan' means a plan which provides, or pays the cost of, health benefits. Such term includes the following, or any combination thereof:

"(A) Part A or part B of the medicare program under title XVIII.

"(B) The medicaid program under title XIX.

"(C) A medicare supplemental policy (as defined in section 1882(g)(1)).

"(D) Coverage issued as a supplement to liability insurance.

"(E) General liability insurance.

"(F) Worker's compensation or similar insurance.

"(G) Automobile or automobile medical-payment insurance.

"(H) A long-term care policy, including a nursing home fixed indemnity policy (unless the Secretary determines that such a policy does not provide sufficiently comprehensive coverage of a benefit so that the policy should be treated as a health plan).

"(I) A hospital or fixed indemnity income-protection policy.

"(J) An employee welfare benefit plan, as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(1)), but only to the extent the plan is established or maintained for the purpose of providing health benefits and has 50 or more participants (as defined in section 3(7) of such Act).

"(K) An employee welfare benefit plan or any other arrangement which is established or maintained for the purpose of offering or providing health benefits to the employees of 2 or more employers.

"(L) The health care program for active military personnel under title 10, United States Code.

"(M) The veterans health care program under chapter 17 of title 38, United States Code.

"(N) The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), as defined in section 1073(4) of title 10, United States Code.

"(O) The Indian health service program under the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

"(P) The Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code.

"(Q) Such other plan or arrangement as the Secretary determines is a health plan.

"(6) INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.—The term 'individually identifiable health information' means any information, including demographic information collected from an individual, that—

"(A) is created or received by a health care provider, health plan, employer, or clearinghouse; and

"(B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and—

"(i) identifies the individual; or

"(ii) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

"(7) STANDARD.—The term 'standard', when used with reference to a data element of health information or a transaction referred to in section 1173(a)(1), means any such data element or transaction that meets each of the standards and implementation specifications adopted or established by the Secretary with respect to the data element or transaction under sections 1172 and 1173.

"(8) STANDARD SETTING ORGANIZATION.—The term 'standard setting organization' means a standard setting organization accredited by the American National Standards Institute, including the National Council for Prescription Drug Programs, that develops standards for information transactions, data elements, or any other standard that is necessary to, or will facilitate, the implementation of this part.

"SEC. 1172. GENERAL REQUIREMENTS FOR ADOPTION OF STANDARDS.

"(a) APPLICABILITY.—Any standard or modification of a standard adopted under this part shall apply to the following persons:

"(1) A health plan.

"(2) A clearinghouse.

"(3) A health care provider who transmits any health information in electronic form in connection with a transaction referred to in section 1173(a)(1).

"(b) REDUCTION OF COSTS.—Any standard or modification of a standard adopted under this part shall be consistent with the objective of reducing the administrative costs of providing and paying for health care.

"(c) ROLE OF STANDARD SETTING ORGANIZATIONS.—

"(1) IN GENERAL.—Except as provided in paragraph (2), any standard or modification of a standard adopted under this part shall be developed or modified by a standard setting organization.

"(2) SPECIAL RULES.—

"(A) DIFFERENT STANDARDS.—The Secretary may adopt a standard or modification of a standard that is different from any standard developed or modified by a standard setting organization, if—

"(i) the different standard or modification will substantially reduce administrative costs to health care providers and health plans compared to the alternatives; and

"(ii) the standard or modification is promulgated in accordance with the rulemaking procedures of subchapter III of chapter 5 of title 5, United States Code.

"(B) NO STANDARD BY STANDARD SETTING ORGANIZATION.—If no standard setting organization has adopted or modified any standard relating to a standard, or a modification of a standard, that the Secretary is authorized or required to adopt under this part—

"(i) paragraph (1) shall not apply; and

"(ii) subsection (f) shall apply.

"(d) IMPLEMENTATION SPECIFICATIONS.—The Secretary shall establish specifications for implementing each of the standards and modifications adopted under this part.

"(e) PROTECTION OF TRADE SECRETS.—Except as otherwise required by law, a standard or modification of a standard adopted under this part shall not require disclosure of trade secrets or confidential commercial information by a person required to comply with this part.

"(f) ASSISTANCE TO THE SECRETARY.—In complying with the requirements of this part, the Secretary shall rely on the recommendations of the Health Information Advisory Committee established under section 1179 and shall consult with appropriate Federal and State agencies and private organizations. The Secretary shall publish in the Federal Register the recommendations of the Health Information Advisory Committee regarding the adoption of a standard or modification of a standard under this part.

"SEC. 1173. STANDARDS FOR INFORMATION TRANSACTIONS AND DATA ELEMENTS.

"(a) STANDARDS TO ENABLE ELECTRONIC EXCHANGE.—

"(1) IN GENERAL.—The Secretary shall adopt standards for transactions, and data elements for such transactions, to enable health information to be exchanged electronically, that are—

"(A) appropriate for the financial and administrative transactions described in paragraph (2); and

"(B) related to other financial and administrative transactions determined appropriate by the Secretary consistent with the goals of improving the operation of the health care system and reducing administrative costs.

"(2) TRANSACTIONS.—The transactions referred to in paragraph (1)(A) are the following:

"(A) Claims (including coordination of benefits) or equivalent encounter information.

"(B) Claims attachments.

"(C) Enrollment and disenrollment.

"(D) Eligibility.

"(E) Health care payment and remittance advice.

"(F) Premium payments.

"(G) First report of injury.

"(H) Claims status.

"(I) Referral certification and authorization.

"(3) ACCOMMODATION OF SPECIFIC PROVIDERS.—The standards adopted by the Secretary under paragraph (1) shall accommodate the needs of different types of health care providers.

"(b) UNIQUE HEALTH IDENTIFIERS.—

"(1) IN GENERAL.—The Secretary shall adopt standards providing for a standard unique health identifier for each individual, employer, health plan, and health care provider for use in the health care system. In carrying out the preceding sentence for each health plan and health care provider, the Secretary shall take into account multiple uses for identifiers and multiple locations and specialty classifications for health care providers.

"(2) USE OF IDENTIFIERS.—The standards adopted under paragraphs (1) shall specify the purposes for which a unique health identifier may be used.

"(c) CODE SETS.—

"(1) IN GENERAL.—The Secretary shall adopt standards that—

"(A) select code sets for appropriate data elements for the transactions referred to in subsection (a)(1) from among the code sets that have been developed by private and public entities; or

"(B) establish code sets for such data elements if no code sets for the data elements have been developed.

"(2) DISTRIBUTION.—The Secretary shall establish efficient and low-cost procedures for distribution (including electronic distribution) of code sets and modifications made to such code sets under section 1174(b).

"(d) SECURITY STANDARDS FOR HEALTH INFORMATION.—

"(1) SECURITY STANDARDS.—The Secretary shall adopt security standards that—

"(A) take into account—

"(i) the technical capabilities of record systems used to maintain health information;

"(ii) the costs of security measures;

"(iii) the need for training persons who have access to health information;

"(iv) the value of audit trails in computerized record systems; and

"(v) the needs and capabilities of small health care providers and rural health care providers (as such providers are defined by the Secretary); and

"(B) ensure that a clearinghouse, if it is part of a larger organization, has policies and security procedures which isolate the activities of the clearinghouse with respect to processing information in a manner that prevents unauthorized access to such information by such larger organization.

"(2) SAFEGUARDS.—Each person described in section 1172(a) who maintains or transmits health information shall maintain reasonable and appropriate administrative, technical, and physical safeguards—

"(A) to ensure the integrity and confidentiality of the information;

"(B) to protect against any reasonably anticipated—

"(i) threats or hazards to the security or integrity of the information; and

"(ii) unauthorized uses or disclosures of the information; and

"(C) otherwise to ensure compliance with this part by the officers and employees of such person.

"(e) PRIVACY STANDARDS FOR HEALTH INFORMATION.—The Secretary shall adopt standards with respect to the privacy of individually identifiable health information. Such standards shall include standards concerning at least the following:

"(1) The rights of an individual who is a subject of such information.

"(2) The procedures to be established for the exercise of such rights.

"(3) The uses and disclosures of such information that are authorized or required.

"(f) ELECTRONIC SIGNATURE.—

"(1) IN GENERAL.—The Secretary, in coordination with the Secretary of Commerce, shall adopt standards specifying procedures for the electronic transmission and authentication of signatures, compliance with which shall be deemed to satisfy Federal and State statutory requirements for written signatures with respect to the transactions referred to in subsection (a)(1).

"(2) PAYMENTS FOR SERVICES AND PREMIUMS.—Nothing in this part shall be construed to prohibit payment for health care services or health plan premiums by debit, credit, payment card or numbers, or other electronic means.

"(g) TRANSFER OF INFORMATION BETWEEN HEALTH PLANS.—The Secretary shall adopt standards for transferring among health plans appropriate standard data ele-

ments needed for the coordination of benefits, the sequential processing of claims, and other data elements for individuals who have more than one health plan.

"SEC. 1174. TIMETABLES FOR ADOPTION OF STANDARDS.

"(a) INITIAL STANDARDS.—The Secretary shall carry out section 1173 not later than 18 months after the date of the enactment of this part, except that standards relating to claims attachments shall be adopted not later than 30 months after such date.

"(b) ADDITIONS AND MODIFICATIONS TO STANDARDS.—

"(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary shall review the standards adopted under section 1173, and shall adopt additional or modified standards, as determined appropriate, but not more frequently than once every 6 months. Any addition or modification to a standard shall be completed in a manner which minimizes the disruption and cost of compliance.

"(2) SPECIAL RULES.—

"(A) FIRST 12-MONTH PERIOD.—Except with respect to additions and modifications to code sets under subparagraph (B), the Secretary may not adopt any modification to a standard adopted under this part during the 12-month period beginning on the date the standard is initially adopted, unless the Secretary determines that the modification is necessary in order to permit compliance with the standard.

"(B) ADDITIONS AND MODIFICATIONS TO CODE SETS.—

"(i) IN GENERAL.—The Secretary shall ensure that procedures exist for the routine maintenance, testing, enhancement, and expansion of code sets.

"(ii) ADDITIONAL RULES.—If a code set is modified under this subsection, the modified code set shall include instructions on how data elements of health information that were encoded prior to the modification may be converted or translated so as to preserve the informational value of the data elements that existed before the modification. Any modification to a code set under this subsection shall be implemented in a manner that minimizes the disruption and cost of complying with such modification.

"SEC. 1175. REQUIREMENTS.

"(a) CONDUCT OF TRANSACTIONS BY PLANS.—

"(1) IN GENERAL.—If a person desires to conduct a transaction referred to in section 1173(a)(1) with a health plan as a standard transaction—

"(A) the health plan may not refuse to conduct such transaction as a standard transaction;

"(B) the health plan may not delay such transaction, or otherwise adversely affect, or attempt to adversely affect, the person or the transaction on the ground that the transaction is a standard transaction; and

"(C) the information transmitted and received in connection with the transaction shall be in the form of standard data elements of health information.

"(2) SATISFACTION OF REQUIREMENTS.—A health plan may satisfy the requirements under paragraph (1) by—

"(A) directly transmitting and receiving standard data elements of health information; or

"(B) submitting nonstandard data elements to a clearinghouse for processing into standard data elements and transmission by the clearinghouse, and receiving standard data elements through the clearinghouse.

"(3) TIMETABLE FOR COMPLIANCE.—Paragraph (1) shall not be construed to require a health plan to comply with any standard, implementation specification, or modification to a standard or specification adopted or established by the Secretary under sections 1172 and 1173 at any time prior to the date on which the plan is required to comply with the standard or specification under subsection (b).

"(b) COMPLIANCE WITH STANDARDS.—

"(1) INITIAL COMPLIANCE.—

"(A) IN GENERAL.—Not later than 24 months after the date on which an initial standard or implementation specification is adopted or established under sections 1172 and 1173, each person to whom the standard or implementation specification applies shall comply with the standard or specification.

"(B) SPECIAL RULE FOR SMALL HEALTH PLANS.—In the case of a small health plan, paragraph (1) shall be applied by substituting '36 months' for

'24 months'. For purposes of this subsection, the Secretary shall determine the plans that qualify as small health plans.

"(2) COMPLIANCE WITH MODIFIED STANDARDS.—If the Secretary adopts a modification to a standard or implementation specification under this part, each person to whom the standard or implementation specification applies shall comply with the modified standard or implementation specification at such time as the Secretary determines appropriate, taking into account the time needed to comply due to the nature and extent of the modification. The time determined appropriate under the preceding sentence may not be earlier than the last day of the 180-day period beginning on the date such modification is adopted. The Secretary may extend the time for compliance for small health plans, if the Secretary determines that such extension is appropriate.

"SEC. 1176. GENERAL PENALTY FOR FAILURE TO COMPLY WITH REQUIREMENTS AND STANDARDS.

"(a) GENERAL PENALTY.—

"(1) IN GENERAL.—Except as provided in subsection (b), the Secretary shall impose on any person who violates a provision of this part a penalty of not more than $100 for each such violation, except that the total amount imposed on the person for all violations of an identical requirement or prohibition during a calendar year may not exceed $25,000.

"(2) PROCEDURES.—The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to the imposition of a civil money penalty under this subsection in the same manner as such provisions apply to the imposition of a penalty under such section 1128A.

"(b) LIMITATIONS.—

"(1) OFFENSES OTHERWISE PUNISHABLE.—A penalty may not be imposed under subsection (a) with respect to an act if the act constitutes an offense punishable under section 1177.

"(2) NONCOMPLIANCE NOT DISCOVERED.—A penalty may not be imposed under subsection (a) with respect to a provision of this part if it is established to the satisfaction of the Secretary that the person liable for the penalty did not know, and by exercising reasonable diligence would not have known, that such person violated the provision.

"(3) FAILURES DUE TO REASONABLE CAUSE.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), a penalty may not be imposed under subsection (a) if—

"(i) the failure to comply was due to reasonable cause and not to willful neglect; and

"(ii) the failure to comply is corrected during the 30-day period beginning on the first date the person liable for the penalty knew, or by exercising reasonable diligence would have known, that the failure to comply occurred.

"(B) EXTENSION OF PERIOD.—

"(i) NO PENALTY.—The period referred to in subparagraph (A)(ii) may be extended as determined appropriate by the Secretary based on the nature and extent of the failure to comply.

"(ii) ASSISTANCE.—If the Secretary determines that a person failed to comply because the person was unable to comply, the Secretary may provide technical assistance to the person during the period described in subparagraph (A)(ii). Such assistance shall be provided in any manner determined appropriate by the Secretary.

"(4) REDUCTION.—In the case of a failure to comply which is due to reasonable cause and not to willful neglect, any penalty under subsection (a) that is not entirely waived under paragraph (3) may be waived to the extent that the payment of such penalty would be excessive relative to the compliance failure involved.

"SEC. 1177. WRONGFUL DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

"(a) OFFENSE.—A person who knowingly and in violation of this part—

"(1) uses or causes to be used a unique health identifier;

"(2) obtains individually identifiable health information relating to an individual; or

"(3) discloses individually identifiable health information to another person, shall be punished as provided in subsection (b).

"(b) PENALTIES.—A person described in subsection (a) shall—

"(1) be fined not more than $50,000, imprisoned not more than 1 year, or both;

"(2) if the offense is committed under false pretenses, be fined not more than $100,000, imprisoned not more than 5 years, or both; and

"(3) if the offense is committed with intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm, fined not more than $250,000, imprisoned not more than 10 years, or both.

"SEC. 1178. EFFECT ON STATE LAW.

"(a) GENERAL EFFECT.—

"(1) GENERAL RULE.—Except as provided in paragraph (2), a provision or requirement under this part, or a standard or implementation specification adopted or established under sections 1172 and 1173, shall supersede any contrary provision of State law, including a provision of State law that requires medical or health plan records (including billing information) to be maintained or transmitted in written rather than electronic form.

"(2) EXCEPTIONS.—A provision or requirement under this part, or a standard or implementation specification adopted or established under sections 1172 and 1173, shall not supersede a contrary provision of State law, if the provision of State law—

"(A) imposes requirements, standards, or implementation specifications that are more stringent than the requirements, standards, or implementation specifications under this part with respect to the privacy of individually identifiable health information; or

"(B) is a provision the Secretary determines—

"(i) is necessary to prevent fraud and abuse, or for other purposes; or

"(ii) addresses controlled substances.

"(b) PUBLIC HEALTH REPORTING.—Nothing in this part shall be construed to invalidate or limit the authority, power, or procedures established under any law providing for the reporting of disease or injury, child abuse, birth, or death, public health surveillance, or public health investigation or intervention.

"SEC. 1179. HEALTH INFORMATION ADVISORY COMMITTEE.

"(a) ESTABLISHMENT.—There is established a committee to be known as the Health Information Advisory Committee (in this section referred to as the 'committee').

"(b) DUTIES.—The committee shall—

"(1) provide assistance to the Secretary in complying with the requirements imposed on the Secretary under this part;

"(2) study the issues related to the adoption of uniform data standards for patient medical record information and the electronic exchange of such information;

"(3) report to the Secretary not later than 4 years after the date of the enactment of this part recommendations and legislative proposals for such standards and electronic exchange; and

"(4) generally be responsible for advising the Secretary and the Congress on the status of the implementation of this part.

"(c) MEMBERSHIP.—

"(1) IN GENERAL.—The committee shall consist of 15 members of whom—

"(A) 3 shall be appointed by the President;

"(B) 6 shall be appointed by the Speaker of the House of Representatives after consultation with the minority leader of the House of Representatives; and

"(C) 6 shall be appointed by the President pro tempore of the Senate after consultation with the minority leader of the Senate.

The appointments of the members shall be made not later than 60 days after the date of the enactment of this part. The President shall designate 1 member as the Chair.

"(2) EXPERTISE.—The membership of the committee shall consist of individuals who are of recognized standing and distinction in the areas of information systems, information networking and integration, consumer health, health care financial management, or privacy, and who possess the demonstrated capacity to discharge the duties imposed on the committee.

"(3) TERMS.—Each member of the committee shall be appointed for a term of 5 years, except that the members first appointed shall serve staggered terms such that the terms of not more than 3 members expire at one time.

"(4) INITIAL MEETING.—Not later than 30 days after the date on which a majority of the members have been appointed, the committee shall hold its first meeting.

"(d) REPORTS.—Not later than 1 year after the date of the enactment of this part, and annually thereafter, the committee shall submit to the Congress, and make public, a report regarding—

"(1) the extent to which persons required to comply with this part are cooperating in implementing the standards adopted under this part;

"(2) the extent to which such entities are meeting the privacy and security standards adopted under this part and the types of penalties assessed for noncompliance with such standards;

"(3) whether the Federal and State Governments are receiving information of sufficient quality to meet their responsibilities under this part;

"(4) any problems that exist with respect to implementation of this part; and

"(5) the extent to which timetables under this part are being met.".

(b) CONFORMING AMENDMENTS.—

(1) REQUIREMENT FOR MEDICARE PROVIDERS.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended—

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

(B) by striking the period at the end of subparagraph (Q) and inserting "; and"; and

(C) by inserting immediately after subparagraph (Q) the following new subparagraph:

"(R) to contract only with a clearinghouse (as defined in section 1171) that meets each standard and implementation specification adopted or established under sections 1172 and 1173 on or after the date on which the clearinghouse is required to comply with the standard or specification.".

(2) TITLE HEADING.—Title XI (42 U.S.C. 1301 et seq.) is amended by striking the title heading and inserting the following:

"TITLE XI—GENERAL PROVISIONS, PEER REVIEW, AND ADMINISTRATIVE SIMPLIFICATION".

PART 2—ADMINISTRATIVE SIMPLIFICATION FOR LABORATORY SERVICES

SEC. 261. ADMINISTRATIVE SIMPLIFICATION FOR LABORATORY SERVICES.

(a) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services (in accordance with the process described in subsection (b)) shall adopt uniform coverage, administration, and payment policies for clinical diagnostic laboratory tests under part B of the medicare program.

(b) PROCESS FOR ADOPTION OF POLICIES.—The Secretary shall adopt uniform policies under subsection (a) in accordance with the following process:

(1) The Secretary shall select from carriers with whom the Secretary has a contract under part B during 1996 15 medical directors, who will meet and develop recommendations for such uniform policies. The medical directors selected shall represent various geographic areas and have a varied range of experience in relevant medical fields, including pathology and clinical laboratory practice.

(2) The medical directors selected under paragraph (1) shall consult with independent experts in each major discipline of clinical laboratory medicine including clinical laboratory personnel, bioanalysts, pathologists, and practicing physicians. The medical directors shall also solicit comments from other individuals and groups who wish to participate, including consumers and other affected parties. This process shall be conducted as a negotiated rulemaking under title 5, United States Code.

(3) Under the negotiated rulemaking, the recommendations for uniform policies shall be designed to simplify and reduce unnecessary administrative burdens in connection with the following:

(A) Beneficiary information required to be submitted with each claim.

(B) Physicians' obligations regarding documentation requirements and recordkeeping.

(C) Procedures for filing claims and for providing remittances by electronic media.

(D) The performance of post-payment review of test claims.

(E) The prohibition of the documentation of medical necessity except when determined to be appropriate after identification of aberrant utilization pattern through focused medical review.

(F) Beneficiary responsibility for payment.

(4) During the pendency of the adoption by the Secretary of the uniform policies, fiscal intermediaries and carriers under the Medicare program may not implement any new requirement relating to the submission of a claim for clinical diagnostic laboratory tests retroactive to January 1, 1996, and carriers may not initiate any new coverage, administrative, or payment policy unless the policy promotes the goal of administrative simplification of requirements imposed on clinical laboratories in accordance with the Secretary's promulgation of the negotiated rulemaking.

(5) Not later than 6 months after the date of the enactment of this Act, the medical directors shall submit their recommendations to the Secretary, and the Secretary shall publish the recommendations and solicit public comment using negotiated rulemaking in accordance with title 5, United States Code. The Secretary shall publish final uniform policies for coverage, administration, and payment of claims for clinical diagnostic laboratory tests, effective after the expiration of the 180-day period which begins on the date of publication.

(6) After the publication of the final uniform policies, the Secretary shall implement identical uniform documentation and processing policies for all clinical diagnostic laboratory tests paid under the Medicare program through fiscal intermediaries or carriers.

(c) OPTIONAL SELECTION OF SINGLE CARRIER.—Effective for claims submitted after the expiration of the 90-day period which begins on the date of the enactment of this Act, an independent laboratory may select a single carrier for the processing of all of its claims for payment under part B of the medicare program, without regard to the location where the laboratory or the patient or provider involved resides or conducts business. Such election of a single carrier shall be made by the clinical laboratory and an agreement made between the carrier and the laboratory shall be forwarded to the Secretary of Health and Human Services. Nothing in this subsection shall be construed to require a laboratory to select a single carrier under this subsection.

(d) CONSISTENCY WITH GENERAL ADMINISTRATIVE SIMPLIFICATION.—In complying with this section, the Secretary shall ensure that the policies adopted under subsection (a) are consistent, to the maximum extent practicable, with part C of title XI of the Social Security Act.

Subtitle G—Duplication and Coordination of Medicare-Related Plans

SEC. 271. DUPLICATION AND COORDINATION OF MEDICARE-RELATED PLANS.

(a) TREATMENT OF CERTAIN HEALTH INSURANCE POLICIES AS NONDUPLICATIVE.—Effective as if included in the enactment of section 4354 of the Omnibus Budget Reconciliation Act of 1990, section 1882(d)(3)(A) (42 U.S.C. 1395ss(d)(3)(A)) is amended—

(1) by amending clause (i) to read as follows:

"(i) It is unlawful for a person to sell or issue to an individual entitled to benefits under part A or enrolled under part B of this title—

"(I) a health insurance policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under this title or title XIX,

"(II) a medicare supplemental policy with knowledge that the individual is entitled to benefits under another medicare supplemental policy, or

"(III) a health insurance policy (other than a medicare supplemental policy) with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled, other than benefits to which the individual is entitled under a requirement of State or Federal law.

Subclause (I) or (III) shall not apply with respect to the sale or issuance of a health insurance policy or plan under which all the benefits are fully payable directly to or on behalf of the individual without regard to other health benefit coverage of the individual.";

(2) in clause (iii), by striking "clause (i)" and inserting "clause (i)(II)"; and

(3) by adding at the end of subparagraph (A) the following:

"(iv) For purposes of this subparagraph, a health insurance policy shall be considered to 'duplicate' benefits only when, under its terms, the policy provides specific reimbursement for identical items and services to the extent paid for under other coverage of such individual, and a health insurance policy providing for benefits which are payable to or on behalf of an individual without regard to other health

benefit coverage of such individual is not considered to 'duplicate' any health benefits.

"(v) For purposes of this subparagraph, a health insurance policy (or a rider to an insurance contract which is not a health insurance policy), providing benefits for long-term care, nursing home care, home health care, or community-based care, or a contract with a health maintenance organization that provides comprehensive health benefits, and that coordinates against or excludes items and services available or paid for under this title and (for policies other than contracts with health maintenance organizations sold or issued on or after 90 days after the date of enactment of this provision) that discloses such coordination or exclusion in the policy's outline of coverage, is not considered to 'duplicate' health benefits under this title. For purposes of this clause, the terms 'coordinates' and 'coordination' mean, with respect to a policy in relation to health benefits under this title, that the policy under its terms is secondary to, or excludes from payment, items and services to the extent available or paid for under this title.

"(vi) Notwithstanding any other provision of law, no criminal or civil penalty may be imposed at any time under this subparagraph and no legal action may be brought or continued at any time in any Federal or State court if the penalty or action is based on an act or omission that occurred after November 5, 1991, and before the date of the enactment of this clause, and relates to the sale, issuance, or renewal of any health insurance policy or rider during such period, if such policy or rider meets the nonduplication requirements of clause (iv) or (v).

"(vii) A State may not impose, in the case of the sale, issuance, or renewal of a health insurance policy (other than a medicare supplemental policy) or rider to an insurance contract which is not a health insurance policy, that meets the nonduplication requirements of this section pursuant to clause (iv) or (v) to an individual entitled to benefits under part A or enrolled under part B, any requirement with respect to the duplication or nonduplication of health benefits to which the individual is otherwise entitled to under this title.".

(b) CONFORMING AMENDMENTS.—Section 1882(d)(3) (42 U.S.C. 1395ss(d)(3)) is amended—

(1) in subparagraph (C)—

(A) by striking "with respect to (i)" and inserting "with respect to", and

(B) by striking ", (ii) the sale" and all that follows up to the period at the end; and

(2) by striking subparagraph (D).

TITLE III—TAX-RELATED HEALTH PROVISIONS

SEC. 300. AMENDMENT OF 1986 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 the Internal Revenue Code of 1986.

Subtitle A—Medical Savings Accounts

SEC. 301. MEDICAL SAVINGS ACCOUNTS.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 (relating to additional itemized deductions for individuals) is amended by redesignating section 220 as section 221 and by inserting after section 219 the following new section:

"SEC. 220. MEDICAL SAVINGS ACCOUNTS.

"(a) DEDUCTION ALLOWED.—In the case of an individual who is an eligible individual for any month during the taxable year, there shall be allowed as a deduction for the taxable year an amount equal to the aggregate amount paid in cash during such taxable year by such individual to a medical savings account of such individual.

"(b) LIMITATIONS.—

"(1) IN GENERAL.—Except as otherwise provided in this subsection, the amount allowable as a deduction under subsection (a) to an individual for the taxable year shall not exceed—

"(A) except as provided in subparagraph (B), the lesser of—

"(i) $2,000, or

"(ii) the annual deductible limit for any individual covered under the high deductible health plan, or

"(B) in the case of a high deductible health plan covering the taxpayer and any other eligible individual who is the spouse or any dependent (as defined in section 152) of the taxpayer, the lesser of—

"(i) $4,000, or

"(ii) the annual limit under the plan on the aggregate amount of deductibles required to be paid by all individuals.

The preceding sentence shall not apply if the spouse of such individual is covered under any other high deductible health plan.

"(2) SPECIAL RULE FOR MARRIED INDIVIDUALS.—

"(A) IN GENERAL.—This subsection shall be applied separately for each married individual.

"(B) SPECIAL RULE.—If individuals who are married to each other are covered under the same high deductible health plan, then the amounts applicable under paragraph (1)(B) shall be divided equally between them unless they agree on a different division.

"(3) COORDINATION WITH EXCLUSION FOR EMPLOYER CONTRIBUTIONS.—No deduction shall be allowed under this section for any amount paid for any taxable year to a medical savings account of an individual if—

"(A) any amount is paid to any medical savings account of such individual which is excludable from gross income under section 106(b) for such year, or

"(B) in a case described in paragraph (2)(B), any amount is paid to any medical savings account of either spouse which is so excludable for such year.

"(4) PRORATION OF LIMITATION.—

"(A) IN GENERAL.—The limitation under paragraph (1) shall be the sum of the monthly limitations for months during the taxable year that the individual is an eligible individual if—

"(i) such individual is not an eligible individual for all months of the taxable year,

"(ii) the deductible under the high deductible health plan covering such individual is not the same throughout such taxable year, or

"(iii) such limitation is determined under paragraph (1)(B) for some but not all months during such taxable year.

"(B) MONTHLY LIMITATION.—The monthly limitation for any month shall be an amount equal to 1/12 of the limitation which would (but for this paragraph and paragraph (3)) be determined under paragraph (1) if the facts and circumstances as of the first day of such month that such individual is covered under a high deductible health plan were true for the entire taxable year.

"(5) DENIAL OF DEDUCTION TO DEPENDENTS.—No deduction shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

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

"(1) ELIGIBLE INDIVIDUAL.—

"(A) IN GENERAL.—The term 'eligible individual' means, with respect to any month, any individual—

"(i) who is covered under a high deductible health plan as of the 1st day of such month, and

"(ii) who is not, while covered under a high deductible health plan, covered under any health plan—

"(I) which is not a high deductible health plan, and

"(II) which provides coverage for any benefit which is covered under the high deductible health plan.

"(B) CERTAIN COVERAGE DISREGARDED.—Subparagraph (A)(ii) shall be applied without regard to—

"(i) coverage for any benefit provided by permitted insurance, and

"(ii) coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

"(2) HIGH DEDUCTIBLE HEALTH PLAN.—The term 'high deductible health plan' means a health plan which—

"(A) has an annual deductible limit for each individual covered by the plan which is not less than $1,500, and

"(B) has an annual limit on the aggregate amount of deductibles required to be paid with respect to all individuals covered by the plan which is not less than $3,000.

Such term does not include a health plan if substantially all of its coverage is coverage described in paragraph (1)(B). A plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for preventive care if the absence of a deductible for such care is required by State law.

"(3) PERMITTED INSURANCE.—The term 'permitted insurance' means—

"(A) Medicare supplemental insurance,

"(B) insurance if substantially all of the coverage provided under such insurance relates to—

"(i) liabilities incurred under workers' compensation laws,

"(ii) tort liabilities,

"(iii) liabilities relating to ownership or use of property, or

"(iv) such other similar liabilities as the Secretary may specify by regulations,

"(C) insurance for a specified disease or illness, and

"(D) insurance paying a fixed amount per day (or other period) of hospitalization.

"(d) MEDICAL SAVINGS ACCOUNT.—For purposes of this section—

"(1) MEDICAL SAVINGS ACCOUNT.—The term 'medical savings account' means a trust created or organized in the United States exclusively for the purpose of paying the qualified medical expenses of the account holder, but only if the written governing instrument creating the trust meets the following requirements:

"(A) Except in the case of a rollover contribution described in subsection (f)(5), no contribution will be accepted—

"(i) unless it is in cash, or

"(ii) to the extent such contribution, when added to previous contributions to the trust for the calendar year, exceeds $4,000.

"(B) The trustee is a bank (as defined in section 408(n)), an insurance company (as defined in section 816), or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with the requirements of this section.

"(C) No part of the trust assets will be invested in life insurance contracts.

"(D) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

"(E) The interest of an individual in the balance in his account is nonforfeitable.

"(2) QUALIFIED MEDICAL EXPENSES.—

"(A) IN GENERAL.—The term 'qualified medical expenses' means, with respect to an account holder, amounts paid by such holder for medical care (as defined in section 213(d)) for such individual, the spouse of such individual, and any dependent (as defined in section 152) of such individual, but only to the extent such amounts are not compensated for by insurance or otherwise.

"(B) HEALTH INSURANCE MAY NOT BE PURCHASED FROM ACCOUNT.—

"(i) IN GENERAL.—Subparagraph (A) shall not apply to any payment for insurance.

"(ii) EXCEPTIONS.—Clause (i) shall not apply to any expense for coverage under—

"(I) a health plan during any period of continuation coverage required under any Federal law,

"(II) a qualified long-term care insurance contract (as defined in section 7702B(b)), or

"(III) a health plan during a period in which the individual is receiving unemployment compensation under any Federal or State law.

"(3) ACCOUNT HOLDER.—The term 'account holder' means the individual on whose behalf the medical savings account was established.

"(4) CERTAIN RULES TO APPLY.—Rules similar to the following rules shall apply for purposes of this section:

"(A) Section 219(d)(2) (relating to no deduction for rollovers).

"(B) Section 219(f)(3) (relating to time when contributions deemed made).

"(C) Except as provided in section 106(b), section 219(f)(5) (relating to employer payments).

"(D) Section 408(g) (relating to community property laws).

"(E) Section 408(h) (relating to custodial accounts).

"(e) TAX TREATMENT OF ACCOUNTS.—

"(1) IN GENERAL.—A medical savings account is exempt from taxation under this subtitle unless such account has ceased to be a medical savings account by reason of paragraph (2) or (3). Notwithstanding the preceding sentence, any such account is subject to the taxes imposed by section 511 (relating to imposition of tax on unrelated business income of charitable, etc. organizations).

"(2) ACCOUNT TERMINATIONS.—Rules similar to the rules of paragraphs (2) and (4) of section 408(e) shall apply to medical savings accounts, and any amount treated as distributed under such rules shall be treated as not used to pay qualified medical expenses.

"(f) TAX TREATMENT OF DISTRIBUTIONS.—

"(1) AMOUNTS USED FOR QUALIFIED MEDICAL EXPENSES.—

"(A) IN GENERAL.—Any amount paid or distributed out of a medical savings account which is used exclusively to pay qualified medical expenses of any account holder (or any spouse or dependent of the holder) shall not be includible in gross income.

"(B) TREATMENT AFTER DEATH OF ACCOUNT HOLDER.—

"(i) TREATMENT IF HOLDER IS SPOUSE.—If, after the death of the account holder, the account holder's interest is payable to (or for the benefit of) the holder's spouse, the medical savings account shall be treated as if the spouse were the account holder.

"(ii) TREATMENT IF DESIGNATED HOLDER IS NOT SPOUSE.—In the case of an account holder's interest in a medical savings account which is payable to (or for the benefit of) any person other than such holder's spouse upon the death of such holder—

"(I) such account shall cease to be a medical savings account as of the date of death, and

"(II) an amount equal to the fair market value of the assets in such account on such date shall be includible if such person is not the estate of such holder, in such person's gross income for the taxable year which includes such date, or if such person is the estate of such holder, in such holder's gross income for the last taxable year of such holder.

"(2) INCLUSION OF AMOUNTS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

"(A) IN GENERAL.—Any amount paid or distributed out of a medical savings account which is not used exclusively to pay the qualified medical expenses of the account holder or of the spouse or dependents of such holder shall be included in the gross income of such holder.

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

"(i) all medical savings accounts of the account holder shall be treated as 1 account,

"(ii) all payments and distributions during any taxable year shall be treated as 1 distribution, and

"(iii) any distribution of property shall be taken into account at its fair market value on the date of the distribution.

"(3) EXCESS CONTRIBUTIONS RETURNED BEFORE DUE DATE OF RETURN.—If the aggregate contributions (other than rollover contributions) for a taxable year to the medical savings accounts of an individual exceed the amount allowable as a deduction under this section for such contributions, paragraph (2) shall not apply to distributions from such accounts (in an amount not greater than such excess) if—

"(A) such distribution is received by the individual on or before the last day prescribed by law (including extensions of time) for filing such individual's return for such taxable year, and

"(B) such distribution is accompanied by the amount of net income attributable to such excess contribution.

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

"(4) PENALTY FOR DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

"(A) IN GENERAL.—The tax imposed by this chapter on the account holder for any taxable year in which there is a payment or distribution from a medical savings account of such holder which is includible in gross income

under paragraph (2) shall be increased by 10 percent of the amount which is so includible.

"(B) EXCEPTION FOR DISABILITY OR DEATH.—Subparagraph (A) shall not apply if the payment or distribution is made after the account holder becomes disabled within the meaning of section 72(m)(7) or dies.

"(C) EXCEPTION FOR DISTRIBUTIONS AFTER AGE 59½.—Subparagraph (A) shall not apply to any payment or distribution after the date on which the account holder attains age 59½.

"(5) ROLLOVER CONTRIBUTION.—An amount is described in this paragraph as a rollover contribution if it meets the requirements of subparagraphs (A) and (B).

"(A) IN GENERAL.—Paragraph (2) shall not apply to any amount paid or distributed from a medical savings account to the account holder to the extent the amount received is paid into a medical savings account for the benefit of such holder not later than the 60th day after the day on which the holder receives the payment or distribution.

"(B) LIMITATION.—This paragraph shall not apply to any amount described in subparagraph (A) received by an individual from a medical savings account if, at any time during the 1-year period ending on the day of such receipt, such individual received any other amount described in subparagraph (A) from a medical savings account which was not includible in the individual's gross income because of the application of this paragraph.

"(6) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—For purposes of determining the amount of the deduction under section 213, any payment or distribution out of a medical savings account for qualified medical expenses shall not be treated as an expense paid for medical care.

"(7) TRANSFER OF ACCOUNT INCIDENT TO DIVORCE.—The transfer of an individual's interest in a medical savings account to an individual's spouse or former spouse under a divorce or separation instrument described in subparagraph (A) of section 71(b)(2) shall not be considered a taxable transfer made by such individual notwithstanding any other provision of this subtitle, and such interest shall, after such transfer, be treated as a medical savings account with respect to which the spouse is the account holder.

"(g) COST-OF-LIVING ADJUSTMENT.—

"(1) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1997, each dollar amount in subsection (b)(1), (c)(2), or (d)(1)(A) shall be increased by an amount equal to—

"(A) such dollar amount, multiplied by

"(B) the medical care cost adjustment for such calendar year.

If any increase under the preceding sentence is not a multiple of $50, such increase shall be rounded to the nearest multiple of $50.

"(2) MEDICAL CARE COST ADJUSTMENT.—For purposes of paragraph (1), the medical care cost adjustment for any calendar year is the percentage (if any) by which—

"(A) the medical care component of the Consumer Price Index (as defined in section 1(f)(5)) for August of the preceding calendar year, exceeds

"(B) such component for August of 1996.

"(h) REPORTS.—The Secretary may require the trustee of a medical savings account to make such reports regarding such account to the Secretary and to the account holder with respect to contributions, distributions, and such other matters as the Secretary determines appropriate. The reports required by this subsection shall be filed at such time and in such manner and furnished to such individuals at such time and in such manner as may be required by those regulations."

(b) DEDUCTION ALLOWED WHETHER OR NOT INDIVIDUAL ITEMIZES OTHER DEDUCTIONS.—Subsection (a) of section 62 is amended by inserting after paragraph (15) the following new paragraph:

"(16) MEDICAL SAVINGS ACCOUNTS.—The deduction allowed by section 220."

(c) EXCLUSIONS FOR EMPLOYER CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

(1) EXCLUSION FROM INCOME TAX.—The text of section 106 (relating to contributions by employer to accident and health plans) is amended to read as follows:

"(a) GENERAL RULE.—Except as otherwise provided in this section, gross income of an employee does not include employer-provided coverage under an accident or health plan.

"(b) CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

"(1) IN GENERAL.—In the case of an employee who is an eligible individual, gross income does not include amounts contributed by such employee's employer to any medical savings account of such employee.

"(2) COORDINATION WITH DEDUCTION LIMITATION.—The amount excluded from the gross income of an employee under this subsection for any taxable year shall not exceed the limitation under section 220(b)(1) (determined without regard to this subsection) which is applicable to such employee for such taxable year.

"(3) NO CONSTRUCTIVE RECEIPT.—No amount shall be included in the gross income of any employee solely because the employee may choose between the contributions referred to in paragraph (1) and employer contributions to another health plan of the employer.

"(4) SPECIAL RULE FOR DEDUCTION OF EMPLOYER CONTRIBUTIONS.—Any employer contribution to a medical savings account, if otherwise allowable as a deduction under this chapter, shall be allowed only for the taxable year in which paid.

"(5) DEFINITIONS.—For purposes of this subsection, the terms 'eligible individual' and 'medical savings account' have the respective meanings given to such terms by section 220."

(2) EXCLUSION FROM EMPLOYMENT TAXES.—

(A) SOCIAL SECURITY TAXES.—

(i) Subsection (a) of section 3121 is amended by striking "or" at the end of paragraph (20), by striking the period at the end of paragraph (21) and inserting "; or", and by inserting after paragraph (21) the following new paragraph:

"(22) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b)."

(ii) Subsection (a) of section 209 of the Social Security Act is amended by striking "or" at the end of paragraph (17), by striking the period at the end of paragraph (18) and inserting "; or", and by inserting after paragraph (18) the following new paragraph:

"(19) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b) of the Internal Revenue Code of 1986."

(B) RAILROAD RETIREMENT TAX.—Subsection (e) of section 3231 is amended by adding at the end the following new paragraph:

"(10) MEDICAL SAVINGS ACCOUNT CONTRIBUTIONS.—The term 'compensation' shall not include any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b)."

(C) UNEMPLOYMENT TAX.—Subsection (b) of section 3306 is amended by striking "or" at the end of paragraph (15), by striking the period at the end of paragraph (16) and inserting "; or", and by inserting after paragraph (16) the following new paragraph:

"(17) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b)."

(D) WITHHOLDING TAX.—Subsection (a) of section 3401 is amended by striking "or" at the end of paragraph (19), by striking the period at the end of paragraph (20) and inserting "; or", and by inserting after paragraph (20) the following new paragraph:

"(21) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b)."

(d) MEDICAL SAVINGS ACCOUNT CONTRIBUTIONS NOT AVAILABLE UNDER CAFETERIA PLANS.—Subsection (f) of section 125 of such Code is amended by inserting "106(b)," before "117".

(e) EXCLUSION OF MEDICAL SAVINGS ACCOUNTS FROM ESTATE TAX.—Part IV of subchapter A of chapter 11 is amended by adding at the end the following new section:

"SEC. 2057. MEDICAL SAVINGS ACCOUNTS.

"For purposes of the tax imposed by section 2001, the value of the taxable estate shall be determined by deducting from the value of the gross estate an amount equal to the value of any medical savings account (as defined in section 220(d)) included in the gross estate."

(f) TAX ON EXCESS CONTRIBUTIONS.—Section 4973 (relating to tax on excess contributions to individual retirement accounts, certain section 403(b) contracts, and certain individual retirement annuities) is amended—

(1) by inserting "medical savings accounts," after "accounts," in the heading of such section,

(2) by striking "or" at the end of paragraph (1) of subsection (a),

(3) by redesignating paragraph (2) of subsection (a) as paragraph (3) and by inserting after paragraph (1) the following:

"(2) a medical savings account (within the meaning of section 220(d)), or", and

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

"(d) EXCESS CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—For purposes of this section, in the case of a medical savings accounts (within the meaning of section 220(d)), the term 'excess contributions' means the sum of—

"(1) the amount by which the amount contributed for the taxable year to the accounts (other than rollover contributions described in section 220(f)(5)) exceeds the amount allowable as a deduction under section 220 for such contributions, and

"(2) the amount determined under this subsection for the preceding taxable year, reduced by the sum of distributions out of the account included in gross income under section 220(f) (2) or (3) and the excess (if any) of the maximum amount allowable as a deduction under section 220 for the taxable year over the amount contributed to the accounts.

For purposes of this subsection, any contribution which is distributed out of the medical savings account in a distribution to which section 220(f)(3) applies shall be treated as an amount not contributed."

(g) TAX ON PROHIBITED TRANSACTIONS.—

(1) Section 4975 (relating to tax on prohibited transactions) is amended by adding at the end of subsection (c) the following new paragraph:

"(4) SPECIAL RULE FOR MEDICAL SAVINGS ACCOUNTS.—An individual for whose benefit a medical savings account (within the meaning of section 220(d)) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a medical savings account by reason of the application of section 220(e)(2) to such account."

(2) Paragraph (1) of section 4975(e) is amended to read as follows:

"(1) PLAN.—For purposes of this section, the term 'plan' means—

"(A) a trust described in section 401(a) which forms a part of a plan, or a plan described in section 403(a), which trust or plan is exempt from tax under section 501(a),

"(B) an individual retirement account described in section 408(a),

"(C) an individual retirement annuity described in section 408(b),

"(D) a medical savings account described in section 220(d), or

"(E) a trust, plan, account, or annuity which, at any time, has been determined by the Secretary to be described in any preceding subparagraph of this paragraph."

(h) FAILURE TO PROVIDE REPORTS ON MEDICAL SAVINGS ACCOUNTS.—

(1) Subsection (a) of section 6693 (relating to failure to provide reports on individual retirement accounts or annuities) is amended to read as follows:

"(a) REPORTS.—

"(1) IN GENERAL.—If a person required to file a report under a provision referred to in paragraph (2) fails to file such report at the time and in the manner required by such provision, such person shall pay a penalty of $50 for each failure unless it is shown that such failure is due to reasonable cause.

"(2) PROVISIONS.—The provisions referred to in this paragraph are—

"(A) subsections (i) and (l) of section 408 (relating to individual retirement plans), and

"(B) section 220(h) (relating to medical savings accounts)."

(i) EXCEPTION FROM CAPITALIZATION OF POLICY ACQUISITION EXPENSES.—Subparagraph (B) of section 848(e)(1) (defining specified insurance contract) is amended by striking "and" at the end of clause (ii), by striking the period at the end of clause (iii) and inserting ", and", and by adding at the end the following new clause:

"(iv) any contract which is a medical savings account (as defined in section 220(d))."

(j) CLERICAL AMENDMENTS.—

(1) The table of sections for part VII of subchapter B of chapter 1 is amended by striking the last item and inserting the following:

"Sec. 220. Medical savings accounts.
"Sec. 221. Cross reference."

(2) The table of sections for part IV of subchapter A of chapter 11 is amended by adding at the end the following new item:

"Sec. 2057. Medical savings accounts."

(k) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1996.

Subtitle B—Increase in Deduction for Health Insurance Costs of Self-Employed Individuals

SEC. 311. INCREASE IN DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

(a) IN GENERAL.—Paragraph (1) of section 162(l) is amended to read as follows:

"(1) ALLOWANCE OF DEDUCTION.—

"(A) IN GENERAL.—In the case of an individual who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an amount equal to the applicable percentage of the amount paid during the taxable year for insurance which constitutes medical care for the taxpayer, his spouse, and dependents.

"(B) APPLICABLE PERCENTAGE.—For purposes of subparagraph (A), the applicable percentage shall be determined under the following table:

"For taxable years beginning in calendar year—	The applicable percentage is—
1998	35 percent
1999, 2000, or 2001	40 percent
2002	45 percent
2003 or thereafter	50 percent."

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 1997.

Subtitle C—Long-Term Care Services and Contracts

PART I—GENERAL PROVISIONS

SEC. 321. TREATMENT OF LONG-TERM CARE INSURANCE.

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

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

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

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

"(2) amounts (other than policyholder dividends, as defined in section 808, or premium refunds) received under a qualified long-term care insurance contract shall be treated as amounts received for personal injuries and sickness and shall be treated as reimbursement for expenses actually incurred for medical care (as defined in section 213(d)),

"(3) any plan of an employer providing coverage under a qualified long-term care insurance contract shall be treated as an accident and health plan with respect to such coverage,

"(4) except as provided in subsection (e)(3), amounts paid for a qualified long-term care insurance contract providing the benefits described in subsection (b)(2)(A) shall be treated as payments made for insurance for purposes of section 213(d)(1)(D), and

"(5) a qualified long-term care insurance contract shall be treated as a guaranteed renewable contract subject to the rules of section 816(e).

"(b) QUALIFIED LONG-TERM CARE INSURANCE CONTRACT.—For purposes of this title—

"(1) IN GENERAL.—The term 'qualified long-term care insurance contract' means any insurance contract if—

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

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

"(C) such contract is guaranteed renewable,

"(D) such contract does not provide for a cash surrender value or other money that can be—

"(i) paid, assigned, or pledged as collateral for a loan, or

"(ii) borrowed,

other than as provided in subparagraph (E) or paragraph (2)(C),

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

"(F) such contract meets the requirements of subsection (f).

"(2) SPECIAL RULES.—

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

"(B) SPECIAL RULES RELATING TO MEDICARE.—

"(i) Paragraph (1)(B) shall not apply to expenses which are reimbursable under title XVIII of the Social Security Act only as a secondary payor.

"(ii) No provision of law shall be construed or applied so as to prohibit the offering of a qualified long-term care insurance contract on the basis that the contract coordinates its benefits with those provided under such title.

"(C) REFUNDS OF PREMIUMS.—Paragraph (1)(E) shall not apply to any refund on the death of the insured, or on a complete surrender or cancellation of the contract, which cannot exceed the aggregate premiums paid under the contract. Any refund on a complete surrender or cancellation of the contract shall be includible in gross income to the extent that any deduction or exclusion was allowable with respect to the premiums.

"(c) QUALIFIED LONG-TERM CARE SERVICES.—For purposes of this section—

"(1) IN GENERAL.—The term 'qualified long-term care services' means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, which—

"(A) are required by a chronically ill individual, and

"(B) are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

"(2) CHRONICALLY ILL INDIVIDUAL.—

"(A) IN GENERAL.—The term 'chronically ill individual' means any individual who has been certified by a licensed health care practitioner as—

"(i) being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living for a period of at least 90 days due to a loss of functional capacity,

"(ii) having a level of disability similar (as determined by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in clause (i), or

"(iii) requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment.

Such term shall not include any individual otherwise meeting the requirements of the preceding sentence unless within the preceding 12-month period a licensed health care practitioner has certified that such individual meets such requirements.

"(B) ACTIVITIES OF DAILY LIVING.—For purposes of subparagraph (A), each of the following is an activity of daily living:

"(i) Eating.

"(ii) Toileting.

"(iii) Transferring.

"(iv) Bathing.

"(v) Dressing.

"(vi) Continence.

Nothing in this section shall be construed to require a contract to take into account all of the preceding activities of daily living.

"(3) MAINTENANCE OR PERSONAL CARE SERVICES.—The term 'maintenance or personal care services' means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

"(4) LICENSED HEALTH CARE PRACTITIONER.—The term 'licensed health care practitioner' means any physician (as defined in section 1861(r)(1) of the Social Security Act) and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary.

"(d) AGGREGATE PAYMENTS IN EXCESS OF LIMITS.—

"(1) IN GENERAL.—If the aggregate amount of periodic payments under all qualified long-term care insurance contracts with respect to an insured for any period exceeds the dollar amount in effect for such period under paragraph (3), such excess payments shall be treated as made for qualified long-term care services only to the extent of the costs incurred by the payee (not otherwise compensated for by insurance or otherwise) for qualified long-term care services provided during such period for such insured.

"(2) PERIODIC PAYMENTS.—For purposes of paragraph (1), the term 'periodic payment' means any payment (whether on a periodic basis or otherwise) made without regard to the extent of the costs incurred by the payee for qualified long-term care services.

"(3) DOLLAR AMOUNT.—The dollar amount in effect under this subsection shall be $175 per day (or the equivalent amount in the case of payments on another periodic basis).

"(4) INFLATION ADJUSTMENT.—In the case of a calendar year after 1997, the dollar amount contained in paragraph (3) shall be increased at the same time and in the same manner as amounts are increased pursuant to section 213(d)(10).

"(e) TREATMENT OF COVERAGE PROVIDED AS PART OF A LIFE INSURANCE CONTRACT.—Except as otherwise provided in regulations prescribed by the Secretary, in the case of any long-term care insurance coverage (whether or not qualified) provided by a rider on or as part of a life insurance contract—

"(1) IN GENERAL.—This section shall apply as if the portion of the contract providing such coverage is a separate contract.

"(2) APPLICATION OF 7702.—Section 7702(c)(2) (relating to the guideline premium limitation) shall be applied by increasing the guideline premium limitation with respect to a life insurance contract, as of any date—

"(A) by the sum of any charges (but not premium payments) against the life insurance contract's cash surrender value (within the meaning of section 7702(f)(2)(A)) for such coverage made to that date under the contract, less

"(B) any such charges the imposition of which reduces the premiums paid for the contract (within the meaning of section 7702(f)(1)).

"(3) APPLICATION OF SECTION 213.—No deduction shall be allowed under section 213(a) for charges against the life insurance contract's cash surrender value described in paragraph (2), unless such charges are includible in income as a result of the application of section 72(e)(10) and the rider is a qualified long-term care insurance contract under subsection (b).

"(4) PORTION DEFINED.—For purposes of this subsection, the term 'portion' means only the terms and benefits under a life insurance contract that are in addition to the terms and benefits under the contract without regard to the coverage under a qualified long-term care insurance contract."

(b) LONG-TERM CARE INSURANCE NOT PERMITTED UNDER CAFETERIA PLANS OR FLEXIBLE SPENDING ARRANGEMENTS.—

(1) CAFETERIA PLANS.—Section 125(f) is amended by adding at the end the following new sentence: "Such term shall not include any long-term care insurance contract (as defined in section 4980C)."

(2) FLEXIBLE SPENDING ARRANGEMENTS.—Section 106 (relating to contributions by employer to accident and health plans), as amended by section 301(c), is amended by adding at the end the following new subsection:

"(c) INCLUSION OF LONG-TERM CARE BENEFITS PROVIDED THROUGH FLEXIBLE SPENDING ARRANGEMENTS.—

"(1) IN GENERAL.—Effective on and after January 1, 1997, gross income of an employee shall include employer-provided coverage for qualified long-term care services (as defined in section 7702B(c)) to the extent that such coverage is provided through a flexible spending or similar arrangement.

"(2) FLEXIBLE SPENDING ARRANGEMENT.—For purposes of this subsection, a flexible spending arrangement is a benefit program which provides employees with coverage under which—

"(A) specified incurred expenses may be reimbursed (subject to reimbursement maximums and other reasonable conditions), and

"(B) the maximum amount of reimbursement which is reasonably available to a participant for such coverage is less than 500 percent of the value of such coverage.

In the case of an insured plan, the maximum amount reasonably available shall be determined on the basis of the underlying coverage."

(c) CONTINUATION COVERAGE EXCISE TAX NOT TO APPLY.—Subsection (f) of section 4980B is amended by adding at the end the following new paragraph:

"(9) CONTINUATION OF LONG-TERM CARE COVERAGE NOT REQUIRED.—A group health plan shall not be treated as failing to meet the requirements of this subsection solely by reason of failing to provide coverage under any qualified long-term care insurance contract (as defined in section 7702B(b))."

(d) CLERICAL AMENDMENT.—The table of sections for chapter 79 is amended by inserting after the item relating to section 7702A the following new item:

"Sec. 7702B. Treatment of qualified long-term care insurance.".

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to contracts issued after December 31, 1996.

(2) CONTINUATION OF EXISTING POLICIES.—In the case of any contract issued before January 1, 1997, which met the long-term care insurance requirements of the State in which the contract was situsued at the time the contract was issued—

(A) such contract shall be treated for purposes of the Internal Revenue Code of 1986 as a qualified long-term care insurance contract (as defined in section 7702B(b) of such Code), and

(B) services provided under, or reimbursed by, such contract shall be treated for such purposes as qualified long-term care services (as defined in section 7702B(c) of such Code).

(3) EXCHANGES OF EXISTING POLICIES.—If, after the date of enactment of this Act and before January 1, 1998, a contract providing for long-term care insurance coverage is exchanged solely for a qualified long-term care insurance contract (as defined in section 7702B(b) of such Code), no gain or loss shall be recognized on the exchange. If, in addition to a qualified long-term care insurance contract, money or other property is received in the exchange, then any gain shall be recognized to the extent of the sum of the money and the fair market value of the other property received. For purposes of this paragraph, the cancellation of a contract providing for long-term care insurance coverage and reinvestment of the cancellation proceeds in a qualified long-term care insurance contract within 60 days thereafter shall be treated as an exchange.

(4) ISSUANCE OF CERTAIN RIDERS PERMITTED.—For purposes of applying sections 101(f), 7702, and 7702A of the Internal Revenue Code of 1986 to any contract—

(A) the issuance of a rider which is treated as a qualified long-term care insurance contract under section 7702B, and

(B) the addition of any provision required to conform any other long-term care rider to be so treated,

shall not be treated as a modification or material change of such contract.

SEC. 322. QUALIFIED LONG-TERM CARE SERVICES TREATED AS MEDICAL CARE.

(a) GENERAL RULE.—Paragraph (1) of section 213(d) (defining medical care) is amended by striking "or" at the end of subparagraph (B), by redesignating subparagraph (C) as subparagraph (D), and by inserting after subparagraph (B) the following new subparagraph:

"(C) for qualified long-term care services (as defined in section 7702B(c)), or".

(b) TECHNICAL AMENDMENTS.—

(1) Subparagraph (D) of section 213(d)(1) (as redesignated by subsection (a)) is amended by inserting before the period "or for any qualified long-term care insurance contract (as defined in section 7702B(b))".

(2)(A) Paragraph (1) of section 213(d) is amended by adding at the end the following new flush sentence:

"In the case of a qualified long-term care insurance contract (as defined in section 7702B(b)), only eligible long-term care premiums (as defined in paragraph (10)) shall be taken into account under subparagraph (D)."

(B) Subsection (d) of section 213 is amended by adding at the end the following new paragraphs:

"(10) ELIGIBLE LONG-TERM CARE PREMIUMS.—

"(A) IN GENERAL.—For purposes of this section, the term 'eligible long-term care premiums' means the amount paid during a taxable year for any qualified long-term care insurance contract (as defined in section 7702B(b)) covering an individual, to the extent such amount does not exceed the limitation determined under the following table:

"In the case of an individual with an attained age before the close of the taxable year of:	The limitation is:
40 or less	$ 200
More than 40 but not more than 50	375
More than 50 but not more than 60	750
More than 60 but not more than 70	2,000
More than 70	2,500.

"(B) INDEXING.—

"(i) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1997, each dollar amount contained in subparagraph (A) shall be increased by the medical care cost adjustment of such amount for such calendar year. If any increase determined under the preceding sentence is not a multiple of $10, such increase shall be rounded to the nearest multiple of $10.

"(ii) MEDICAL CARE COST ADJUSTMENT.—For purposes of clause (i), the medical care cost adjustment for any calendar year is the percentage (if any) by which—

"(I) the medical care component of the Consumer Price Index (as defined in section 1(f)(5)) for August of the preceding calendar year, exceeds

"(II) such component for August of 1996.

The Secretary shall, in consultation with the Secretary of Health and Human Services, prescribe an adjustment which the Secretary determines is more appropriate for purposes of this paragraph than the adjustment described in the preceding sentence, and the adjustment so prescribed shall apply in lieu of the adjustment described in the preceding sentence.

"(11) CERTAIN PAYMENTS TO RELATIVES TREATED AS NOT PAID FOR MEDICAL CARE.—An amount paid for a qualified long-term care service (as defined in section 7702B(c)) provided to an individual shall be treated as not paid for medical care if such service is provided—

"(A) by the spouse of the individual or by a relative (directly or through a partnership, corporation, or other entity) unless the service is provided by a licensed professional with respect to such service, or

"(B) by a corporation or partnership which is related (within the meaning of section 267(b) or 707(b)) to the individual.

For purposes of this paragraph, the term 'relative' means an individual bearing a relationship to the individual which is described in any of paragraphs (1) through (8) of section 152(a). This paragraph shall not apply for purposes of section 105(b) with respect to reimbursements through insurance."

(3) Paragraph (6) of section 213(d) is amended—

(A) by striking "subparagraphs (A) and (B)" and inserting "subparagraphs (A), (B), and (C)", and

(B) by striking "paragraph (1)(C)" in subparagraph (A) and inserting "paragraph (1)(D)".

(4) Paragraph (7) of section 213(d) is amended by striking "subparagraphs (A) and (B)" and inserting "subparagraphs (A), (B), and (C)".

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to taxable years beginning after December 31, 1996.

(2) DEDUCTION FOR LONG-TERM CARE SERVICES.—Amounts paid for qualified long-term care services (as defined in section 7702B(c) of the Internal Revenue Code of 1986, as added by this Act) furnished in any taxable year beginning before January 1, 1998, shall not be taken into account under section 213 of the Internal Revenue Code of 1986.

SEC. 323. REPORTING REQUIREMENTS.

(a) IN GENERAL.—Subpart B of part III of subchapter A of chapter 61 is amended by adding at the end the following new section:

"SEC. 6050Q. CERTAIN LONG-TERM CARE BENEFITS.

"(a) REQUIREMENT OF REPORTING.—Any person who pays long-term care benefits shall make a return, according to the forms or regulations prescribed by the Secretary, setting forth—

"(1) the aggregate amount of such benefits paid by such person to any individual during any calendar year, and

"(2) the name, address, and TIN of such individual.

"(b) STATEMENTS TO BE FURNISHED TO PERSONS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required to be set forth in such return a written statement showing—

"(1) the name of the person making the payments, and

"(2) the aggregate amount of long-term care benefits paid to the individual which are required to be shown on such return.

The written statement required under the preceding sentence shall be furnished to the individual on or before January 31 of the year following the calendar year for which the return under subsection (a) was required to be made.

"(c) LONG-TERM CARE BENEFITS.—For purposes of this section, the term 'long-term care benefit' means—

"(1) any amount paid under a long-term care insurance policy (within the meaning of section 4980C(e)), and

"(2) payments which are excludable from gross income by reason of section 101(g).".

(b) PENALTIES.—

(1) Subparagraph (B) of section 6724(d)(1) is amended by redesignating clauses (ix) through (xiv) as clauses (x) through (xv), respectively, and by inserting after clause (viii) the following new clause:

"(ix) section 6050Q (relating to certain long-term care benefits),".

(2) Paragraph (2) of section 6724(d) is amended by redesignating subparagraphs (Q) through (T) as subparagraphs (R) through (U), respectively, and by inserting after subparagraph (P) the following new subparagraph:

"(Q) section 6050Q(b) (relating to certain long-term care benefits),".

(c) CLERICAL AMENDMENT.—The table of sections for subpart B of part III of subchapter A of chapter 61 is amended by adding at the end the following new item:

"Sec. 6050Q. Certain long-term care benefits."

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to benefits paid after December 31, 1996.

PART II—CONSUMER PROTECTION PROVISIONS

SEC. 325. POLICY REQUIREMENTS.

Section 7702B (as added by section 321) is amended by adding at the end the following new subsection:

"(f) CONSUMER PROTECTION PROVISIONS.—

"(1) IN GENERAL.—The requirements of this subsection are met with respect to any contract if any long-term care insurance policy issued under the contract meets—

"(A) the requirements of the model regulation and model Act described in paragraph (2),

"(B) the disclosure requirement of paragraph (3), and

"(C) the requirements relating to nonforfeitability under paragraph (4).

"(2) REQUIREMENTS OF MODEL REGULATION AND ACT.—

"(A) IN GENERAL.—The requirements of this paragraph are met with respect to any policy if such policy meets—

"(i) MODEL REGULATION.—The following requirements of the model regulation:

"(I) Section 7A (relating to guaranteed renewal or noncancellability), and the requirements of section 6B of the model Act relating to such section 7A.

"(II) Section 7B (relating to prohibitions on limitations and exclusions).

"(III) Section 7C (relating to extension of benefits).

"(IV) Section 7D (relating to continuation or conversion of coverage).

"(V) Section 7E (relating to discontinuance and replacement of policies).

"(VI) Section 8 (relating to unintentional lapse).

"(VII) Section 9 (relating to disclosure), other than section 9F thereof.

"(VIII) Section 10 (relating to prohibitions against post-claims underwriting).

"(IX) Section 11 (relating to minimum standards).

"(X) Section 12 (relating to requirement to offer inflation protection), except that any requirement for a signature on a rejection of inflation protection shall permit the signature to be on an application or on a separate form.

"(XI) Section 23 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

"(ii) MODEL ACT.—The following requirements of the model Act:

"(I) Section 6C (relating to preexisting conditions).

"(II) Section 6D (relating to prior hospitalization).

"(B) DEFINITIONS.—For purposes of this paragraph—

"(i) MODEL PROVISIONS.—The terms 'model regulation' and 'model Act' mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of January 1993).

"(ii) COORDINATION.—Any provision of the model regulation or model Act listed under clause (i) or (ii) of subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision.

"(iii) DETERMINATION.—For purposes of this section and section 4980C, the determination of whether any requirement of a model regulation or the model Act has been met shall be made by the Secretary.

"(3) DISCLOSURE REQUIREMENT.—The requirement of this paragraph is met with respect to any policy if such policy meets the requirements of section 4980C(d)(1).

"(4) NONFORFEITURE REQUIREMENTS.—

"(A) IN GENERAL.—The requirements of this paragraph are met with respect to any level premium long-term care insurance policy, if the issuer of such policy offers to the policyholder, including any group policyholder, a nonforfeiture provision meeting the requirements of subparagraph (B).

"(B) REQUIREMENTS OF PROVISION.—The nonforfeiture provision required under subparagraph (A) shall meet the following requirements:

"(i) The nonforfeiture provision shall be appropriately captioned.

"(ii) The nonforfeiture provision shall provide for a benefit available in the event of a default in the payment of any premiums and the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying policies approved by the Secretary for the same policy form.

"(iii) The nonforfeiture provision shall provide at least one of the following:

"(I) Reduced paid-up insurance.

"(II) Extended term insurance.

"(III) Shortened benefit period.

"(IV) Other similar offerings approved by the Secretary.

"(5) LONG-TERM CARE INSURANCE POLICY DEFINED.—For purposes of this subsection, the term 'long-term care insurance policy' has the meaning given such term by section 4980C(e).".

SEC. 326. REQUIREMENTS FOR ISSUERS OF LONG-TERM CARE INSURANCE POLICIES.

(a) IN GENERAL.—Chapter 43 is amended by adding at the end the following new section:

"SEC. 4980C. REQUIREMENTS FOR ISSUERS OF LONG-TERM CARE INSURANCE POLICIES.

"(a) GENERAL RULE.—There is hereby imposed on any person failing to meet the requirements of subsection (c) or (d) a tax in the amount determined under subsection (b).

"(b) AMOUNT.—

"(1) IN GENERAL.—The amount of the tax imposed by subsection (a) shall be $100 per policy for each day any requirements of subsection (c) or (d) are not met with respect to each long-term care insurance policy.

"(2) WAIVER.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that payment of the tax would be excessive relative to the failure involved.

"(c) RESPONSIBILITIES.—The requirements of this subsection are as follows:

"(1) REQUIREMENTS OF MODEL PROVISIONS.—

"(A) MODEL REGULATION.—The following requirements of the model regulation must be met:

"(i) Section 13 (relating to application forms and replacement coverage).

"(ii) Section 14 (relating to reporting requirements), except that the issuer shall also report at least annually the number of claims denied during the reporting period for each class of business (expressed as a percentage of claims denied), other than claims denied for failure to meet the waiting period or because of any applicable preexisting condition.

"(iii) Section 20 (relating to filing requirements for marketing).

"(iv) Section 21 (relating to standards for marketing), including inaccurate completion of medical histories, other than sections 21C(1) and 21C(6) thereof, except that—

"(I) in addition to such requirements, no person shall, in selling or offering to sell a long-term care insurance policy, misrepresent a material fact; and

"(II) no such requirements shall include a requirement to inquire or identify whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance.

"(v) Section 22 (relating to appropriateness of recommended purchase).

"(vi) Section 24 (relating to standard format outline of coverage).

"(vii) Section 25 (relating to requirement to deliver shopper's guide).

"(B) MODEL ACT.—The following requirements of the model Act must be met:

"(i) Section 6F (relating to right to return), except that such section shall also apply to denials of applications and any refund shall be made within 30 days of the return or denial.

"(ii) Section 6G (relating to outline of coverage).

"(iii) Section 6H (relating to requirements for certificates under group plans).

"(iv) Section 6I (relating to policy summary).

"(v) Section 6J (relating to monthly reports on accelerated death benefits).

"(vi) Section 7 (relating to incontestability period).

"(C) DEFINITIONS.—For purposes of this paragraph, the terms 'model regulation' and 'model Act' have the meanings given such terms by section 7702B(f)(2)(B).

"(2) DELIVERY OF POLICY.—If an application for a long-term care insurance policy (or for a certificate under a group long-term care insurance policy) is approved, the issuer shall deliver to the applicant (or policyholder or certificateholder) the policy (or certificate) of insurance not later than 30 days after the date of the approval.

"(3) INFORMATION ON DENIALS OF CLAIMS.—If a claim under a long-term care insurance policy is denied, the issuer shall, within 60 days of the date of a written request by the policyholder or certificateholder (or representative)—

"(A) provide a written explanation of the reasons for the denial, and

"(B) make available all information directly relating to such denial.

"(d) DISCLOSURE.—The requirements of this subsection are met if the issuer of a long-term care insurance policy discloses in such policy and in the outline of coverage required under subsection (c)(1)(B)(ii) that the policy is intended to be a qualified long-term care insurance contract under section 7702B(b).

"(e) LONG-TERM CARE INSURANCE POLICY DEFINED.—For purposes of this section, the term 'long-term care insurance policy' means any product which is advertised, marketed, or offered as long-term care insurance.".

(b) CONFORMING AMENDMENT.—The table of sections for chapter 43 is amended by adding at the end the following new item:

"Sec. 4980C. Requirements for issuers of long-term care insurance policies.".

SEC. 327. COORDINATION WITH STATE REQUIREMENTS.

Nothing in this part shall prevent a State from establishing, implementing, or continuing in effect standards related to the protection of policyholders of long-term care insurance policies (as defined in section 4980C(e) of the Internal Revenue Code of 1986), if such standards are not in conflict with or inconsistent with the standards established under such Code.

SEC. 328. EFFECTIVE DATES.

(a) IN GENERAL.—The provisions of, and amendments made by, this part shall apply to contracts issued after December 31, 1996. The provisions of section 321(g) (relating to transition rule) shall apply to such contracts.

(b) ISSUERS.—The amendments made by section 326 shall apply to actions taken after December 31, 1996.

Subtitle D—Treatment of Accelerated Death Benefits

SEC. 331. TREATMENT OF ACCELERATED DEATH BENEFITS BY RECIPIENT.

(a) IN GENERAL.—Section 101 (relating to certain death benefits) is amended by adding at the end the following new subsection:

"(g) TREATMENT OF CERTAIN ACCELERATED DEATH BENEFITS.—

"(1) IN GENERAL.—For purposes of this section, the following amounts shall be treated as an amount paid by reason of the death of an insured:

"(A) Any amount received under a life insurance contract on the life of an insured who is a terminally ill individual.

"(B) Any amount received under a life insurance contract on the life of an insured who is a chronically ill individual (as defined in section 7702B(c)(2)) but only if such amount is received under a rider or other provision of such contract which is treated as a qualified long-term care insurance contract under section 7702B and such amount is treated under section 7702B (after the application of subsection (d) thereof) as a payment for qualified long-term care services (as defined in such section).

"(2) TREATMENT OF VIATICAL SETTLEMENTS.—

"(A) IN GENERAL.—In the case of a life insurance contract on the life of an insured described in paragraph (1), if—

"(i) any portion of such contract is sold to any viatical settlement provider, or

"(ii) any portion of the death benefit is assigned to such a provider, the amount paid for such sale or assignment shall be treated as an amount paid under the life insurance contract by reason of the death of such insured.

"(B) VIATICAL SETTLEMENT PROVIDER.—The term 'viatical settlement provider' means any person regularly engaged in the trade or business of purchasing, or taking assignments of, life insurance contracts on the lives of insureds described in paragraph (1) if—

"(i) such person is licensed for such purposes in the State in which the insured resides, or

"(ii) in the case of an insured who resides in a State not requiring the licensing of such persons for such purposes—

"(I) such person meets the requirements of sections 8 and 9 of the Viatical Settlements Model Act of the National Association of Insurance Commissioners, and

"(II) meets the requirements of the Model Regulations of the National Association of Insurance Commissioners (relating to standards for evaluation of reasonable payments) in determining amounts paid by such person in connection with such purchases or assignments.

"(3) DEFINITIONS.—For purposes of this subsection—

"(A) TERMINALLY ILL INDIVIDUAL.—The term 'terminally ill individual' means an individual who has been certified by a physician as having an illness or physical condition which can reasonably be expected to result in death in 24 months or less after the date of the certification.

"(B) PHYSICIAN.—The term 'physician' has the meaning given to such term by section 1861(r)(1) of the Social Security Act (42 U.S.C. 1395x(r)(1)).

"(4) EXCEPTION FOR BUSINESS-RELATED POLICIES.—This subsection shall not apply in the case of any amount paid to any taxpayer other than the insured if such taxpayer has an insurable interest with respect to the life of the insured by reason of the insured being a director, officer, or employee of the taxpayer or by reason of the insured being financially interested in any trade or business carried on by the taxpayer."

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to amounts received after December 31, 1996.

SEC. 332. TAX TREATMENT OF COMPANIES ISSUING QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.

(a) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—Section 818 (relating to other definitions and special rules) is amended by adding at the end the following new subsection:

"(g) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—For purposes of this part—

"(1) IN GENERAL.—Any reference to a life insurance contract shall be treated as including a reference to a qualified accelerated death benefit rider on such contract.

"(2) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.—For purposes of this subsection, the term 'qualified accelerated death benefit rider' means any rider on a life insurance contract if the only payments under the rider are payments meeting the requirements of section 101(g).

"(3) EXCEPTION FOR LONG-TERM CARE RIDERS.—Paragraph (1) shall not apply to any rider which is treated as a long-term care insurance contract under section 7702B."

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by this section shall take effect on January 1, 1997.

(2) ISSUANCE OF RIDER NOT TREATED AS MATERIAL CHANGE.—For purposes of applying sections 101(f), 7702, and 7702A of the Internal Revenue Code of 1986 to any contract—

(A) the issuance of a qualified accelerated death benefit rider (as defined in section 818(g) of such Code (as added by this Act)), and

(B) the addition of any provision required to conform an accelerated death benefit rider to the requirements of such section 818(g),

shall not be treated as a modification or material change of such contract.

Subtitle E—High-Risk Pools

SEC. 341. EXEMPTION FROM INCOME TAX FOR STATE-SPONSORED ORGANIZATIONS PROVIDING HEALTH COVERAGE FOR HIGH-RISK INDIVIDUALS.

(a) IN GENERAL.—Subsection (c) of section 501 (relating to list of exempt organizations) is amended by adding at the end the following new paragraph:

"(26) Any membership organization if—

"(A) such organization is established by a State exclusively to provide coverage for medical care (as defined in section 213(d)) on a not-for-profit basis to individuals described in subparagraph (B) through—

"(i) insurance issued by the organization, or

"(ii) a health maintenance organization under an arrangement with the organization,

"(B) the only individuals receiving such coverage through the organization are individuals—

"(i) who are residents of such State, and

"(ii) who, by reason of the existence or history of a medical condition, are unable to acquire medical care coverage for such condition through insurance or from a health maintenance organization or are able to acquire such coverage only at a rate which is substantially in excess of the rate for such coverage through the membership organization,

"(C) the composition of the membership in such organization is specified by such State, and

"(D) no part of the net earnings of the organization inures to the benefit of any private shareholder or individual."

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 1996.

Subtitle F—Organizations Subject to Section 833

SEC. 351. ORGANIZATIONS SUBJECT TO SECTION 833.

(a) IN GENERAL.—Section 833(c) (relating to organization to which section applies) is amended by adding at the end the following new paragraph:

"(4) TREATMENT AS EXISTING BLUE CROSS OR BLUE SHIELD ORGANIZATION.—

"(A) IN GENERAL.—Paragraph (2) shall be applied to an organization described in subparagraph (B) as if it were a Blue Cross or Blue Shield organization.

"(B) APPLICABLE ORGANIZATION.—An organization is described in this subparagraph if it—

"(i) is organized under, and governed by, State laws which are specifically and exclusively applicable to not-for-profit health insurance or health service type organizations, and

"(ii) is not a Blue Cross or Blue Shield organization or health maintenance organization.".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years ending after December 31, 1996.

TITLE IV—REVENUE OFFSETS

SEC. 400. AMENDMENT OF 1986 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 the Internal Revenue Code of 1986.

Subtitle A—Repeal of Bad Debt Reserve Method for Thrift Savings Associations

SEC. 401. REPEAL OF BAD DEBT RESERVE METHOD FOR THRIFT SAVINGS ASSOCIATIONS.

(a) IN GENERAL.—Section 593 (relating to reserves for losses on loans) is amended by adding at the end the following new subsections:

"(f) TERMINATION OF RESERVE METHOD.—Subsections (a), (b), (c), and (d) shall not apply to any taxable year beginning after December 31, 1995.

"(g) 6-YEAR SPREAD OF ADJUSTMENTS.—

"(1) IN GENERAL.—In the case of any taxpayer who is required by reason of subsection (f) to change its method of computing reserves for bad debts—

"(A) such change shall be treated as a change in a method of accounting,

"(B) such change shall be treated as initiated by the taxpayer and as having been made with the consent of the Secretary, and

"(C) the net amount of the adjustments required to be taken into account by the taxpayer under section 481(a)—

"(i) shall be determined by taking into account only applicable excess reserves, and

"(ii) as so determined, shall be taken into account ratably over the 6-taxable year period beginning with the first taxable year beginning after December 31, 1995.

"(2) APPLICABLE EXCESS RESERVES.—

"(A) IN GENERAL.—For purposes of paragraph (1), the term 'applicable excess reserves' means the excess (if any) of—

"(i) the balance of the reserves described in subsection (c)(1) (other than the supplemental reserve) as of the close of the taxpayer's last taxable year beginning before December 31, 1995, over

"(ii) the lesser of—

"(I) the balance of such reserves as of the close of the taxpayer's last taxable year beginning before January 1, 1988, or

"(II) the balance of the reserves described in subclause (I), reduced in the same manner as under section 585(b)(2)(B)(ii) on the basis of the taxable years described in clause (i) and this clause.

"(B) SPECIAL RULE FOR THRIFTS WHICH BECOME SMALL BANKS.—In the case of a bank (as defined in section 581) which was not a large bank (as

defined in section 585(c)(2)) for its first taxable year beginning after December 31, 1995—

"(i) the balance taken into account under subparagraph (A)(ii) shall not be less than the amount which would be the balance of such reserves as of the close of its last taxable year beginning before such date if the additions to such reserves for all taxable years had been determined under section 585(b)(2)(A), and

"(ii) the opening balance of the reserve for bad debts as of the beginning of such first taxable year shall be the balance taken into account under subparagraph (A)(ii) (determined after the application of clause (i) of this subparagraph).

The preceding sentence shall not apply for purposes of paragraphs (5) and (6) or subsection (e)(1).

"(3) RECAPTURE OF PRE-1988 RESERVES WHERE TAXPAYER CEASES TO BE BANK.—If, during any taxable year beginning after December 31, 1995, a taxpayer to which paragraph (1) applied is not a bank (as defined in section 581), paragraph (1) shall apply to the reserves described in paragraph (2)(A)(ii) and the supplemental reserve; except that such reserves shall be taken into account ratably over the 6-taxable year period beginning with such taxable year.

"(4) SUSPENSION OF RECAPTURE IF RESIDENTIAL LOAN REQUIREMENT MET.—

"(A) IN GENERAL.—In the case of a bank which meets the residential loan requirement of subparagraph (B) for the first taxable year beginning after December 31, 1995, or for the following taxable year—

"(i) no adjustment shall be taken into account under paragraph (1) for such taxable year, and

"(ii) such taxable year shall be disregarded in determining—

"(I) whether any other taxable year is a taxable year for which an adjustment is required to be taken into account under paragraph (1), and

"(II) the amount of such adjustment.

"(B) RESIDENTIAL LOAN REQUIREMENT.—A taxpayer meets the residential loan requirement of this subparagraph for any taxable year if the principal amount of the residential loans made by the taxpayer during such year is not less than the base amount for such year.

"(C) RESIDENTIAL LOAN.—For purposes of this paragraph, the term 'residential loan' means any loan described in clause (v) of section 7701(a)(19)(C) but only if such loan is incurred in acquiring, constructing, or improving the property described in such clause.

"(D) BASE AMOUNT.—For purposes of subparagraph (B), the base amount is the average of the principal amounts of the residential loans made by the taxpayer during the 6 most recent taxable years beginning on or before December 31, 1995. At the election of the taxpayer who made such loans during each of such 6 taxable years, the preceding sentence shall be applied without regard to the taxable year in which such principal amount was the highest and the taxable year in such principal amount was the lowest. Such an election may be made only for the first taxable year beginning after such date, and, if made for such taxable year, shall apply to the succeeding taxable year unless revoked with the consent of the Secretary.

"(E) CONTROLLED GROUPS.—In the case of a taxpayer which is a member of any controlled group of corporations described in section 1563(a)(1), subparagraph (B) shall be applied with respect to such group.

"(5) CONTINUED APPLICATION OF FRESH START UNDER SECTION 585 TRANSITIONAL RULES.—In the case of a taxpayer to which paragraph (1) applied and which was not a large bank (as defined in section 585(c)(2)) for its first taxable year beginning after December 31, 1995:

"(A) IN GENERAL.—For purposes of determining the net amount of adjustments referred to in section 585(c)(3)(A)(iii), there shall be taken into account only the excess (if any) of the reserve for bad debts as of the close of the last taxable year before the disqualification year over the balance taken into account by such taxpayer under paragraph (2)(A)(ii) of this subsection.

"(B) TREATMENT UNDER ELECTIVE CUT-OFF METHOD.—For purposes of applying section 585(c)(4)—

"(i) the balance of the reserve taken into account under subparagraph (B) thereof shall be reduced by the balance taken into account by such taxpayer under paragraph (2)(A)(ii) of this subsection, and

"(ii) no amount shall be includible in gross income by reason of such reduction.

"(6) SUSPENDED RESERVE INCLUDED AS SECTION 381(c) ITEMS.—The balance taken into account by a taxpayer under paragraph (2)(A)(ii) of this subsection and the supplemental reserve shall be treated as items described in section 381(c).

"(7) CONVERSIONS TO CREDIT UNIONS.—In the case of a taxpayer to which paragraph (1) applied which becomes a credit union described in section 501(c) and exempt from taxation under section 501(a)—

"(A) any amount required to be included in the gross income of the credit union by reason of this subsection shall be treated as derived from an unrelated trade or business (as defined in section 513), and

"(B) for purposes of paragraph (3), the credit union shall not be treated as if it were a bank.

"(8) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out this subsection and subsection (e), including regulations providing for the application of such subsections in the case of acquisitions, mergers, spin-offs, and other reorganizations."

(b) CONFORMING AMENDMENTS.—

(1) Subsection (d) of section 50 is amended by adding at the end the following new sentence:

"Paragraphs (1)(A), (2)(A), and (4) of the section 46(e) referred to in paragraph (1) of this subsection shall not apply to any taxable year beginning after December 31, 1995."

(2) Subsection (e) of section 52 is amended by striking paragraph (1) and by redesignating paragraphs (2) and (3) as paragraphs (1) and (2), respectively.

(3) Subsection (a) of section 57 is amended by striking paragraph (4).

(4) Section 246 is amended by striking subsection (f).

(5) Clause (i) of section 291(e)(1)(B) is amended by striking "or to which section 593 applies".

(6) Subparagraph (A) of section 585(a)(2) is amended by striking "other than an organization to which section 593 applies".

(7)(A) The material preceding subparagraph (A) of section 593(e)(1) is amended by striking "by a domestic building and loan association or an institution that is treated as a mutual savings bank under section 591(b)" and inserting "by a taxpayer having a balance described in subsection (g)(2)(A)(ii)".

(B) Subparagraph (B) of section 593(e)(1) is amended to read as follows:

"(B) then out of the balance taken into account under subsection (g)(2)(A)(ii) (properly adjusted for amounts charged against such reserves for taxable years beginning after December 31, 1987),".

(C) Paragraph (1) of section 593(e) is amended by adding at the end the following new sentence: "This paragraph shall not apply to any distribution of all of the stock of a bank (as defined in section 581) to another corporation if, immediately after the distribution, such bank and such other corporation are members of the same affiliated group (as defined in section 1504) and the provisions of section 5(e) of the Federal Deposit Insurance Act (as in effect on December 31, 1995) or similar provisions are in effect."

(8) Section 595 is hereby repealed.

(9) Section 596 is hereby repealed.

(10) Subsection (a) of section 860E is amended—

(A) by striking "Except as provided in paragraph (2), the" in paragraph (1) and inserting "The",

(B) by striking paragraphs (2) and (4) and redesignating paragraphs (3) and (5) as paragraphs (2) and (3), respectively, and

(C) by striking in paragraph (2) (as so redesignated) all that follows "subsection" and inserting a period.

(11) Paragraph (3) of section 992(d) is amended by striking "or 593".

(12) Section 1038 is amended by striking subsection (f).

(13) Clause (ii) of section 1042(c)(4)(B) is amended by striking "or 593".

(14) Subsection (c) of section 1277 is amended by striking "or to which section 593 applies".

(15) Subparagraph (B) of section 1361(b)(2) is amended by striking "or to which section 593 applies".

(16) The table of sections for part II of subchapter H of chapter 1 is amended by striking the items relating to sections 595 and 596.

(c) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall apply to taxable years beginning after December 31, 1995.

(2) SUBSECTION (b)(7).—The amendments made by subsection (b)(7) shall not apply to any distribution with respect to preferred stock if—

(A) such stock is outstanding at all times after October 31, 1995, and before the distribution, and

(B) such distribution is made before the date which is 1 year after the date of the enactment of this Act (or, in the case of stock which may be redeemed, if later, the date which is 30 days after the earliest date that such stock may be redeemed).

(3) SUBSECTION (b)(8).—The amendment made by subsection (b)(8) shall apply to property acquired in taxable years beginning after December 31, 1995.

(4) SUBSECTION (b)(10).—The amendments made by subsection (b)(10) shall not apply to any residual interest held by a taxpayer if such interest has been held by such taxpayer at all times after October 31, 1995.

Subtitle B—Reform of the Earned Income Credit

SEC. 411. EARNED INCOME CREDIT DENIED TO INDIVIDUALS NOT AUTHORIZED TO BE EMPLOYED IN THE UNITED STATES.

(a) IN GENERAL.—Section 32(c)(1) (relating to individuals eligible to claim the earned income credit) is amended by adding at the end the following new subparagraph:

"(F) IDENTIFICATION NUMBER REQUIREMENT.—The term 'eligible individual' does not include any individual who does not include on the return of tax for the taxable year—

"(i) such individual's taxpayer identification number, and

"(ii) if the individual is married (within the meaning of section 7703), the taxpayer identification number of such individual's spouse.".

(b) SPECIAL IDENTIFICATION NUMBER.—Section 32 is amended by adding at the end the following new subsection:

"(l) IDENTIFICATION NUMBERS.—Solely for purposes of subsections (c)(1)(F) and (c)(3)(D), a taxpayer identification number means a social security number issued to an individual by the Social Security Administration (other than a social security number issued pursuant to clause (II) (or that portion of clause (III) that relates to clause (II)) of section 205(c)(2)(B)(i) of the Social Security Act).".

(c) EXTENSION OF PROCEDURES APPLICABLE TO MATHEMATICAL OR CLERICAL ERRORS.—Section 6213(g)(2) (relating to the definition of mathematical or clerical errors) is amended by striking "and" at the end of subparagraph (D), by striking the period at the end of subparagraph (E) and inserting a comma, and by inserting after subparagraph (E) the following new subparagraphs:

"(F) an omission of a correct taxpayer identification number required under section 32 (relating to the earned income credit) to be included on a return, and

"(G) an entry on a return claiming the credit under section 32 with respect to net earnings from self-employment described in section 32(c)(2)(A) to the extent the tax imposed by section 1401 (relating to self-employment tax) on such net earnings has not been paid.".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

Subtitle C—Treatment of Individuals Who Lose United States Citizenship

SEC. 421. REVISION OF INCOME, ESTATE, AND GIFT TAXES ON INDIVIDUALS WHO LOSE UNITED STATES CITIZENSHIP.

(a) IN GENERAL.—Subsection (a) of section 877 is amended to read as follows:

"(a) TREATMENT OF EXPATRIATES.—

"(1) IN GENERAL.—Every nonresident alien individual who, within the 10-year period immediately preceding the close of the taxable year, lost United States citizenship, unless such loss did not have for 1 of its principal purposes the avoidance of taxes under this subtitle or subtitle B, shall be taxable for such taxable year in the manner provided in subsection (b) if the tax imposed pursuant to such subsection exceeds the tax which, without regard to this section, is imposed pursuant to section 871.

"(2) CERTAIN INDIVIDUALS TREATED AS HAVING TAX AVOIDANCE PURPOSE.—For purposes of paragraph (1), an individual shall be treated as having a principal purpose to avoid such taxes if—

"(A) the average annual net income tax (as defined in section 38(c)(1)) of such individual for the period of 5 taxable years ending before the date of the loss of United States citizenship is greater than $100,000, or

"(B) the net worth of the individual as of such date is $500,000 or more.

In the case of the loss of United States citizenship in any calendar year after 1996, such $100,000 and $500,000 amounts shall be increased by an amount equal to such dollar amount multiplied by the cost-of-living adjustment determined under section 1(f)(3) for such calendar year by substituting '1994' for '1992' in subparagraph (B) thereof. Any increase under the preceding sentence shall be rounded to the nearest multiple of $1,000."

(b) EXCEPTIONS.—

(1) IN GENERAL.—Section 877 is amended by striking subsection (d), by redesignating subsection (c) as subsection (d), and by inserting after subsection (b) the following new subsection:

"(c) TAX AVOIDANCE NOT PRESUMED IN CERTAIN CASES.—

"(1) IN GENERAL.—Subsection (a)(2) shall not apply to an individual if—

"(A) such individual is described in a subparagraph of paragraph (2) of this subsection, and

"(B) within the 1-year period beginning on the date of the loss of United States citizenship, such individual submits a ruling request for the Secretary's determination as to whether such loss has for 1 of its principal purposes the avoidance of taxes under this subtitle or subtitle B.

"(2) INDIVIDUALS DESCRIBED.—

"(A) DUAL CITIZENSHIP, ETC.—An individual is described in this subparagraph if—

"(i) the individual became at birth a citizen of the United States and a citizen of another country and continues to be a citizen of such other country, or

"(ii) the individual becomes (not later than the close of a reasonable period after loss of United States citizenship) a citizen of the country in which—

"(I) such individual was born,

"(II) if such individual is married, such individual's spouse was born, or

"(III) either of such individual's parents were born.

"(B) LONG-TERM FOREIGN RESIDENTS.—An individual is described in this subparagraph if, for each year in the 10-year period ending on the date of loss of United States citizenship, the individual was present in the United States for 30 days or less. The rule of section 7701(b)(3)(D)(ii) shall apply for purposes of this subparagraph.

"(C) RENUNCIATION UPON REACHING AGE OF MAJORITY.—An individual is described in this subparagraph if the individual's loss of United States citizenship occurs before such individual attains age 18½.

"(D) INDIVIDUALS SPECIFIED IN REGULATIONS.—An individual is described in this subparagraph if the individual is described in a category of individuals prescribed by regulation by the Secretary."

(2) TECHNICAL AMENDMENT.—Paragraph (1) of section 877(b) of such Code is amended by striking "subsection (c)" and inserting "subsection (d)".

(c) TREATMENT OF PROPERTY DISPOSED OF IN NONRECOGNITION TRANSACTIONS; TREATMENT OF DISTRIBUTIONS FROM CERTAIN CONTROLLED FOREIGN CORPORATIONS.—Subsection (d) of section 877, as redesignated by subsection (b), is amended to read as follows:

"(d) SPECIAL RULES FOR SOURCE, ETC.—For purposes of subsection (b)—

"(1) SOURCE RULES.—The following items of gross income shall be treated as income from sources within the United States:

"(A) SALE OF PROPERTY.—Gains on the sale or exchange of property (other than stock or debt obligations) located in the United States.

"(B) STOCK OR DEBT OBLIGATIONS.—Gains on the sale or exchange of stock issued by a domestic corporation or debt obligations of United States persons or of the United States, a State or political subdivision thereof, or the District of Columbia.

"(C) INCOME OR GAIN DERIVED FROM CONTROLLED FOREIGN CORPORATION.—Any income or gain derived from stock in a foreign corporation but only—

"(i) if the individual losing United States citizenship owned (within the meaning of section 958(a)), or is considered as owning (by applying the ownership rules of section 958(b)), at any time during the 2-year period ending on the date of the loss of United States citizenship, more than 50 percent of—

"(I) the total combined voting power of all classes of stock entitled to vote of such corporation, or

"(II) the total value of the stock of such corporation, and

"(ii) to the extent such income or gain does not exceed the earnings and profits attributable to such stock which were earned or accumulated before the loss of citizenship and during periods that the ownership requirements of clause (i) are met.

"(2) GAIN RECOGNITION ON CERTAIN EXCHANGES.—

"(A) IN GENERAL.—In the case of any exchange of property to which this paragraph applies, notwithstanding any other provision of this title, such property shall be treated as sold for its fair market value on the date of such exchange, and any gain shall be recognized for the taxable year which includes such date.

"(B) EXCHANGES TO WHICH PARAGRAPH APPLIES.—This paragraph shall apply to any exchange during the 10-year period described in subsection (a) if—

"(i) gain would not (but for this paragraph) be recognized on such exchange in whole or in part for purposes of this subtitle,

"(ii) income derived from such property was from sources within the United States (or, if no income was so derived, would have been from such sources), and

"(iii) income derived from the property acquired in the exchange would be from sources outside the United States.

"(C) EXCEPTION.—Subparagraph (A) shall not apply if the individual enters into an agreement with the Secretary which specifies that any income or gain derived from the property acquired in the exchange (or any other property which has a basis determined in whole or part by reference to such property) during such 10-year period shall be treated as from sources within the United States. If the property transferred in the exchange is disposed of by the person acquiring such property, such agreement shall terminate and any gain which was not recognized by reason of such agreement shall be recognized as of the date of such disposition.

"(D) SECRETARY MAY EXTEND PERIOD.—To the extent provided in regulations prescribed by the Secretary, subparagraph (B) shall be applied by substituting the 15-year period beginning 5 years before the loss of United States citizenship for the 10-year period referred to therein.

"(E) SECRETARY MAY REQUIRE RECOGNITION OF GAIN IN CERTAIN CASES.—To the extent provided in regulations prescribed by the Secretary—

"(i) the removal of appreciated tangible personal property from the United States, and

"(ii) any other occurrence which (without recognition of gain) results in a change in the source of the income or gain from property from sources within the United States to sources outside the United States, shall be treated as an exchange to which this paragraph applies.

"(3) SUBSTANTIAL DIMINISHING OF RISKS OF OWNERSHIP.—For purposes of determining whether this section applies to any gain on the sale or exchange of any property, the running of the 10-year period described in subsection (a) shall be suspended for any period during which the individual's risk of loss with respect to the property is substantially diminished by—

"(A) the holding of a put with respect to such property (or similar property),

"(B) the holding by another person of a right to acquire the property, or

"(C) a short sale or any other transaction."

(d) CREDIT FOR FOREIGN TAXES IMPOSED ON UNITED STATES SOURCE INCOME.—

(1) Subsection (b) of section 877 is amended by adding at the end the following new sentence: "The tax imposed solely by reason of this section shall be reduced (but not below zero) by the amount of any income, war profits, and excess profits taxes (within the meaning of section 903) paid to any foreign country or possession of the United States on any income of the taxpayer on which tax is imposed solely by reason of this section."

(2) Subsection (a) of section 877, as amended by subsection (a), is amended by inserting "(after any reduction in such tax under the last sentence of such subsection)" after "such subsection".

(e) COMPARABLE ESTATE AND GIFT TAX TREATMENT.—

(1) ESTATE TAX.—

(A) IN GENERAL.—Subsection (a) of section 2107 is amended to read as follows:

"(a) TREATMENT OF EXPATRIATES.—

"(1) RATE OF TAX.—A tax computed in accordance with the table contained in section 2001 is hereby imposed on the transfer of the taxable estate, determined as provided in section 2106, of every decedent nonresident not a citizen of the United States if, within the 10-year period ending with the date of death, such decedent lost United States citizenship, unless such loss did not have for 1 of its principal purposes the avoidance of taxes under this subtitle or subtitle A.

"(2) CERTAIN INDIVIDUALS TREATED AS HAVING TAX AVOIDANCE PURPOSE.—

"(A) IN GENERAL.—For purposes of paragraph (1), an individual shall be treated as having a principal purpose to avoid such taxes if such individual is so treated under section 877(a)(2).

"(B) EXCEPTION.—Subparagraph (A) shall not apply to a decedent meeting the requirements of section 877(c)(1)."

(B) CREDIT FOR FOREIGN DEATH TAXES.—Subsection (c) of section 2107 is amended by redesignating paragraph (2) as paragraph (3) and by inserting after paragraph (1) the following new paragraph:

"(2) CREDIT FOR FOREIGN DEATH TAXES.—

"(A) IN GENERAL.—The tax imposed by subsection (a) shall be credited with the amount of any estate, inheritance, legacy, or succession taxes actually paid to any foreign country in respect of any property which is included in the gross estate solely by reason of subsection (b).

"(B) LIMITATION ON CREDIT.—The credit allowed by subparagraph (A) for such taxes paid to a foreign country shall not exceed the lesser of—

"(i) the amount which bears the same ratio to the amount of such taxes actually paid to such foreign country in respect of property included in the gross estate as the value of the property included in the gross estate solely by reason of subsection (b) bears to the value of all property subjected to such taxes by such foreign country, or

"(ii) such property's proportionate share of the excess of—

"(I) the tax imposed by subsection (a), over

"(II) the tax which would be imposed by section 2101 but for this section.

"(C) PROPORTIONATE SHARE.—For purposes of subparagraph (B), a property's proportionate share is the percentage of the value of the property which is included in the gross estate solely by reason of subsection (b) bears to the total value of the gross estate."

(C) EXPANSION OF INCLUSION IN GROSS ESTATE OF STOCK OF FOREIGN CORPORATIONS.—Paragraph (2) of section 2107(b) is amended by striking "more than 50 percent of" and all that follows and inserting "more than 50 percent of—

"(A) the total combined voting power of all classes of stock entitled to vote of such corporation, or

"(B) the total value of the stock of such corporation,".

(2) GIFT TAX.—

(A) IN GENERAL.—Paragraph (3) of section 2501(a) is amended to read as follows:

"(3) EXCEPTION.—

"(A) CERTAIN INDIVIDUALS.—Paragraph (2) shall not apply in the case of a donor who, within the 10-year period ending with the date of transfer, lost United States citizenship, unless such loss did not have for 1 of its principal purposes the avoidance of taxes under this subtitle or subtitle A.

"(B) CERTAIN INDIVIDUALS TREATED AS HAVING TAX AVOIDANCE PURPOSE.—For purposes of subparagraph (A), an individual shall be treated as having a principal purpose to avoid such taxes if such individual is so treated under section 877(a)(2).

"(C) EXCEPTION FOR CERTAIN INDIVIDUALS.—Subparagraph (B) shall not apply to a decedent meeting the requirements of section 877(c)(1).

"(D) CREDIT FOR FOREIGN GIFT TAXES.—The tax imposed by this section solely by reason of this paragraph shall be credited with the amount of any gift tax actually paid to any foreign country in respect of any gift which is taxable under this section solely by reason of this paragraph."

(f) COMPARABLE TREATMENT OF LAWFUL PERMANENT RESIDENTS WHO CEASE TO BE TAXED AS RESIDENTS.—

(1) IN GENERAL.—Section 877 is amended by redesignating subsection (e) as subsection (f) and by inserting after subsection (d) the following new subsection:

"(e) COMPARABLE TREATMENT OF LAWFUL PERMANENT RESIDENTS WHO CEASE TO BE TAXED AS RESIDENTS.—

"(1) IN GENERAL.—Any long-term resident of the United States who—

"(A) ceases to be a lawful permanent resident of the United States (within the meaning of section 7701(b)(6)), or

"(B) commences to be treated as a resident of a foreign country under the provisions of a tax treaty between the United States and the foreign country and who does not waive the benefits of such treaty applicable to residents of the foreign country,

shall be treated for purposes of this section and sections 2107, 2501, and 6039F in the same manner as if such resident were a citizen of the United States who lost United States citizenship on the date of such cessation or commencement.

"(2) LONG-TERM RESIDENT.—For purposes of this subsection, the term 'long-term resident' means any individual (other than a citizen of the United States) who is a lawful permanent resident of the United States in at least 8 taxable years during the period of 15 taxable years ending with the taxable year during which the event described in subparagraph (A) or (B) of paragraph (1) occurs. For purposes of the preceding sentence, an individual shall not be treated as a lawful permanent resident for any taxable year if such individual is treated as a resident of a foreign country for the taxable year under the provisions of a tax treaty between the United States and the foreign country and does not waive the benefits of such treaty applicable to residents of the foreign country.

"(3) SPECIAL RULES.—

"(A) EXCEPTIONS NOT TO APPLY.—Subsection (c) shall not apply to an individual who is treated as provided in paragraph (1).

"(B) STEP-UP IN BASIS.—Solely for purposes of determining any tax imposed by reason of this subsection, property which was held by the long-term resident on the date the individual first became a resident of the United States shall be treated as having a basis on such date of not less than the fair market value of such property on such date. The preceding sentence shall not apply if the individual elects not to have such sentence apply. Such an election, once made, shall be irrevocable.

"(4) AUTHORITY TO EXEMPT INDIVIDUALS.—This subsection shall not apply to an individual who is described in a category of individuals prescribed by regulation by the Secretary.

"(5) REGULATIONS.—The Secretary shall prescribe such regulations as may be appropriate to carry out this subsection, including regulations providing for the application of this subsection in cases where an alien individual becomes a resident of the United States during the 10-year period after being treated as provided in paragraph (1)."

(2) CONFORMING AMENDMENTS.—

(A) Section 2107 is amended by striking subsection (d), by redesignating subsection (e) as subsection (d), and by inserting after subsection (d) (as so redesignated) the following new subsection:

"(e) CROSS REFERENCE.—

"For comparable treatment of long-term lawful permanent residents who ceased to be taxed as residents, see section 877(e)."

(B) Paragraph (3) of section 2501(a) (as amended by subsection (e)) is amended by adding at the end the following new subparagraph:

"(E) CROSS REFERENCE.—

"For comparable treatment of long-term lawful permanent residents who ceased to be taxed as residents, see section 877(e)."

(g) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to—

(A) individuals losing United States citizenship (within the meaning of section 877 of the Internal Revenue Code of 1986) on or after February 6, 1995, and

(B) long-term residents of the United States with respect to whom an event described in subparagraph (A) or (B) of section 877(e)(1) of such Code occurs on or after February 6, 1995.

(2) SPECIAL RULE.—

(A) IN GENERAL.—In the case of an individual who performed an act of expatriation specified in paragraph (1), (2), (3), or (4) of section 349(a) of

the Immigration and Nationality Act (8 U.S.C. 1481(a)(1)–(4)) before February 6, 1995, but who did not, on or before such date, furnish to the United States Department of State a signed statement of voluntary relinquishment of United States nationality confirming the performance of such act, the amendments made by this section and section 11349 shall apply to such individual except that—

(i) the 10-year period described in section 877(a) of such Code shall not expire before the end of the 10-year period beginning on the date such statement is so furnished, and

(ii) the 1-year period referred to in section 877(c) of such Code, as amended by this section, shall not expire before the date which is 1 year after the date of the enactment of this Act.

(B) EXCEPTION.—Subparagraph (A) shall not apply if the individual establishes to the satisfaction of the Secretary of the Treasury that such loss of United States citizenship occurred before February 6, 1994.

SEC. 422. INFORMATION ON INDIVIDUALS LOSING UNITED STATES CITIZENSHIP.

(a) IN GENERAL.—Subpart A of part III of subchapter A of chapter 61 is amended by inserting after section 6039E the following new section:

"SEC. 6039F. INFORMATION ON INDIVIDUALS LOSING UNITED STATES CITIZENSHIP.

"(a) IN GENERAL.—Notwithstanding any other provision of law, any individual who loses United States citizenship (within the meaning of section 877(a)) shall provide a statement which includes the information described in subsection (b). Such statement shall be—

"(1) provided not later than the earliest date of any act referred to in subsection (c), and

"(2) provided to the person or court referred to in subsection (c) with respect to such act.

"(b) INFORMATION TO BE PROVIDED.—Information required under subsection (a) shall include—

"(1) the taxpayer's TIN,

"(2) the mailing address of such individual's principal foreign residence,

"(3) the foreign country in which such individual is residing,

"(4) the foreign country of which such individual is a citizen,

"(5) in the case of an individual having a net worth of at least the dollar amount applicable under section 877(a)(2)(B), information detailing the assets and liabilities of such individual, and

"(6) such other information as the Secretary may prescribe.

"(c) ACTS DESCRIBED.—For purposes of this section, the acts referred to in this subsection are—

"(1) the individual's renunciation of his United States nationality before a diplomatic or consular officer of the United States pursuant to paragraph (5) of section 349(a) of the Immigration and Nationality Act (8 U.S.C. 1481(a)(5)),

"(2) the individual's furnishing to the United States Department of State a signed statement of voluntary relinquishment of United States nationality confirming the performance of an act of expatriation specified in paragraph (1), (2), (3), or (4) of section 349(a) of the Immigration and Nationality Act (8 U.S.C. 1481(a)(1)–(4)),

"(3) the issuance by the United States Department of State of a certificate of loss of nationality to the individual, or

"(4) the cancellation by a court of the United States of a naturalized citizen's certificate of naturalization.

"(d) PENALTY.—Any individual failing to provide a statement required under subsection (a) shall be subject to a penalty for each year (of the 10-year period beginning on the date of loss of United States citizenship) during any portion of which such failure continues in an amount equal to the greater of—

"(1) 5 percent of the tax required to be paid under section 877 for the taxable year ending during such year, or

"(2) $1,000,

unless it is shown that such failure is due to reasonable cause and not to willful neglect.

"(e) INFORMATION TO BE PROVIDED TO SECRETARY.—Notwithstanding any other provision of law—

"(1) any Federal agency or court which collects (or is required to collect) the statement under subsection (a) shall provide to the Secretary—

"(A) a copy of any such statement, and

"(B) the name (and any other identifying information) of any individual refusing to comply with the provisions of subsection (a),

"(2) the Secretary of State shall provide to the Secretary a copy of each certificate as to the loss of American nationality under section 358 of the Immigration and Nationality Act which is approved by the Secretary of State, and

"(3) the Federal agency primarily responsible for administering the immigration laws shall provide to the Secretary the name of each lawful permanent resident of the United States (within the meaning of section 7701(b)(6)) whose status as such has been revoked or has been administratively or judicially determined to have been abandoned.

Notwithstanding any other provision of law, not later than 30 days after the close of each calendar quarter, the Secretary shall publish in the Federal Register the name of each individual losing United States citizenship (within the meaning of section 877(a)) with respect to whom the Secretary receives information under the preceding sentence during such quarter.

"(f) REPORTING BY LONG-TERM LAWFUL PERMANENT RESIDENTS WHO CEASE TO BE TAXED AS RESIDENTS.—In lieu of applying the last sentence of subsection (a), any individual who is required to provide a statement under this section by reason of section 877(e)(1) shall provide such statement with the return of tax imposed by chapter 1 for the taxable year during which the event described in such section occurs.

"(g) EXEMPTION.—The Secretary may by regulations exempt any class of individuals from the requirements of this section if he determines that applying this section to such individuals is not necessary to carry out the purposes of this section."

(b) CLERICAL AMENDMENT.—The table of sections for such subpart A is amended by inserting after the item relating to section 6039E the following new item:

"Sec. 6039F. Information on individuals losing United States citizenship."

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to—

(1) individuals losing United States citizenship (within the meaning of section 877 of the Internal Revenue Code of 1986) on or after February 6, 1995, and

(2) long-term residents of the United States with respect to whom an event described in subparagraph (A) or (B) of section 877(e)(1) of such Code occurs on or after such date.

In no event shall any statement required by such amendments be due before the 90th day after the date of the enactment of this Act.

SEC. 423. REPORT ON TAX COMPLIANCE BY UNITED STATES CITIZENS AND RESIDENTS LIVING ABROAD.

Not later than 90 days after the date of the enactment of this Act, the Secretary of the Treasury shall prepare and submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report—

(1) describing the compliance with subtitle A of the Internal Revenue Code of 1986 by citizens and lawful permanent residents of the United States (within the meaning of section 7701(b)(6) of such Code) residing outside the United States, and

(2) recommending measures to improve such compliance (including improved coordination between executive branch agencies).

A. Purpose and Summary

H.R. 3103 (the "Health Coverage Availability and Affordability Act of 1996"), as amended, includes titles relating to improving the availability and portability of health insurance coverage (Title I), preventing health care fraud and health care administrative simplification (Title II), tax-related health provisions (Title III), and providing certain revenue offsets for the bill (Title IV).

Title I. Improved Availability and Portability of Health Insurance Coverage

Title I of the bill provides for portability of coverage for previously covered individuals, eliminates or reduces preexisting condition limitation periods, prohibits exclusions based on health status, gives States flexibility to provide greater health care protec-

tion, and extends the excise tax for failure to satisfy the health care continuation rules to failures to comply with the rules.

Title II. Preventing Health Care Fraud and Abuse; Administrative Simplification

Title II of the bill establishes a national health care fraud and abuse control program to coordinate Federal, State and local law enforcement to combat health care plan fraud, extends certain criminal penalties for violations, increases funding for investigations, reviews and prosecutions relating to health care plans, and improves the efficiency and effectiveness of the health care system by encouraging the development of a health care network through the establishment of standards and requirements for the electronic transmission of certain health information.

Title III. Tax-Related Health Provisions

Title III of the bill provides the following tax-related health provisions:

Medical savings accounts.—The bill allows, within certain limits, individuals covered by a high deductible health plan to make tax deductible contributions to a medical savings account ("MSA"). Within the same limits, contributions to an MSA are excludable from income (and wages for social security purposes) if made by the employer of an eligible individual. Earnings on amounts in an MSA are not currently taxable. Distributions from an MSA for medical expenses are not taxable.

Deduction for health insurance costs of self-employed individuals.—The bill increases the deduction for health insurance costs of self-employed individuals from the current 30 percent to 35 percent for 1998, 40 percent for 1999–2001, 45 percent for 2002, and 50 percent for 2003 and thereafter.

Long-term care insurance provisions.—Under the bill, amounts received under a long-term care insurance contract are excludable from gross income (subject to an annual dollar limit in the case of per diem type contracts). Unreimbursed expenses for qualified long-term care services and long-term care insurance premiums not exceeding specified dollar limits (based on the individual's age) are treated as medical expenses for purposes of the itemized deduction for medical expenses. Employer-provided long-term care insurance is excludable from income, except if provided through a cafeteria plan. In addition, long-term care insurance contracts (and issuers of contracts) are required to satisfy certain consumer protection provisions.

Accelerated benefits under life insurance contracts.—The bill extends the present-law exclusion from income for amounts paid under a life insurance contract by reason of the death of the insured to accelerated death benefits and viatical settlements paid with respect to certain terminally ill and chronically ill insured individuals.

High-risk pools.—The bill provides tax-exempt status to membership organizations that are established by a State exclusively to provide coverage for medical care on a nonprofit basis to certain high-risk individuals.

Health insurance organizations under Code section 833.—The bill allows certain group health insurance organizations to be treated as "Blue Cross/Blue Shield" organizations for purposes of Code section 833.

Title IV. Revenue Offsets

Title IV of the bill provides certain revenue offsets for the bill to avoid increasing the budget deficit:

Bad debt deduction for thrift institutions.—The bill repeals the Code section 593 deduction for bad debt reserves for thrift institutions, effective for taxable years beginning after 1995. Thrift institutions required to change their method of accounting for bad debt reserves will not be required to recapture the portion of their bad debt reserves accumulated before 1988.

Earned income credit provisions.—The bill denies the earned income credit (EIC) to individuals not authorized to be employed in the United States, and also if the individual does not include a taxpayer identification number on the tax return. The bill also applies the math error procedures to failures to provide a correct tax identification number and in the case of a taxpayer who claims the EIC with respect to net earnings from self-employment and fails to pay the proper amount of self-employment tax on such net earnings.

Revision of expatriation tax rules.—The bill expands and substantially strengthens the present-law provisions that subject U.S. citizens who lose their citizenship for tax avoidance purposes to special tax rules for 10 years after such loss of citizenship. The bill extends the expatriation tax provisions to apply to certain long-term residents of the United States whose U.S. residency is terminated, subjects certain individuals to the expatriation tax provisions without inquiry as to their motive for losing their U.S. citizenship or residency, expands the categories of income and gains that are taxed under the expatriation tax provisions, and provides relief from double taxation in circumstances where another country imposes tax on items that would be taxed under the expatriation tax provisions. The bill also contains information reporting and sharing rules to enhance compliance with the expatriation tax provisions, and directs the Treasury Department to undertake a study of U.S. tax compliance by individuals living abroad.

B. Background and Need for Legislation

Today, over 39 million Americans lack health insurance coverage. From 1965 to 1995, health care spending has grown at an average annual rate of 11.2% over twice the average annual rate of growth in spending as measured in the Consumer Price Index for all items and services. Largely because of the cost factor, which is harder for many small firms to absorb, the rate of employment-based coverage ranges from 92% of workers in firms of 1,000-plus employees to only 67% in the smallest firms of 10 or fewer workers. Any effort to maintain the employer-based health insurance system, while increasing coverage, necessarily must focus on increasing health insurance coverage among those who own and work for small businesses.

One specific concern of the public about employer-based health insurance is that breadwinners may lose their coverage or the cov-

erage for a dependent if they change jobs. Frequently, employees will require that new employees go through a pre-existing condition waiting period when they become eligible for an employer's group health plan. The fear that many have of losing coverage during a pre-existing waiting period because of the health status of the worker or one of their dependents, results in "job-lock" for many Americans. They simply cannot afford to lose health insurance coverage for even a short time, and thus are not able to consider changes in employment. In periods of downsizing and other changes in the employment market, this problem becomes even more compelling because many will have no choice but to switch jobs thereby risking pre-existing condition limitation rules, even at the risk of great personal cost.

Separately, with respect to long-term care, Americans spend over $70 billion a year on nursing home care. Medicaid covers over half of all spending for nursing homes and many of those covered by Medicaid "spent down" their personal savings and other resources in order to qualify for assistance. In addition, many Americans who are not in nursing homes require assistance simply to perform basic activities of daily living. If they had purchased long-term care insurance, many of those Americans could have remained more independent instead of being forced to rely on Medicaid or family members who may have to pay all or part of the costs of their long-term care.

Additionally, in their efforts to contain the health insurance premium costs for their employees, employers have chosen two major strategies. Employers are either turning to managed care plans to provide coverage of their employees, or increasing employee cost sharing in their health insurance. For employers and employees who want to make more of their own health care decisions, these alternatives do not offer the choices many Americans want. An alternative for employers and employees would be combining a high deductible health insurance plan with a medical savings account (MSA). The personal management of the funds in the MSA allows the plan participants to take a more active role in their health care spending, and provides them greater freedom in making cost effective decisions about their medical care. This option, however, does not currently have favored tax consideration comparable to that of conventionally purchased employer-based health coverage, so the use of this alternative has not spread widely.

In order to address the problem of health care cost inflation and make insurance more affordable, it is important to focus on key sources affecting levels of the underlying health care costs. Two key sources of excessive cost are medical fraud and abuse, and the current medical paperwork burden.

According to the General Accounting Office (GAO), as much as 10 percent of total health care costs are lost to fraudulent or abusive practices by unscrupulous health care providers. The GAO reports that only a small fraction of the fraud and abuse committed in the health care system is identified and dealt with. Federal funding for prevention, detection, and prosecutions of the perpetrators of health care fraud and abuse has not kept pace with the problem. Coordination of the various law enforcement agencies at the federal and state levels has been insufficient, and law enforce-

ment agencies agree that penalties for health care fraud and abuse should be increased.

The demand by third party payers and others involved in reviewing medical claims for documentation regarding claims has increased the paperwork burden on those payers, health care providers, employers, and enrollees in health plans. As health care claims information moves to a "paperless" system it is critical for efficiency and cost saving that uniform standards for that information be adopted. The lack of uniform data standards for financial and administrative information is a barrier of modernizing health care information systems as well as obtaining the savings that moderation can provide.

In response to these specific problems of availability and affordability of health insurance in the United States, the Ways and Means Committee has targeted the reforms it has adopted in H.R. 3103. H.R. 3103 specifically addresses the concerns outlined here including promoting coverage in the small employer group coverage, ensuring portability of health insurance from one job to the next, providing for a new tax consideration of medical savings accounts, clarifying tax consideration of long-term care insurance and expenses, providing additional funding, coordination and penalties against fraud and abuse, and establishing a process for administrative simplification. The bill further makes these reforms in a budget neutral manner with savings from increased federal fraud and abuse efforts and revenue provisions.

H.R. 3103 is the culmination of the Committee's work in the current Congress on health care reform. The Committees on Commerce, Economic and Educational Opportunities, and Judiciary are developing health care reform measures to complement the Ways and Means Committee's efforts to increase the availability and affordability of health insurance.

C. Legislative History

H.R. 3103 was introduced by Chairman Archer and Mr. Thomas on March 18, 1996, and was amended by the Committee in a markup on March 19, 1996. The bill, as amended, was ordered favorably reported on March 19, 1996, by a roll call vote of 25–11.

Provisions substantially similar to the tax-related provisions of the bill (except for the provision relating to the COBRA tax sanctions and the high-risk pool provision) were previously included in legislation approved by the Committee and passed by the Congress in H.R. 2491, the "Balanced Budget Act of 1995" (see conference report, H. Rept. 104–350, November 16, 1995), which was vetoed by the President. The revenue provision relating to bad debt deductions of thrift institutions also was reported by the Committee in H.R. 2494 (H. Rept. 104–324, November 7, 1995). A substantially similar revenue provision relating to expatriation tax rules also was reported by the Committee in H.R. 1812 (H. Rept. 104–145, June 16, 1995).

Provisions substantially similar to the fraud and abuse provisions of the bill were previously included in legislation approved by the Committee and passed by the Congress in H.R. 2425, the "Medicare Preservation Act of 1995" (see conference report H. Rept. 104–276, October 16, 1995), and H.R. 2491, "The Balanced Budget

Act of 1995" (see conference report, H. Rept. 104–350, November 16, 1995), which was vetoed by the President. Provisions substantially similar to the administrative simplification provisions of the bill were also reported by the Committee in H.R. 2425 (H. Rept. 104–276), and H.R. 2491 (H. Rept. 104–350).

The Health Subcommittee held hearings on several substantially similar provisions of the bill in 1995 including: Long Term Care Provisions in the "Contract with America" (Rept. 104–1, January 20, 1995), Health Insurance Premium Tax Deductions for the Self-Employed, (January 17, 1995), Health Insurance Portability (Rept. 104–32, May 12, 1995), and H.R. 1818, The Family Medical Savings and Investment Act (June 27, 1995).

In addition to the roll call votes on amendments (as shown in Part III of this report), the Committee approved the following provisions by voice vote as amendments to Chairman Archer's amendment in the nature of a substitute: En bloc amendments by Mrs. Johnson to Title I relating to (1) shorter look-back period for determination of preexisting condition, (2) shorter eligibility periods, (3) nondiscrimination on the basis of genetic information, (4) shorter look-back periods for State preemption, and (5) counting government programs as qualifying previous coverage.

Amendment to Title I by Mr. English to state that the scope of health insurance coverage includes conditions arising out of acts of domestic violence.

Amendment to Title III by Mr. Houghton to add a new section relating to the tax treatment of certain health insurance organizations under Code section 833.

Amendment by Mr. Ensign to (1) Title III to treat qualified long-term care expenses as deductible medical expenses and (2) Title IV to add provisions regarding expatriation tax rules as a revenue offset to (1).

Amendment by Mr. Shaw to strike section 412 of the bill (relating to increases in tax return preparer penalties).

Further, the Committee approved by voice vote the Chairman's amendment in the nature of a substitute, as amended.

II. EXPLANATION OF THE BILL

TITLE I.—IMPROVED AVAILABILITY AND PORTABILITY OF HEALTH INSURANCE COVERAGE

SUBTITLE A—COVERAGE UNDER GROUP HEALTH PLANS

Present law

Group health plans often exclude coverage for a period of time for services related to a preexisting medical condition of a newly covered employee or his or her dependents regardless of previous health insurance coverage. As a result, individuals changing jobs may face gaps in insurance coverage for themselves or family members with ongoing health problems, even when both jobs provide similar health benefits. Coverage gaps are even more likely in the individual market. Most individual insurance policies impose preexisting condition exclusions or limitations; individuals with chronic health conditions may be entirely denied coverage.

Current federal law does not impose any requirements on employers to provide or contribute toward the health insurance coverage of their employees or their employees' dependents. However, specific Federal requirements do apply to existing employer-sponsored health plans.

The Employee Retirement Income Security Act of 1974 (ERISA) imposes Federal requirements on most employer-sponsored health plans. Exempt from ERISA are health benefit plans that are provided by Federal, State and local governments, churches, and certain educational organization plans. The ERISA requirements on health benefit plans relate to reporting and disclosure obligations, and fiduciary standards. Also applicable to health plans are ERISA provisions relating to claims review and enforcement. In addition, ERISA extends certain nondiscrimination protections to participants in employer-sponsored health plans.

OBRA of 1993 (P.L. 103–66) amended ERISA to require existing employer health plans to comply with State laws relating to medical child support orders. The 1993 law also amended ERISA to require employers with existing plans providing dependent coverage to cover adopted children. In addition, employer plans were prohibited from reducing coverage for the cost of pediatric vaccines below that provided on May 1, 1993.

ERISA does not regulate the content and design of health plans provided by employers. This is up to the employer in negotiation with the employer's workforce. Moreover, under section 514 of ERISA, States are preempted from regulating employee health benefit plans. Accordingly, while plans purchased by employers from insurers must comply with State insurance law and regulations, self-insured employers are relatively free to structure their plans as they desire, or through the collective bargaining process, if their employees are represented by a union. (Self-insured plans are those in which the employer assumes all or some of the risk for paying claims, instead of paying premiums to an insurance company which in turn assumes the risk.)

Employer sponsored health plans (be they insured or self-insured) must also comply with the health insurance continuation provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, P.L. 99–272). COBRA requires that employers with 20 or more employees offer employees and their dependents continued coverage under the employer's group health plan in the case of certain qualifying events, such as termination from employment, reduction in hours, or a change in family status. The duration of coverage is 18 to 36 months depending on the qualifying event. The employer may require the eligible participant or beneficiary to pay 102% of the total premium. The requirements under COBRA are enforced through the Internal Revenue Code (section 4980B), ERISA, and for State and local government plans, the Public Health Service (PHS) Act. Under the Internal Revenue Code provisions, noncomplying employers are subject to an excise tax. Under ERISA, individuals may bring a civil action against the plan or the employer to recover benefits due, enforce rights, or to clarify rights to future benefits. Noncomplying plans may also be fined by the Department of Labor. Under the PHS Act, an individual who is aggrieved may bring an action for appropriate equitable relief.

In OBRA of 1993 (P.L. 103–66), Congress provided for the COBRA tax penalties to apply to plans that failed to continue paying as much for the costs of pediatric immunizations as they had prior to May 1, 1993.

Additional federal laws also apply. For example, self-insured employer health plans must comply with nondiscrimination requirements under section 105(h) of the Internal Revenue Code. Under a 1978 amendment to the Civil Rights Act (P.L. 95–555), it is unlawful for an employer to discriminate between men and women with regard to fringe benefits. The effect of this law is to prohibit existing employer health plans covering 15 or more employees from discriminating on the basis of pregnancy, child birth, or related conditions. Finally, under a series of amendments to the Social Security Act, (beginning with the Omnibus Budget Reconciliation Act of 1981), employer health plans must be the first payer of health services in the event that an employee or other eligible beneficiary is also eligible for Medicare.

Regulation of the business of insurance has traditionally been left to the states and presently there is no Federal law regulating the terms of sale of private insurance by insurers sold to small or large employers. One exception is that the federal government regulates certain health maintenance organizations (HMOs) that have elected to meet certain federal financial, organizational, and operational standards and become a "qualified HMO" under title XIII of the Public Health Service Act. Non-federally qualified HMOs are regulated under state law.

In recent years, most states have adopted small group health insurance market reform laws that are identical or similar to a model law issued by the National Association of Insurance Commissioners (NAIC) in 1992, and revised in 1995. These laws seek to ensure greater availability, portability, and more affordable coverage in the small group market. A much smaller number of states have enacted laws providing for reform of the individual (nongroup) health insurance market. These too are aimed at expanding the availability of coverage and making it more portable and affordable. However, under the federal preemption provision of ERISA (section 514), these state laws do not apply to employer-sponsored health plans. They only apply to insurance that is sold to employers and directly to individuals. As a result, employees covered under self-insured (i.e., self-funded) employer plans are not subject to state insurance laws.

Sec. 101. Portability of Coverage for Previously Covered Individuals

Reasons for change

One of the most compelling issues faced by workers and their families is the problem referred to as "job-lock." Job-lock occurs when breadwinners are reluctant to take new jobs or pursue new career opportunities because doing so could result in a loss of health insurance coverage because they or one of their dependents have medical conditions that existed prior to their change in employment. Further, if a breadwinner is facing lay-offs, involuntary transfers or other types of employment dislocations, they still must cope with the potential loss of health insurance coverage, even if

the worker seeks and secures a new position. This occurs because employers or insurers may choose to impose preexisting condition exclusions on individuals (or their dependents, if family coverage is offered), when the worker changes jobs. Such exclusions can be time-limited, but sometimes they are permanent, causing the potential of genuine hardship for some.

To place this problem in context, it is important to understand that employer-based health insurance is the principal source of health insurance protection in the United States. After paid vacations, health insurance is the most common fringe benefit offered by employers to employees. According to recent data, over 62% of all Americans are covered by employment-based health insurance. Therefore, the practices of employers and insurers with respect to the administration of group health plans are of considerable significance to all workers and their families, and have been receiving the careful attention of members of this Committee.

In designing the portability provisions, it was the Committee's intent to both encourage workers to maintain health insurance coverage whenever it is offered through their employers and to require group health plans to credit such coverage towards any preexisting condition limitation the plan would otherwise be permitted to impose. The Committee views this as an important step to correcting the practice that some employers and insurers engage in of repeatedly screening individuals and their dependents whenever workers change jobs, even when the individual has "played by the rules" and continuously maintained health insurance.

In addition, in order to facilitate portability of benefits, it is important for plans to certify to the coverage that a worker has previously carried to assist coverage determinations as the worker enrolls in a new plan. The Committee views these requirements on employers and insurers to be relatively modest and necessary if employers are going to be required to forgo imposition of preexisting condition limitations based on a new employee's prior group coverage.

The bill would offer group health plans two options for judging the scope of prior coverage carried by an individual. It is the Committee's hope and expectation that the standard option will become routine operating procedure for most or all group health plans. This option simply accepts prior group health plan coverage as being bona-fide, "qualified" coverage for crediting purposes towards any otherwise applicable preexisting condition exclusion. However, currently many plans make judgments about the scope of prior coverage on a benefit-by-benefit basis to determine whether there were important gaps in the prior coverage that, if not addressed in the new plan, would be a source of costly adverse selection to the new plan. These are benefit-specific judgments that are permitted to lead to time-limited exclusions from coverage in the new plan. The Committee was reluctant to propose immediately halting a practice that may have some validity in discouraging individuals from skimping on coverage until they have a medical reason for seeking more comprehensive coverage. However, as stated earlier, it is the Committee's preference and expectation that the employer-based insurance system will evolve towards the more administratively simple, primary standard described in the bill.

Explanation of provision

Group health plans, and insurers and health maintenance organizations offering health insurance coverage in connection with a group health plan, would be required to credit periods of qualified previous coverage toward the fulfillment of a preexisting condition exclusion period when an individual moved from one source of group health coverage to another. Specifically, a preexisting condition limitation period would be reduced by the length of the aggregate period of any qualified prior coverage. Prior coverage would not have to be credited toward a preexisting condition limitation period if the individual experienced a break in qualified group coverage of more than 60 days. (Qualified group coverage means any period of coverage of the individual under a group health-plan, health insurance coverage, Medicaid.) A waiting period for any coverage under a group health plan (or for health insurance coverage offered in connection with a group health plan) would not be considered a break in coverage.

Presentation of a certification of prior coverage would establish an individual's eligibility for credit against a preexisting condition limitation period. Group health plan administrators, insurers, HMOs, and state Medicaid programs would be required to provide such certifications of coverage upon request of the individual.

In determining whether an individual has met qualified coverage periods, a group health plan, insurer, or HMO offering group coverage could elect one of two methods. Under the standard method, first, it could include all periods, without regard to the specific benefits offered during the period of prior coverage. Under the second alternative method, it could look at periods of prior coverage on a benefit-specific basis and not include as a qualified coverage period a specific benefit unless coverage for that benefit was included at the end of the most recent period of coverage. Entities electing the second method would have to state prominently in any disclosure statements concerning the plan or coverage and to each enrollee at the time of enrollment or sale that the plan or coverage had made such an election and would have to include a description of the effect of this election. Upon the request of the plan, insurer, or HMO, the entity providing the certification would have to promptly disclose information on benefits under its plan. It could charge the reasonable cost for providing this information.

Sec. 102. Limitation of Preexisting Conditions Exclusions; No Application to Certain Newborns, Adopted Children, and Pregnancy

Reasons for change

It was the Committee's intent to set a ceiling on the extent to which group health plans could exclude preexisting conditions of otherwise eligible individuals from coverage. Plans may choose to not exclude preexisting conditions or impose shorter exclusion periods. However, consistent with the Committee's intent to encourage workers to maintain coverage, the bill would permit group health plans to impose a longer exclusion period, not to exceed 18 months, if the individual refuses coverage when it is initially offered but subsequently enrolls late.

Note that nothing here is intended to define the benefits offered by employers and that an employer can choose to impose waiting periods between initial employment and eligibility for enrollment in the employer's group health plan. Such waiting periods are not counted as a lapse in coverage for purposes of determining whether an individual has maintained qualified prior coverage.

Explanation of provision

Group health plans, and insurers and health maintenance organization offering health insurance coverage in connection with a group health plan, would be prohibited from imposing a preexisting condition exclusion that exceeded 12 months for conditions for which medial advice, diagnosis, or treatment was received or recommended within the previous 6 months prior to becoming insured. In the event that the individual was a late enrollee, the preexisting condition exclusion could not exceed 18 months for conditions arising within 6 months prior to becoming insured.

Preexisting condition exclusions or limitations could not be applied to newborns and adopted children so long as these individuals became insured within 30 days of birth or placement for adoption. Pregnancy could not be treated as a pre-existing condition.

Sec. 103. Prohibiting Exclusions Based on Health Status and Providing for Enrollment Periods

Explanation of provision

This section would ensure that individuals in group health plans could not be excluded from coverage or from renewing their coverage based on their health status. Health status is defined to include, with respect to an individual, medical condition, claims experience, receipt of health care, medical history, evidence of insurability, or disability.

The Committee notes that the inclusion of evidence of insurability in the definition of "health status" is intended to ensure, among other things, the individuals are not excluded from health care coverage due to their participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing and other similar activities.

Group health plans would be required to provide for special enrollment periods for eligible individuals who lose other sources of coverage if certain conditions were met. An individual would have to be allowed to enroll under at least one benefit option if: (1) the employee (or dependent) had been covered under another group health plan at the time coverage was previously offered, (2) that this was the reason for declining enrollment, (3) that the individual lost their coverage as a result of certain event (loss of eligibility for coverage, termination or employment, or reduction in the number of hours of employment), and (4) the employee requested such enrollment within 30 days of termination of the coverage.

In the event that a group health plan provided family coverage, the plan could not require, as a condition of coverage of a beneficiary or participant in the plan, a waiting period applicable to the coverage of a beneficiary who is a newborn, an adopted child or child placed for adoption, or a spouse, at the time of marriage, if

the participant has met any waiting period applicable to that participant. The bill defines timely enrollment as being within 30 days of the birth, adoption, or marriage if family coverage was available as of that date.

Sec. 104. Enforcement

Explanation of provision

The above provisions would be enforced through penalties assessed through the Internal Revenue Code (IRC), ERISA, or through civil money penalties assessed by the Secretary of Health and Human Services. The Secretaries of Treasury, Labor, and HHS would be required to issue regulations that were nonduplicative and in a manner that assured coordination and nonduplication in their activities as provided for under this Act.

Enforcement through the IRC

IRC enforcement would be done through the COBRA health insurance continuation provisions (section 4980B). In general, a noncomplying plan would be subject to an excise tax of $100 per day per violation. Penalties would not be assessed in the event that the failure was determined to be unintentional or a correction was made within 30 days. For purposes of applying the COBRA enforcement language, special rules would apply:

No tax could be imposed by this provision on a noncomplying insurer or HMO subject to state insurance regulation if the Secretary of HHS determined that the state had an effective enforcement mechanism.

In the case of a group health plan of a small employer the provided coverage solely through a contract with an insurer or HMO, no tax would be imposed upon the employer if the failure was solely because of the product offered by the insurer or HMO.

No tax penalty would be assessed for a failure under this provision if a sanction had been imposed under ERISA or by the Secretary of HHS with respect to such failure.

Enforcement through ERISA

Enforcement on certain group health plans would also be through ERISA sanctions. Such sanctions would only apply to an insurer or HMO that was subject to state law in the event that the Secretary of Labor determined that the state had not provided for effective enforcement of the above provisions of this Act. Sanctions would not apply in the event that the Secretary of Labor established that none of the persons against whom the liability would be imposed knew, or exercising reasonable diligence, would have known that a failure existed, or if the noncomplying entity acted within 30 days to correct the failure. In no case would a civil money penalty be imposed under ERISA for a violation for which an excise tax under the COBRA enforcement provisions was imposed or for which a civil money penalty was imposed by the Secretary of HHS.

Enforcement through civil money penalties

A group health plan, insurer, or HMO that failed to meet the above requirements would be subject to civil money penalty. Rules similar to those imposed under the COBRA penalties would apply. The maximum amount of penalty would be $100 for each day for each individual with respect to which a failure occurred. In determining the penalty amount, the Secretary would be required to take into account the previous record of compliance of the person being assessed with the applicable requirements of the bill, the gravity of the violation, and the overall limitations for unintentional failures provided under the IRC COBRA provisions. No penalty could be assessed if the failure was not intentional or if the failure was corrected within 30 days. A procedure would be available for administrative and judicial review of a penalty assessment. Any penalties collected would be paid to the Secretary and would be available without appropriation for the purpose of enforcing the provisions with respect to which the penalty was imposed.

The authority for the Secretary of HHS to impose civil money penalties would not apply to enforcement with respect to any entity which offered health insurance coverage and which was an insurer or HMO subject to state regulation by an applicable state authority if the Secretary of HHS determined that the state had established an effective enforcement plan. In no case would a civil money penalty be imposed under this provision for a violation for which an excise tax under COBRA or civil money penalty under ERISA was assessed.

SUBTITLE B—DEFINITIONS; GENERAL PROVISIONS

Present law

See Subtitle A.

Sec. 191. Definitions; Scope of Coverage

Explanation of provision

Definitions are provided for these terms: group health plan, church plans, governmental plans, bona fide association, health insurance coverage, health maintenance organization, health status, individual health insurance coverage, insurer, medical care, network plan, waiting period, individual market, large group market, small employer, and small group market.

Sec. 192. State Flexibility to Provide Greater Protection

Explanation of provision

This provides for state flexibility to provide greater protection than required under the Act. Specifically, nothing in this bill should be construed to preempt state laws that require insurers or HMOs to impose a limitation or exclusion of benefits relating to the treatment of a preexisting condition period for a period that is shorter than the applicable period provided under this Act; to allow individuals, participants, and beneficiaries to be considered to be in a period of previous qualifying coverage if such individual, participant, or beneficiary experiences a lapse in coverage that is greater

than the 60-day periods provided for under this Act, or to impose shorter look-back periods for determining whether a preexisting condition period exists.

Nothing in this Act shall be construed to affect or modify the provisions of section 514 of ERISA (relating to federal preemption of laws regulating employee benefit plans).

Sec. 193. Effective Date

Explanation of provision

In general, except as otherwise provided for in this title, the provisions of this title would apply with respect to: (1) group health plans and health insurance coverage offered in connection with group health plans, for plan years beginning on or after January 1, 1998; and (2) individual insurance coverage issued, renewed, in effect, or operated on or after January 1, 1998.

The Secretaries of HHS, Treasury, and Labor would be required to issue regulations on a timely basis as may be required to carry out this title.

Sec. 194. Rule of Construction

Explanation of provision

Nothing in this title or any amendment made thereby may be construed to require the coverage of any specific procedure, treatment, or service as part of a group health plan or health insurance coverage under this title or through regulation.

TITLE II—PREVENTING HEALTH CARE FRAUD AND ABUSE; ADMINISTRATIVE SIMPLIFICATION

SUBTITLE A—FRAUD AND ABUSE CONTROL PROGRAM

Sec. 201. Fraud and Abuse Control Program

Present law

Currently Medicare's program integrity functions are subsumed under Medicare's general administrative budget. These functions are performed, along with general claims processing functions, by insurance companies under contract with the Health Care Financing Administration.

Reasons for change

A multiplicity of Federal, State and local law enforcement agencies, as well as private health insurers and health plans, are involved in various aspects of the investigation and prosecution of health care fraud. It is crucial that these efforts be as coordinated as possible in order to detect, prevent, and successfully prosecute health care fraud and abuse.

Explanation of provision

The Secretary of the Department of Health and Human Services (acting through the Office of the Inspector General) and the Attorney General would be required to jointly establish a national health care fraud and abuse control program to coordinate Federal,

State and local law enforcement to combat fraud with respect to health plans. To facilitate the enforcement of this fraud and abuse control program the Secretary and Attorney General would be authorized to conduct investigations, audits, evaluations and inspections relating to the delivery of and payment for health care, and would be required to arrange for the sharing of data with representatives of public and private third party payers. This program, implemented by guidelines issued by the Secretary and the Attorney General, would also facilitate the enforcement of applicable Federal statutes relating to health care fraud and abuse, and would provide for the provision of guidance to health care providers through the issuance of safe harbors, interpretive rulings and special fraud alerts.

The Secretary and Attorney General would consult with and share data with representatives of health plans. Guidelines issued by the Secretary and Attorney General would ensure the confidentiality of information furnished by health plans, providers and others, as well as the privacy of individuals receiving health care services. The Inspector General would retain all current authorities and would receive reimbursement for costs of investigations, audits and other functions under this section.

For purposes of this section the term "health plan" means a plan or program that provides health benefits through insurance or otherwise. Such plans include health insurance policies, contracts of service benefit organizations, and membership agreements with health maintenance organizations or other prepaid health plans.

Establishment of Health Care Fraud and Abuse Control Account in Federal Hospital Insurance Trust Fund

The Health Care Fraud and Abuse Control Account would be established as an expenditure account within the Federal Hospital Insurance (HI) Trust Fund. Monies derived from the coordinated health care anti-fraud and abuse programs from the imposition of civil money penalties, fines, forfeitures and damages assessed in criminal, civil or administrative health care cases, along with any gifts or bequests would be transferred into the Medicare HI trust fund. There are appropriated from the HI trust fund to the Account such sums as the Secretary and the Attorney General certify are necessary to carry out certain functions, subject to specified limits for each fiscal year beginning with 1996.

There are also appropriated from the general fund of the U.S. Treasury to the Fraud and Abuse Account for transfer to the FBI certain funds, subject to fiscal year limitations, for specified functions. These functions include prosecuting health care matters, investigations, audits of health care programs and operations, inspections and other evaluations, and provider and consumer education regarding compliance with fraud and abuse provisions. Amounts in the Account would also be available to the various State Medicaid fraud control units to reimburse such units for the costs of certain activities. The Secretary and the Attorney General are required to submit a joint annual report to Congress on the revenues and expenditures, and the justification for such disbursements from the Health Care Fraud and Abuse Control Account.

Sec. 202. Medicare Integrity Program

Present law

Currently Medicare's program integrity functions are subsumed under Medicare's general administrative budget. These functions are performed, along with general claims processing functions, by insurance companies under contract with the Health Care Financing Administration.

Reasons for change

Federal spending for the prevention, detection, and enforcement of health care fraud and abuse has not kept pace with the growth in Medicare or other health care expenditures. As a result, today, Medicare spends 30 percent less per claim on fraud and abuse activities of what was spent in 1989, despite strong evidence that fraud and abuse is on the rise. These provisions provide a mandatory funding stream to modernize Medicare's fraud and abuse detection and prevention capacities, and give Medicare greater flexibility to contract with firms that have demonstrated expertise in the area of claims review and fraud and abuse detection and prevention. The overall commitment by the federal government to fighting Medicare fraud and abuse will also be increased dramatically. The HHS Office of the Inspector General (IG) and the FBI will receive fixed increases in funding over the next six years with funding not less than $150 million a year after 2002 for the IG and funding of $114 million a year after 2002 for the FBI.

Explanation of provision

Establishment of Medicare Integrity Program

This provision would establish a Medicare Integrity Program under which the Secretary would promote the integrity of the Medicare program by entering into contracts with eligible private entities to carry out certain activities. These activities would include the following: (1) review of activities of providers of services or other individuals and entities furnishing items and services for which payment may be made under the Medicare program, including medical and utilization review and fraud review, (2) audit of cost reports, (3) determinations as to whether payment should not be, or should not have been, made by reason of Medicare as secondary payor provisions and recovery of payments that should not have been made, (4) education of providers of services, beneficiaries, and other persons with respect to payment integrity and benefit quality assurance issues, and (5) developing and updating a list of durable medical equipment pursuant to section 1834(a)(15) of the Social Security Act.

Eligibility of entities

The Secretary would impose certain eligibility requirements on entities entering into contracts under this Medicare Integrity Program, including conflict of interest requirements.

The Secretary would be authorized to establish, by regulation, procedures for entering into contracts, with eligible entities including procedures relating to the number of contracts and the timing

of contracts, competitive procedures for new contracts, and waiver of competitive procedures for renewed contracts under certain circumstances.

The Secretary would be required to provide, by regulation, for the limitation of a contractor's liability under the Medicare Integrity Program. The Secretary would employ, to the extent he finds appropriate, the same or comparable standards and other substantive and procedural provisions as are contained in section 1157 of the Social Security Act.

Elimination of fiscal intermediary and carrier responsibility for carrying out activities subject to program

This provision prohibits any agency, organization, or carrier, from carrying out (or receiving payment for carrying out) any activity pursuant to an agreement under this section to the extent that the activity is carried out pursuant to a contract under the Medicare Integrity Program.

Sec. 203. Beneficiary Incentive Programs

Present law

No provision.

Reasons for change

Medicare beneficiaries are in the best position to identify potentially fraudulent or abusive practices or excessive charges. The Committee believes they should be given incentives to provide information to the Medicare program concerning such suspect practices. Moreover, the Committee believes that the Medicare beneficiaries and the medical providers and suppliers should have an incentive to identify opportunities to improve the efficiency of the Medicare program and reduce fraud and abuse.

Explanation of provision

Clarification of requirement to provide explanation of Medicare benefits

The Secretary would be required to provide an explanation of Medicare benefits with respect to each item or service for which payment may be made, without regard to whether a deductible or coinsurance may be imposed with respect to the item or service.

Program to collect information on fraud and abuse

This provision would require the Secretary, within three months after enactment of this bill, to establish a program to encourage individuals to report to the Secretary information on individuals and entities who are engaging or who have engaged in acts or omissions that constitute grounds for sanctions under sections 1128, 1128A, or 1128B of the Social Security Act, or who have otherwise engaged in fraud and abuse against the Medicare program. If an individual reports information to the Secretary under this program that serves as a basis for the collection by the Secretary or the Attorney General of any amount of at least $100 (other than amounts paid as a penalty under section 1128B), the Secretary may pay a portion of the amount collected to the individual, under procedures similar

to those applicable under section 7623 of the Internal Revenue Code of 1986.

Program to collect information on program efficiency

The Secretary would be required, within three months after enactment of this bill, to establish a program to encourage individuals to submit to the Secretary suggestions on methods to improve the efficiency of the Medicare program. If the Secretary adopts a suggestion and savings to the program result, the Secretary could make a payment to the individual of an amount the Secretary considers appropriate.

Sec. 204. Application of Certain Health Anti-Fraud and Abuse Sanctions to Fraud and Abuse Against Federal Health Care Programs

Present law

Section 1128B provides for certain criminal penalties for convictions of Medicare and Medicaid (and other state health care programs) program-related fraud.

Reasons for change

The Committee felt that greater deterrence was needed against fraud and abuse in all of the traditional fee-for-service federal programs in addition to Medicare and Medicaid.

However, the Committee decided that the current anti-kickback statute is not well suited to the Federal Employee Health Benefit Program (FEHBP) which operates more like a private sector program with a wide range of primarily managed care options for federal employees. The fee-for-service and entitlement nature of the Medicare program and other federal health programs give rise to potentially fraudulent or abusive practices that are not present in an environment with managed care coverage.

Explanation of provision

This section would extend certain criminal penalties for fraud and abuse violations under the Medicare and Medicaid programs to similar violations in Federal health care programs generally. The term "Federal health care program" would mean any plan or program that provides health benefits, whether directly, through insurance, or otherwise which is funded directly, in whole or in part by the United States Government (other than the health insurance program under chapter 89 of title 5, United States Code). The term also would include any state health care program, which under section 1228(h), includes Medicaid, the Maternal and Child Health Services Block Grant Program and the Social Services Block Grant Program.

Sec. 205. Guidance Regarding Application of Health Care Fraud and Abuse Sanctions

Present law

The 1987 Medicare and Medicaid Patient and Program Protection Act specified various payment practices which, although poten-

tially capable of including referrals of business under Medicare or State health care programs, are protected from criminal prosecution or civil sanction under the anti-kickback provisions of the law. The 1987 law also established authority for the Secretary to promulgate regulations specifying additional payment practices, known as ''safe harbors,'' which will not be subject to sanctions under the fraud and abuse provisions.

Reasons for change

Greater public involvement in the process for identifying changes or additions to safe harbors, and fraud alerts will stimulate more timely and responsive information for assisting providers and suppliers in understanding Medicare requirements, as well as, enabling federal and state criminal justice agencies to focus on the most deliberate cases of fraudulent and abusive practices.

Explanation of provision

The Secretary would publish an annual notice in the Federal Register soliciting proposals for modifications to existing safe harbors and new safe harbors. After considering such proposals the Secretary, in consultation with the Attorney General, would issue final rules modifying existing safe harbors and establishing new safe harbors, as appropriate. The Inspector General would submit an annual report to Congress describing the proposals received, as well as the action taken regarding the proposals. The Secretary, in considering proposals, may consider a number of factors including the extent to which the proposals would affect access to health care services, quality of care services, patient freedom of choice among health care providers, competition among health care providers, ability of health care facilities to provide services in medically underserved areas or to medically underserved populations, and the like.

The Secretary of Health and Human Services would publish the first notice in the Federal Register soliciting proposals for new or modified safe harbors no later than January 1, 1997.

ADVISORY OPINIONS

Present law

No provision.

Reasons for change

Providers want to comply with the fraud and abuse statute, but many are unsure of how the statute affects them. These providers should be able to receive guidance from the government regarding financial arrangements. Little or no guidance is currently provided because there are no regulations and only insufficient safe harbors. Without this ability, a chilling effect is placed on legitimate arrangements, particularly when providers are attempting to structure new and innovative health care delivery systems to contain health care cost.

Explanation of provision

The Secretary shall issue written advisory opinions regarding (i) what constitutes prohibited remuneration under section 1128B(b); (ii) whether an arrangement or proposed arrangement satisfies the criteria for activities which do not result in prohibited remuneration; (iii) what constitutes an inducement to reduce or limit services to individuals entitled to benefits; and (iv) whether an activity constitutes grounds for the imposition of a sanction under section 1128, 1128A, or 1128B(b). Advisory opinions shall be binding as to the Secretary and the party requesting the opinion.

SPECIAL FRAUD ALERTS

Present law

No provision.

Reasons for change

Providers should be able to receive information and warnings on practices that the government has determined are suspect and are of particular concern.

Explanation of provision

Any person may request the Inspector General to issue a special fraud alert informing the public of practices which the Inspector General considers to be suspect or of particular concern under the Medicare program or a State health care program, as defined in section 1128(h) of the Social Security Act. After investigation of the subject matter of the request, and, if appropriate, the Inspector General shall issue a special fraud alert in response to the request, published in the Federal Register.

SUBTITLE B—REVISIONS TO CURRENT SANCTIONS FOR FRAUD AND ABUSE

Sec. 211. Mandatory Exclusion From Participation in Medicare and State Health Care Programs

Present law

Section 1128 of the Social Security Act authorizes the Secretary to impose mandatory and permissive exclusions of individuals and entities from participation in the Medicare program, Medicaid program and programs receiving funds under the Maternal and Child Health Services Block Grant, or the Social Services Block Grant. Mandatory exclusions are authorized for convictions of criminal offenses related to the delivery of health care services under Medicare and State health care programs, as well as for convictions relating to patient abuse in connection with the delivery of a health care item or service. In the case of an exclusion under the mandatory exclusion authority the minimum period of exclusion could be no less than five years, with certain exceptions. Permissive exclusions are authorized for a number of offenses relating to fraud, kickbacks, obstruction of an investigation, and controlled substances, and activities relating to license revocations or suspensions, claims for excessive charges or unnecessary services, and the like.

Reasons for change

The Committee felt that greater deterrence was needed to protect the Medicare program from providers who have been convicted of health care, fraud felonies and felonies relating to controlled substances.

Explanation of provision

Individual convicted of felony relating to health care fraud

This section would require the Secretary to exclude individuals and entities from Medicare and State health care programs who have been convicted of felony offenses relating to health care fraud for a minimum five year period. The Secretary would also retain the discretionary authority to exclude individuals from Medicare and State health care programs who have been convicted of misdemeanor criminal health care fraud offense, or who have been convicted of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in programs (other than health care programs) funded in whole or part by any Federal, State or local agency.

Individual convicted of felony relating to controlled substance

This section would require the Secretary to exclude individuals and entities from Medicare and State health care programs who have been convicted of felony offenses relating to controlled substances for a minimum five year period. The Secretary would retain the discretionary authority to exclude individual from Medicare and State health care programs who have been convicted of misdemeanor offenses relating to controlled substances.

Effective date

This section would apply to convictions after the date of the enactment of this statute.

Sec. 212. Establishment of Minimum Period of Exclusion for Certain Individuals and Entities Subject to Permissive Exclusion From Medicare and State Health Care Programs

Present law

Section 1128 of the Social Security Act authorizes the Secretary to impose mandatory and permissive exclusions of individuals and entities from participation in Medicare program, Medicaid program and programs receiving funds under the Maternal and Child Health Service Block Grant, or the Social Services Block Grant. Mandatory exclusions are authorized for convictions of criminal offenses related to the delivery of health care services under Medicare and State health care programs, as well as for convictions relating to patient abuse in connection with the delivery of a health care item or service. In the case of an exclusion under the mandatory exclusion authority the minimum period of exclusion could be no less than five years, with certain exceptions. Permissive exclusions are authorized for a number of offenses relating to fraud, kickbacks, obstruction of an investigation, and controlled substances, and activities relating to license revocations or suspen-

sions, claims for excessive charges or unnecessary services, and the like.

Reason for change

The Committee felt that greater deterrence was needed to protect the Medicare program from providers who have been convicted of misdemeanor health care fraud offenses, obstructing an investigation, or whose health care license has been suspended or revoked.

Explanation of provision

This section would establish a minimum period of exclusion for certain permissive exclusions from participation in Medicare and State health care programs.

For convictions of misdemeanor criminal health care fraud offenses, criminal offenses relating to fraud in non-health care Federal or State programs, convictions relating to obstruction of an investigation of health care fraud offenses, and convictions of misdemeanor offenses relating to controlled substances the minimum period of exclusion would be three years, unless the Secretary determines that a longer or shorter period is appropriate, due to aggravating or mitigating circumstances.

For permissive exclusions from Medicare or State health care programs due to the revocation or suspension of a health care license of an individual or entity, the minimum period of exclusion would not be less than the period during which the individual's or entity's license was revoked or suspended.

For permissive exclusions from Medicare or State health care programs due to exclusions from any Federal health care program or State health care program for reasons bearing on an individual's or entity's professional competence or financial integrity, the minimum period of exclusion would not be less than the period the individual or entity is excluded or suspended from a Federal or State health care program.

For permissive exclusions from Medicare or State health care programs due to a determination by the Secretary that an individual or entity has furnished items or services to patients substantially in excess of the needs of such patients or of a quality which fails to meet professionally recognized standards of health care, the period of exclusion would be not less than one year.

Sec. 213. Permissive Exclusion of Individuals With Ownership or Control Interest in Sanctioned Entities

Present law

Section 1128 of the Social Security Act authorizes the Secretary to impose mandatory and permissive exclusions of individuals and entities from participation in the Medicare program, Medicaid program and programs receiving funds under the Maternal and Child Health Services Block Grant, or the Social Services Block Grant. Mandatory exclusions are authorized for convictions of criminal offenses related to the delivery of health care services under Medicare and State health care programs, as well as for convictions relating to patient abuse in connection with the delivery of a health care item or service. In the case of an exclusion under the manda-

tory exclusion authority the minimum period of exclusion could be no less than five years, with certain exceptions. Permissive exclusions are authorized for a number of offenses relating to fraud, kickbacks, obstruction of an investigation, and controlled substances, and activities relating to license revocations or suspensions, claims for excessive charges or unnecessary services, and the like.

Reasons for change

The Committee felt that greater deterrence against fraud and abuse was needed in the Medicare program.

Explanation of provision

Entities owned, controlled, or managed by a sanctioned individual are already subject to permissive exclusion from participation in Medicare and State health programs by the Secretary. Under this new authority an individual who has a direct or indirect ownership or control interest in a sanctioned entity and who knows or should know of the action constituting the basis for the conviction or exclusion, or who is an officer or managing employee of such an entity, may also be excluded from participation in Medicare and State health care programs by the Secretary if the entity has previously been convicted of an offense listed in Section 1129(a) or (b)(1), (2) or (3) or otherwise excluded from program participation. Under the new provision, the culpable individual would also be subject to program exclusion, even if not initially convicted or excluded.

Sec. 214. Sanctions Against Practitioners and Persons for Failure to Comply With Statutory Obligations

Present law

The Secretary has the authority to impose administrative sanctions against practitioners and persons who have failed to comply with certain statutory obligations relating to the quality of medical care rendered. Under this section the Secretary may require, in cases involving medically improper or unnecessary health care services, that the practitioner or person pay the United States an amount up to $10,000 for each instance of medically improper or unnecessary health care services. In such cases the practitioner or person would be permitted to continue to be eligible to receive reimbursement for health care services rendered to program beneficiaries.

Reasons for change

The Committee felt that greater deterrence was needed to protect Medicare beneficiaries from providers who have failed to comply with certain statutory obligations relating to the quality of medical care rendered.

Explanation of provision

Minimum period of exclusion for practitioners and persons failing to meet statutory obligations

Under this section, the Secretary may exclude a practitioner or person for such period as the Secretary may prescribe, except that such period shall not be less than one year.

Repeal of "unwilling or unable" conditions for imposition of sanction

The Secretary, in making his determination that a practitioner or person should be sanctioned for failure to comply with certain statutory obligations relating to quality of health care, will no longer be required to prove that the individual was either unwilling or unable to comply with such obligations.

Sec. 215. Intermediate Sanctions for Medicare Health Maintenance Organizations

Present law

A contract between the Secretary and a Medicare Health Maintenance Organization (HMO) is generally for a one year term, with an option for automatic renewal. However, the Secretary may terminate any such contract at any time, after reasonable notice and an opportunity for a hearing, if the Medicare HMO has failed substantially to carry out the contract, or is carrying out the contract in a manner inconsistent with the efficient and effective administration of the requirements of section 1876 of the Social Security Act, or if the Medicare HMO no longer substantially meets the statutory requirements contained in Section 1876(b), (c), (e) and (f) of the Social Security Act.

Reasons for change

The Committee determined that there could be situations where a Medicare HMO has failed substantially to carry out its contract, however, the offense is not sufficiently egregious to warrant termination of an HMO's contract with Medicare. In those situations, intermediate sanctions such as civil monetary penalties should be available to be imposed by the Secretary.

Explanation of provision

Application of intermediate sanctions for any program violations

Under this section the Secretary may terminate a contract with a Medicare Health Maintenance Organization (HMO) or may impose certain intermediate sanctions on the organization if the Secretary determines that the Medicare HMO has failed substantially to carry out the contract; is carrying out the contract in a manner substantially inconsistent with the efficient and effective administration of this section; or, if the Medicare HMO no longer substantially meets the statutory requirements contained in Section 1876(b), (c), (e) and (f) the Social Security Act.

If the basis for the determination by the Secretary that intermediate sanctions should be imposed on an eligible organization is

other than that the organization has failed substantially to carry out its contract with the Secretary, then the Secretary may apply intermediate sanctions as follows: civil money penalties of not more than $25,000 for each determination if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract; civil money penalties or not more than $10,000 for each week of a continuing violation; and suspension of enrollment of individuals until the Secretary is satisfied that the deficiency has been corrected and is not likely to recur.

Whenever the Secretary seeks to either terminate a Medicare HMO contract or impose intermediate sanctions on such an organization, the Secretary must do so pursuant to a formal investigation and under compliance procedures which provide the organization with a reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's adverse determination. In making a decision whether to impose sanctions the Secretary is required to consider aggravating factors such as whether an entity has a history of deficiencies or has not taken action to correct deficiencies the Secretary has brought to their attention. The Secretary's compliance procedures must also include notice and opportunity for a hearing (including the right to appeal an initial decision) before the Secretary imposes any sanction or terminates the contract of a Medicare HMO, and there must not be any unreasonable or unnecessary delay between the finding of a deficiency and the imposition of sanctions.

Agreements With Peer Review Organizations

Under this section each risk-sharing contract with a Medicare HMO must provide that the organization will maintain a written agreement with a utilization and quality control peer review organization or similar organization for quality review functions.

Effective date

The amendments made by this section shall apply to the contract years beginning on or after January 1, 1997.

Sec. 216. Additional Exception to Anti-Kickback Penalties for Discounting and Managed Care Arrangements

Present law

The anti-kickback provision in Section 1128(b) contains several exceptions. These exceptions include discounts or other reductions in price obtained by a provider of services or other entity under Medicare or a State health care program if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under Medicare or a State health care program; any amount paid by an employer to an employee for employment in the provision of covered items or services; any amount paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of individuals or entities under specified conditions; a waiver of any coinsurance under Part B of Medicare by a Federally qualified health care center with respect to an individual who qualifies for sub-

sidized services under a provision of the Public Health Service Act; and any payment practice specified by the Secretary as a Safe Harbor exception.

Reasons for change

Absent this exception, nearly all managed care arrangements (except those that comply with the current safe harbors for HMO's that contract with Medicare and Medicaid) could potentially be deemed unlawful. This is because an essential feature of managed care is the offer of remuneration (in the form of discounting or risk sharing arrangements in exchange for provider access to the health plan's enrollee population. Another common feature of managed care is the offer by health plans to providers of incentives to encourage adherence to cost-saving measures and practice protocols. There is no assurance that either of these (as well as other arrangements inherent in managed care) are permissible under the anti-kickback law. In addition, without the discount exception, cost saving measures such as combined products like procedure kits which contain all items needed to perform a specific procedure or provide a specific treatment, and aggregate discounts for a group of products purchased, such as radiology supplies could be prohibited. The current statute places a chilling effect even on cost saving measures because manufacturers are steering away from this discounting arrangements such as combined products and aggregate discounts within the Medicare program for fear of acting in violation of the current statute.

It is the intent of the Committee that the managed care exception apply to waiver of any deductible amount under Part A of Title XVIII as part of a price reduction agreement between a provider and a third-party payor that is part of a contract for the furnishing of items and services to a beneficiary of a Medicare supplemental policy approved by a state and issued under the terms of Section 1882(t)(1) of the Social Security Act. This provision would apply to hospitals providing services under Title XVIII, including PPS-exempt hospitals and units such as psychiatric, rehabilitation, and long-term care facilities.

Explanation of provision

This section would add a new exception to the anti-kickback provisions allowing remuneration between an eligible organization under Section 1876 and an individual or entity providing items or services pursuant to a written agreement between an eligible organization under Section 1876 and the individual or entity. Remuneration would also be allowed between an organization and an individual or entity if a written agreement places the individual or entity at substantial financial risk for the cost or utilization of the items or services which the individual or entity is obligated to provide. The risk arrangement may be provided through a withhold, capitation, incentive pool, per diem payment or other similar risk arrangement. This amendment would apply to acts or omissions occurring after January 1, 1997.

Sec. 217. Criminal Penalty for the Fraudulent Disposition of Assets in Order to Obtain Medicaid Benefits

Present law

Under section 1128B, upon conviction of a program-related felony, an individual may be fined not more than $25,000 or imprisoned for not more than five years or both.

Explanation of provision

This section would add a new crime to the list of prohibited activities under section 1128B of the Social Security Act for cases where a person knowingly and willfully disposes of assets by transferring assets in order to become eligible for benefits under a state health care program, including the Medicaid program, if disposing of the assets results in the imposition of a period of ineligibility.

Sec. 218. Effective Date

Explanation of provision

Except as otherwise provided, the amendments made by this chapter shall take effect January 1, 1997.

SUBTITLE C—DATA COLLECTION

Sec. 221. Establishment of the Health Care Fraud and Abuse Data Collection Program

Present law

No provision.

Reasons for change

Beside the current lack of a coordinated effort between Federal agencies and state agencies on fraud and abuse prevention, detection, and prosecution, there is an insufficient lack of uniform data on providers and suppliers who have had adverse actions against them. This data bank would provide a source for up-to-date information on adverse actions against providers and suppliers that can be used in investigating fraud and abuse cases, and used when providers or suppliers are seeking new licenses, renewal of licenses, or hospital privileges.

Explanation of provision

In general

The Secretary of Health and Human Services is required to establish a national health care fraud and abuse data collection program for reporting final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practioners.

Each government agency and health plan would, on a monthly basis, report any final adverse action taken against a health care provider, supplier, or practitioner. Certain information would be included in the report, including a description of the acts or omissions and injuries upon which the final adverse action was taken.

The Secretary would, however, protect the privacy of individuals receiving health care services.

The Secretary would, by regulation, provide for disclosure of the information about adverse actions, upon request to the health care provider, supplier, or licensed practitioner and provide procedures in the case of disputed accuracy of the information. Each government agency and health plan is required to report corrections of information already reported about any final adverse action taken against a health care provider, supplier, or practitioner in such form and manner that the Secretary prescribes by regulation.

The information in the database would be available to Federal and State government agencies and health plans. The Secretary may approve reasonable fees for the disclosure of information in the database (other than with respect to requests by Federal agencies). The amount of such a fee shall be sufficient to recover the full costs of operating the data base.

No person or entity would be held liable in a civil action with respect to any report made as required by this section, unless the person or entity knows the information is false. The definition for ''final adverse action'' and other related terms are specified in this section.

Improved prevention in issuance of Medicare provider numbers

The Secretary may impose appropriate fees on physicians to cover the cost of investigation and recertification activities with respect to the issuance of identifiers for physicians who furnish services for which Medicare payments are made.

SUBTITLE D—CIVIL MONETARY PENALTIES

Sec. 231. Social Security Act Civil Monetary Penalties

Present law

Section 1128 of the Social Security Act authorizes the Secretary to impose mandatory and permissive exclusions of individuals and entities from participation in the Medicare program, Medicaid program and programs receiving funds under the Maternal and Child Health Services Block Grant, or the Social Services Block Grant. Mandatory exclusions are authorized for convictions of criminal offenses related to the delivery of health care services under Medicare and State health care program, as well as for convictions relating to patient abuse in connection with the delivery of a health care item or service. In the case of an exclusion under the mandatory exclusion authority the minimum period of exclusion could be no less than five years, with certain exceptions. Permissive exclusions are authorized for a number of offenses relating to fraud, kickbacks, obstruction of an investigation, and controlled substances, and activities relating to license revocations or suspensions, claims for excessive charges or unnecessary services, and the like.

Under Section 1128A of the Social Security Act civil monetary penalties may be imposed for false and fraudulent claims for reimbursement under the Medicare and State health care programs.

Under section 1128B, upon conviction of a program-related felony, an individual may be fined not more than $25,000 or imprisoned for not more than five years, or both.

Reason for change

The Committee determined that greater deterrence was needed to protect the Medicare program from providers who have been convicted of defrauding Medicare and other federal programs.

Explanation of provision

General civil monetary penalties

The provisions under the Medicare and Medicaid programs which provide for civil money penalties for specified fraud and abuse violations would apply to similar violations involving other Federal health care programs. Federal health care programs would include any health insurance plans or programs funded, in whole or part, by the Federal government, such as CHAMPUS and FEHBP.

Civil money penalties and assessments received by the Secretary would be deposited into the Health Care Fraud and Abuse Control Account established under this Act.

Excluded individual retaining ownership or control interest in participating entity

Any person who has been excluded from participating in Medicare or a State health care program and who retains a direct or indirect ownership or control interest in an entity that is participating in a program under Medicare or a State health care program, and who knows or should know of the action constituting the basis for the exclusion, or who is an officer or managing employee of such an entity would be subject to a civil money penalty of not more than $10,000 for each day the prohibited relationship occurs.

Modification of amounts of penalties and assessments

This section would amend the civil money penalty provisions of Section 1128A(a) by increasing the amount of a civil money penalty from $2,000 to $10,000 for each item or service involved. This section also increases the assessment which a person may be subject to from "not more than twice the amount" to "not more than three times the amount" claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim.

Claim for item or service based on incorrect coding or medically unnecessary services

This section would add two practices to the list of prohibited practices for which civil money penalties may be assessed. The first occurs when a person engages in a pattern or practice of presenting a claim for an item or service based on a code that the person knows or should know will result in greater payments than appropriate. The second is the practice whereby a person submits a claim that the person knows or should know is for a medical item or service which is not medically necessary.

The sanction against practitioners and person who fail to comply with certain statutory obligations is changed from an amount equal to "the actual or estimated cost" of the medically improper or unnecessary services provided, to "up to $10,000 for each instance of medical improper or unnecessary services provided.

Procedural provisions

The procedural provisions outlined in Section 1128A, such as notice, hearings, and judicial review rights shall apply to civil money penalties assessed against Medicare Health Maintenance Organizations in the same manner as they apply to civil money penalties assessed against health care providers generally.

Prohibition against offering inducements to individuals enrolled under programs or plans

This section would add a new practice to the list of prohibited practices for which civil money penalties may be assessed. Any person who offers remuneration to an individual eligible for benefits under Medicare or a State health program that such individual knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner or supplier any item or service reimbursable under Medicare or a State health care program, shall be subject to the various civil money penalties, assessments and exclusion provisions of Section 1128A of the Social Security Act.

The term "remuneration" is defined to include the waiver of part or all of coinsurance and deductible amounts, as well as transfers of items or services for free, or for other than fair market value. There are exceptions to this definition. The waiver of part or all of coinsurance and deductible amounts would not be considered remuneration under this section if the waiver is not offered as part of any advertisement or solicitation, the person does not routinely waive coinsurance or deductible amounts, and the person either waives the coinsurance and deductible amounts because the individual is in financial need, or fails to collect the amounts after reasonable collection efforts, or provides for a permissible waiver under regulations issued by the Secretary. In addition, the term remuneration would not include differentials in coinsurance and deductible amounts as part of a benefit plan design if the differentials have been disclosed in writing to all beneficiaries, third party payors, and providers, and if the differentials meet the standards defined in the Secretary's regulations. Remuneration would also not include incentives given to individuals to promote the delivery of preventive care under the Secretary's regulations.

Effective date

January 1, 1997.

Sec. 232. Clarification of Level of Intent Required for Imposition of Civil Monetary Penalties

Present law

Civil money penalties may be imposed for seeking reimbursement under the Medicare and Medicaid programs for items or serv-

ices not provided or for services provided by someone who is not a licensed physician, whose license was obtained through misrepresentation, or who misrepresented his or her qualification as a specialist, or where the claim is otherwise fraudulent. Civil penalties may also be sought for presenting a claim due for payments which are in violation of (1) contracts limiting payment due to assignment of a patient (2) agreements with state agencies limiting permitted charges, (3) agreement with participating physicians or supplier, and (4) agreements with providers of service. Civil penalties may also be sought against persons who provide false or misleading information that could reasonably be expected to influence a decision to discharge a person from a hospital. A person is subject to these provisions if they presented a claim and he or she "knows or should have known" that the claim fell into one of the categories listed above.

Reasons for change

The current standard of "knows or should know" is inconsistent with the Civil False Claims Act which applies to all other federal programs. Additionally, concerns have been raised that the standard currently applied by the Health and Human Services Department Office of the Inspector General may be less specific, and can result in the pursuit of allegation based on honest and simple mistakes where a provider had no knowledge of an alleged violation. The IG reports that the providers they generally pursue have shown deliberate patterns of abuse. Therefore, a modification in the intent standard should have no impact on the IG's ability to pursue offenders under this Act.

Explanation of provision

This section adds a requirement, similar to the False Claims Act, that a person is subject to this provision when the person "knowingly" presents a claim that the person "knows or should know" fell into one of the prohibited categories. Thus, an assessment under this provision would only be made where a person had actual knowledge that he or she had submitted a claim or had actual knowledge that he or she had submitted a claim or had provided false or misleading information, and where the person had actual knowledge of the fraudulent nature of the claim, acted in deliberate ignorance, or acted in reckless disregard. The requirement that a person "knowingly" presents a claim or "knowingly" makes a false or misleading statement which influences discharge would prevent charging persons who inadvertently perform these acts.

Sec. 233. Penalty for False Certification for Home Health Services

Present law

No provision.

Reasons for change

Expert testimony has indicated that physicians sometimes do not adequately review statements certifying patients' eligibility for home health care.

Explanation of provision

In general

This provision would add an additional civil monetary penalty of not more than three times the amount of the payments, or $5,000, whichever is greater, for a physician who certifies that an individual meets all of Medicare's requirements to receive home health care while knowing that the individual does not meet all such requirements.

Effective date

The amendment by this section would apply to certifications made on or after the date of enactment of this Act.

SUBTITLE F—ADMINISTRATIVE SIMPLIFICATION

PART 1. GENERAL ADMINISTRATIVE SIMPLIFICATION

Sec. 251. Purpose

Present law

No provision.

Reason for change

One of the primary barriers to cost-effective health information is the lack of uniform standards for financial administrative health information. Uniform standards for health information would reduce health care spending by enabling the public and private sectors to reduce paperwork, expose fraud and abuse, provide consumers with the information they need to compare health plans and services, and would be less burdensome for providers. It is estimated that an electronic health information system could produce net savings to health care spending of over $29 billion over a five year period to health plans and providers.

Explanation of provision

Provides the purpose of the subtitle as improving the Medicare and Medicaid programs, and the efficiency and effectiveness of the health care system, by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information.

Sec. 252. Amends Title XI of the Social Security Act by Adding Part C—Administrative Simplification

Explanation of provision

Amends title XI of the Social Security Act by adding Part C—Administrative Simplification.

Sec. 1171. Administrative Simplification Definitions

Present law

No provision.

Explanation of provision

Provides definitions for the part including the following: clearinghouse, code set, health care provider, health information, health plan, individually identifiable health information, standard, and standard setting organization. A clearinghouse would be a public or private entity that processes or facilitates the processing of nonstandard data elements of health information into standard data elements, or provides the means by which persons may meet the requirements of this part. A health plan would include Medicare, Medicaid, a Medicare supplemental policy, supplemental liability insurance, general liability insurance, worker's compensation or similar insurance, automobile or automobile medical-payment insurance, a long-term care policy, a hospital or fixed indemnity income-protection policy, and employee welfare benefit plan provided for 50 or more participants, an employee welfare benefit plan provided for 2 or more employers, the health care program for active military personnel, the veterans health care program, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), the Indian health service program, the Federal Employees Health Benefits Plan, and such other plan or arrangement as the Secretary determines is a health plan

Sec. 1172. General Requirements for Adoption of Standards

Present law

No provision.

Reasons for change

Most health plans already transmit data electronically, but the data is transmitted in a non-standard or incomplete form, and generally cannot be used to transfer information between health plans or be used to effectively track fraud and abuse. These provisions build upon the public/private framework originally established by HHS Secretary Louis Sullivan through the private sector industry group, the Workgroup for Electronic Data Interchange (WEDI). Despite the fact, under current law, that HCFA has the authority to adopt government standards for health information, and to mandate the use of those standards by the private sector, current law provisions do not extend HCFA's authority to allow it to adopt standards that have been developed by a voluntary, consensus process of private and public sector payors. This bill establishes such a process for the standardization of health data that builds on the progress in the private sector. This process would ensure that the Secretary integrates Medicare's standards with the standards developed by the private sector.

Explanation of provision

Requires that any standard or modification of a standard adopted applies to the following persons: (1) a health plan, (2) a clearinghouse, or (3) a health care provider, but only to the extent that the provider was conducting transactions referred to in the bill. The bill would require that any standard or modification of a standard adopted must reduce the administrative cost of providing and paying for health care. The standard setting organization would be re-

quired to develop or modify any standard or modification adopted. The Secretary could adopt a standard or modification of a standard that was different from any standard developed by such organization if the different standard or modification was promulgated in accordance with rule-making procedures and would substantially reduce administrative costs to providers and plans. The Secretary would be required to establish specifications for implementing each of the standards and modifications adopted. The standards adopted would be prohibited from requiring disclosure of trade secrets or confidential commercial information by a participant in the health information network. In complying with the requirements of this part, the Secretary would be required to rely on the recommendations of the Health Information Advisory Committee established by the bill, and consult with appropriate Federal and State agencies and private organizations. If no standard-setting organization has adopted or modified any standard relating to a standard, the Secretary would be required to rely on recommendations of the Health Information Advisory Committee, and would be required to consult with appropriate Federal and State agencies and private organizations.

Sec. 1173. Standards for Information Transactions and Data Elements

Present law

No provision.

Reasons for change

This section provides uniformity for health plans providing health benefits in the area of information transactions, limited to financial and administrative transactions. The Committee does not intend for these requirements apply to information collected that is beyond this scope such as, for example, but not limited to, personnel records of employers who provide health plan benefits or medical records of patients. While requiring standardization of data transmitted electronically among persons governed by this part, the provisions in this part would not impose any requirement for information collection or reporting. Health plans only, and not providers, are required to comply with these standards.

The Committee recognizes the role of the private sector in establishing innovative data transaction systems relating to electronic exchange, unique health identifiers, code sets, security standards, privacy standards, and electronic signatures. The standards adopted would protect the privacy and confidentiality of health information. Health information is considered relatively "safe" today, not because it is secure, but because it is difficult to access. These standards improve access and establish strict privacy protections. The term "equivalent encounter information" pertains to health plans such as HMO's, that do not generate a claims form at the time a medical professional renders a service. At the time, an enrollee has contact with a medical professional, a notation is made which includes the name of the provider, and the treatment rendered.

This section further directs the Secretary to adopt standards relating to the privacy of individually identifiable health information concerning the rights of individuals who are the subject of such information, the procedures for exercising such rights, and the authorized uses and disclosures of such information. Protecting the privacy of individuals is paramount. However, the Committee recognizes that certain uses of individually identifiable information are appropriate, and do not compromise the privacy of an individual. Examples of such use of information include the transfer of information when making referrals from primary care to specialty care, and the transfer of information from a health plan to an organization for the sole purpose of conducting health care-related research. As health care plans and providers continue to focus on outcomes research and innovation, it is important that the exchange and aggregate use of health care research be allowed.

Explanation of provisions

Requires the Secretary to adopt appropriate standards for financial and administrative transactions and data elements exchanged electronically that are consistent with the goals of improving the operation of the health care system and reducing administrative costs. Financial and administrative transactions would include claims, claims attachments, enrollment and disenrollment, eligibility, health care payment and remittance advice, premium payments, first report of injury, claims status, and referral certification and authorization. Standards adopted by the Secretary would be required to accommodate the needs of different types of health care providers.

The Secretary would be required to adopt standards providing for a standard unique health identifier for each individual, employer, health plan, and health care provider for use in the health care system. The Secretary would be required to adopt standards that select code sets for appropriate data elements or establish such code sets, and establish efficient and low-cost procedures for the distribution of code sets and modifications.

The Secretary would be required to establish security standards that (1) take into account the technical capabilities of record systems to maintain health information, the costs of security measures, the need for training persons with access to health information, the value of audit trails in computerized record systems used, and the needs and capabilities of small health care providers and rural health care providers; and (2) ensure that a clearinghouse, if it is part of a larger organization, has policies and security procedures which isolate the activities of such service to prevent unauthorized access to such information by such larger organization. Each person who maintains or transmits health information or data elements of health information would be required to maintain reasonable and appropriate administrative, technical and physical safeguards to (1) ensure the integrity and confidentiality of the information, (2) protect against any reasonably anticipated threats or hazards to the security or integrity of the information and the unauthorized uses or disclosures of the information, and (3) otherwise ensure compliance with these requirements by the officers and employees of such person.

The Secretary would be required to establish standards and modifications to such standards regarding the privacy of individually identifiable health information that is in the health information network. Such standards would be required to include at least (1) the rights of an individual who is subject to such information, (2) the procedures to be established for the exercise of such rights, and (3) the uses and disclosures of such information that are authorized or required. The Secretary, in coordination with the Secretary of Commerce, would be required to adopt standards specifying procedures for the electronic transmission and authentication of signatures, compliance with which would be deemed to satisfy Federal and State statutory requirements for written signatures with respect to the transactions specified by the bill. This part would not be construed to prohibit the payment of health care services or health plan premiums by debit, credit, payment card or numbers, or other electronics means. The Secretary would be required to adopt standards for determining the financial liability of health plans when health benefits are payable under two or more health plans, and for transferring among health plans appropriate standard elements needed for the coordination of benefits, the sequential processing of claims, and other data elements for individuals who have more than one health plan.

Sec. 1174. Timetables for Adoption of Standards

Sec. 1175. Requirements

Present law

No provision.

Reasons for change

The Committee determined that it is necessary to place the Secretary on a rapid timetable in order that the new electronic transactions system is put into place as soon as possible.

Explanation of provisions

Requires the Secretary to adopt standards relating to the transactions, data elements of health information, security and privacy by not later than 18 months after the date of enactment of the part, except that standards relating to claims attachments would be required to be adopted not later than 30 months after enactment. The Secretary would be required to review the adopted standards and adopt additional or modified standard as appropriate, but not more frequently than once every 6 months, except during the first 12-month period after the standards are adopted unless the Secretary determines that a modification is necessary in order to permit compliance with the standards. The Secretary would also be required to ensure that procedures exist for the routine maintenance, testing, enhancement, and expansion of code sets.

Present law

No provision.

Explanation of provision

Establish that if a person desires to conduct a financial or administrative transaction with a health plan as a standard transaction, (1) the health plan may not refuse to conduct such transaction as a standard transaction, (2) the health plan many not delay such transaction, or otherwise adversely affect, or attempt to adversely affect, the person or the transaction on the grounds that the transaction is a standard transaction, and (3) the information transmitted and received in connection with the transaction would be required to be in a form of standard data elements for health information. Health plans could satisfy the transmission of information by directly transmitting standard data elements of health information, or submitting nonstandard data elements to a clearinghouse for processing in to standard data elements and transmission. Not later than 24 months after the date on which standard or implementation specification was adopted or established under this part, each person to which the standard applied would be required to comply with the standard or specification. Small health plans, determined by the Secretary, would be required to comply not later than 36 months after standards were adopted. If the Secretary modified a standard or implementation specification, each person to whom it applied would be required to comply with the modified standard at such time as the Secretary determine appropriate, but no earlier than 180 days after such modification was adopted.

Sec. 1176. General Penalty for Failure to Comply With Requirements and Standards

Present law

No provision.

Explanation of provision

Requires the Secretary to impose on any person who violates a provision under the bill a penalty of not more than $100 for each such violation of a specific standard or requirement, except that the total amount imposed on the person for all such violations during a calendar year would not exceed $25,000. A penalty would not be imposed if it was established that the person liable for the penalty did not know, and by exercising reasonable diligence would not have known, that such person violated the provision. A penalty would not be imposed if (1) the failure to comply was due to reasonable cause and not willful neglect, and (2) the failure to comply was corrected during the 30-day period beginning on the first date the person liable for the penalty know, or would have known, that the failure to comply occurred. The Secretary would be permitted to extend the 30-day period when appropriate, and could provide technical assistance to the person that failed to comply because they were unable to comply. In cases of a failure to comply due to reasonable cause and not to willful neglect, any penalty that was not entirely waived, could be waived to the extent that the payment of such penalty would be excessive relative to the compliance failure involved.

Sec. 1177. Wrongful Disclosure of Individually Identifiable Health Information

No provision.

Reasons for change

This section reflects the Committee's concern that an individual's privacy be protected.

Explanation of provision

Defines the offense of wrongful disclosure of individually identifiable health information as instances when a person who knowingly (1) uses or causes to be used a unique health identifier in violation of a provision in this part, (2) obtains individually identifiable health information for relating to an individual in violation of a provision in this part, or (3) discloses individually identifiable health information to another person in violation of this part. A person committing such an offense would be required to (1) be fined not more than $50,000, imprisoned not more than 1 year, or both; (2) if the offense was committed under false pretenses, be fined not more than $100,000, imprisoned not more than 5 years, or both; and (3) if the offense was committed with intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm, fined not more than $250,000, imprisoned not more than 10 years, or both.

Sec. 1178. Effect on State Law

No provision.

Reasons for change

The intent of this section is to ensure that state privacy laws that are more stringent than the requirements and standards contained in the bill are not superseded.

Explanation of provision

Requires that a provision, requirement, or standard provided by the bill supersede any contrary provision of state law, including a provision of state law that required medical or health plan records (including billing information) to be maintained or transmitted in written rather than electronic form. A provision under the bill would not supersede a contrary provision of state law if the provision of state law (1) was more stringent than the requirements of the bill with respect to privacy or individually identifiable health information, or (2) was a provision the Secretary determined was necessary to prevent fraud and abuse with respect to controlled substances or for other purposes. Nothing in this section would be construed to invalidate or limit the authority, power, or procedures established under any law providing for the reporting of disease or injury, child abuse, birth or death, public health surveillance, or public health investigation or intervention.

Sec. 1179. Health Information Advisory Committee

Present law

No provision.

Reasons for change

This section directs the Secretary to rely on recommendations of the Health Information Advisory Committee, the membership of which will consist of individuals who are of recognized standing and distinction in the areas of information systems, information networking and integration, consumer health, health care financial management, or privacy. This development process depends on expert advice from individuals in the private sector, and it is imperative that the Secretary consult with the Advisory Committee on issues related to the adoption of uniform transaction standards.

Explanation of provision

Provides for the establishment of a committee known as the Health Information Advisory Committee, consisting of 15 members. The committee would be required to (1) provide assistance to the Secretary with complying with the requirements of the bill; (2) study the issues related to the adoption of uniform data standards for patient medical record information and electronic exchange of such information; (3) report to the Secretary not later than 4 years after enactment recommendations and legislative proposals for such standards and electronic exchange; and (4) be generally responsible for advising the Secretary and the Congress on the status of the future of the health information network. The committee would be required, not later than 1 year after enactment, to report to Congress, health care providers, health plans, and other entities using the health information network regarding (1) the extent to which entities using the network were meeting the standards adopted and working together to form an integrated network that meets the needs of its users; (2) the extent to which entities were meeting the privacy and security standards, and the types of penalties assessed for noncompliance; (3) whether the federal and state governments were receiving information of sufficient quality to met their responsibilities; (4) any problems that exist with implementation of the network; and (5) the extent to which timetables established under this part of the bill were being met.

PART 2. ADMINISTRATIVE SIMPLIFICATION FOR LABORATORY SERVICES

Sec. 261 Administrative Simplification for Laboratory Services

Present law

No provision.

Reasons for change

Concerns have been raised about the widely varying documentation required by Medicare carriers regarding claims for clinical laboratory tests. The resulting significant administrative costs associ-

ated with this documentation, particularly for laboratories which send claims to multiple carriers.

Explanation of provision

Requires the Secretary to adopt uniform coverage, administration and payment policies for clinical diagnostic laboratory tests within one year of enactment. The Secretary would be required to select 15 carrier medical directors to develop recommendations to the Secretary for such policies. The directors would be representative of geographic areas and have a varied range of interest in relevant fields including pathology and clinical laboratory practice. The directors would be required to consult with independent experts in each major discipline of clinical laboratory medicine (including clinical laboratory personnel, bioanalysts, pathologists, and practicing physicians). The medical directors would also solicit comments from other individuals and groups wishing to participate. The provision would provide that the process would be conducted as negotiated rule-making as provided under the Administrative Procedure Act.

Provide that the negotiated rule-making would result in recommendations for uniform policies in the following areas: (i) beneficiary information required to be submitted with each claim; (ii) physicians' obligations regarding documentation and record keeping; (iii) procedures for filing claims and for providing remittances electronically; (iv) performance of post-payment review; (v) prohibition of documentation of medical necessity except where determined to be appropriate after identification of aberrant medical patterns through focused medical review; and beneficiary responsibility for payment.

Prohibits carriers and intermediaries from implementing any new requirements for submission of claims retroactive to January 1, 1995 during the period when the Secretary is adopting new policies. Further, carriers would be prohibited from issuing new coverage, administration or payment policies unless they promote the goal of administrative simplification.

Requires the medical directors to forward their recommendations to the Secretary within six months of enactment. The Secretary would provide for publication of recommendations for public comment using negotiated rule-making. The Secretary would publish final uniform policies which would become effective 180 days following publication. Following publication, the Secretary would implement uniform documentation and processing policies.

Permits any independent laboratory to select one carrier for processing all of its claims for payment regardless of where the laboratory, patient, or provider resides or conducts business. The election would be made by the laboratories and an agreement between the carrier and the laboratory would be forwarded to the Secretary. No laboratory would be required to select a single carrier.

DUPLICATION AND COORDINATION OF MEDICARE-RELATED PRODUCTS

Present law

Many Medicare beneficiaries purchase private health insurance to supplement their Medicare coverage. These individually purchased policies are commonly known as Medigap policies. OBRA

90, P.L. 101–508 provided for a standardization of Medigap policies. OBRA 90 also substantially modified the antiduplication provision contained in law. The intent of the OBRA 90 anti-duplication provision was to prohibit sales of duplicative Medigap policies. However, the statutory language applied, with very limited exceptions, to all "health insurance policies" sold to Medicare beneficiaries. Observers noted that this provision could thus apply to a broad range of policies including hospital indemnity plans, dread disease policies, and long-term care insurance policies.

The Social Security Amendments of 1994 (P.L. 103–432) included a number of technical modifications to the Medigap statute, including modifications to the anti-duplication provisions. Under the revised language, it is illegal to sell or issue the following policies to Medicare beneficiaries: (i) a health insurance policy with knowledge that it duplicates Medicare or Medicaid benefits to which a beneficiary is otherwise entitled; (ii) a Medigap policy, with knowledge that the beneficiary already has a Medigap policy, or (iii) a health insurance policy (other than Medigap) with knowledge that it duplicates private health benefits to which the beneficiary is already entitled. A number of exceptions to these prohibitions are established. The sale of a Medigap policy is not in violation of the provisions relating to duplication of Medicaid coverage if: (i) the State Medicaid program pays the premiums for the policy; (ii) in the case of qualified Medicare beneficiaries (QMBs), the policy includes prescription drug coverage; or (iii) the only Medicaid assistance the individual is entitled to is payment of Medicare Part B premiums.

The sale of a health insurance policy (other than a Medigap policy) that duplicates private coverage is not prohibited if the policy pays benefits directly to the individual without regard to other coverage. Further, the sale of a health insurance policy (other than a Medigap policy to an individual entitled to Medicaid) is not in violation of the prohibition relating to selling of a policy duplicating Medicare or Medicaid, if the benefits are paid without regard to the duplication in coverage. This exception is conditional on the prominent disclosure of the extent of the duplication, as part of or together with, the application statement.

P.L. 103–432 provided for the development by the National Association of Insurance Commissioners (NAIC) of disclosure statements describing the extent of duplication for each of the types of private health insurance policies. Statements were to be developed, at a minimum, for policies paying fixed cash benefits directly to the beneficiary and policies limiting benefits to specific diseases. The NAIC identified 10 types of health insurance policies requiring disclosure statements and developed statements for them. These were approved by the Secretary and published in the FEDERAL REGISTER on June 12, 1995.

Reasons for change

The enactment of H.R. 5252, the Social Security Act Amendments of 1994 (P.L. 103–432) has created confusion in the market regarding the sale of Medigap polices and other health insurance policies to individuals on Medicare. This has resulted because the new law is confusing and unclear, and imposes a nearly impossible

requirement that is misleading, contradictory and potentially harmful to the very population it is intended to serve. First, the statute does not define the term ''duplication'' and, as a result the NAIC has declared that all policies are duplicative of Medicare without findings of any factual duplication. Second, the extent of duplication cannot be determined except on a case by case basis after application of Medicare's medical necessity determination, exclusions, and other limitations to a specific beneficiaries circumstance. The disclosure statements developed by the NAIC do not offer any helpful assistance to beneficiaries by declaring all policies are duplicative.

With respect to long-term care policies, the NAIC has recommended a disclosure statement which declares the long-term care policies duplicate some Medicare benefits, and significant issues are raised with respect to long-term care policies that coordinate against Medicare. The Secretary's approval and publication of the disclosure statements in the FEDERAL REGISTER on June 12, 1995 has resulted in the adoption of a position which is adverse to long-term care policies that coordinate against Medicare. The Secretary has essentially taken the position that such policies are technically illegal as of October 31, 1994, which is the effective date of H.R. 5252. However, the agency has not issued a written legal explanation or rule stating its position. The HCFA position on long-term care policies assumes that duplication exists and therefore policies must pay regardless of other coverage.

Concerns have been expressed to the Committee that HCFA's unofficial pronouncements are having a significant chilling effect on the long-term care insurance industry and the industry has no benefit of a written legal rulemaking or explanation of HCFA's rationale.

In addition, HCFA appears to be arguing that coordination is not good public policy. However, coordination against Medicare by long-term care policies is consistent with current public policy. Both State and Congressional policy is supportive of long-term care policies coordinating against Medicare. The Robert Wood Johnson State Medicaid and private long-term care policy partnership program requires coordination with Medicare. The bill includes provisions to clarify the tax treatment of long-term care insurance contracts. The Committee has determined that clarifying the tax treatment of long-term care insurance will help contribute to the development of the private long-term care insurance market. Therefore, it is imperative that Medicare plans are able to coordinate with long-term care insurance plans.

The developed statements far exceed the intent of Congress in both allowing coordination of long-term care policies and providing clear understandable information to Medicare beneficiaries regarding the choice of health insurance.

Finally, the current provisions are preventing the sale of individual major medical insurance policies to Medicare-eligible disabled persons.

Explanation of provision

Duplication and coordination of Medicare-related products

The Provision would modify the anti-duplication provisions. It would be unlawful to sell to a Medicare beneficiary a health insurance policy (other than a Medigap policy) with knowledge that it duplicated benefits under Medicare or Medicaid. It would be unlawful to sell, to persons not electing MedicarePlus, a Medigap policy with knowledge that the person is entitled to benefits under another Medigap policy. A policy would be considered duplicative if the policy provided specific reimbursement for identical items and services to the extent paid for under Medicare. A policy would not be considered duplicative if it provided for payment of benefits without regard to other health benefits coverage of the individual. The provision would change the disclosure requirements contained in P.L. 103–432 to require plans to disclose the extent to which they may coordinate benefits with Medicare as part of their separate outline of coverage.

A health insurance policy (or a rider to an insurance contract which is not a health insurance policy) that coordinates against or excludes items and services covered under Medicare, and for policies sold after January 1, 1996, discloses such coordination or exclusion in the policy's outline of coverage would not be considered duplicative. For this purpose, health insurance policies would include policies providing benefits for long-term care, nursing home care, home health care, or community-based care; or a contract with an HMO providing comprehensive health benefits.

The provision would prohibit the imposition of criminal or civil penalties or the bringing or continuing of legal action relating to selling duplicative policies if the penalty or action was based on actions occurring after November 1, 1991 and before enactment of OBRA of 1995 and if the policy was not duplicative under the revised language. The provision would also prohibit a State from imposing any requirement related to the sale or issuance of a policy (or rider) to a Medicare beneficiary based on the premise that the policy or rider was duplicative of Medicare.

Effective date

The provisions of this section are effective as if they were included in the enactment of section 4354 of the Omnibus Budget Reconciliation Act of 1990.

TITLE III. TAX-RELATED HEALTH PROVISIONS

A. Application of COBRA Sanctions (sec. 104(b) of the bill and sec. 4980B of the Code)

Present law

The health care continuation rules (referred to as "COBRA," after the name of the law that imposed the rules[1] require that most employer-sponsored group health plans must offer qualified beneficiaries the opportunity to continue to participate for a specified period of the employer's group health plan after the occurrence

[1] The Consolidated Omnibus Budget Reconciliation Act of 1985.

of certain qualifying events (such as termination for employment) that otherwise would have terminated such participation.

A tax is imposed on the failure of a plan to satisfy the health care continuation rules. The tax may be imposed on the employer sponsoring the plan in the case of a plan other than a multiemployer plan, on the plan in the case of a multiemployer plan, or on each person who is responsible for administering or providing benefits under the plan if such person has, by written agreement, assumed responsibility for performing the act pursuant to which the violation occurs.

The amount of the tax is equal to $100 dollars a day for each day for each day on which here is noncompliance. The maximum tax that can be imposed for a year with respect to violations occurring during the year generally is the lesser of (1) 10 percent of the employer's payments under group health plans (or under the trust funding the plan in the case of a multiemployer plan), or (2) $500,000. If the tax is imposed on another person responsible for administering the plan, the maximum penalty for failures during the year is $2 million. The Secretary of the Treasury may waive all or part of the tax to the extent that payment of the tax would be excessive relative to the failure involved.

Reasons for change

The Committee believes that the present-law sanctions for violations of the health care continuation rules will be an effective enforcement mechanism with the respect to the provisions of the bill relating to portability, limitations on exclusion of preexisting conditions, and prohibitions on excluding individuals from coverage based on health status.

Explanation of provision

Under the bill, group health plus, insurers, and health maintenance organizations are subject to certain requirements regarding portability, limitations on exclusion of preexisting conditions, and prohibitions on excluding individuals from coverage based on health status. The provision extends the tax for failure to satisfy the health care continuation rules to failures to comply with these requirements. No tax is imposed on an insurer that is governed under a State law that the Secretary of Health and Human Services has determined to provide similar enforcement. In addition, no tax is impose if here has been enforcement by the Secretary of Labor or the Secretary of Health and Human Services.

Effective date

The provision generally is effective with respect to plan years beginning on or after January 1, 1998.

B. Medical Savings Accounts (sec. 301 of the bill and new sec. 220 of the Code)

Present law

The tax treatment of health expenses depends on whether the individual is an employee or self-employed, and whether the individual is covered under an employer-sponsored health plan. Employer

contributions to a health plan for coverage for the employee and the employee's spouse and dependents are excludable from the employee's income and wages for social security tax purposes. Self-employed individuals are entitled to deduct 30 percent of the amount paid for health insurance for the self-employed individual and his or her spouse or dependents. The 30-percent deduction is available with respect to self insurance, as well as commercial insurance. The self-insured plan must in fact be insurance (e.g., there must be appropriate risk shifting) and not merely a reimbursement arrangement. Individuals who itemize their tax deductions may deduct unreimbursed medical expenses (including expenses for medical insurance) paid during the year to the extent that the total of such expenses exceeds 7.5 percent of the individual's adjusted gross income ("AGI"). Present law does not contain any special rules for medical savings accounts.

Reasons for change

The fact that Americans with low-deductible health insurance have few incentives to lower their health costs or benefit from staying well is a major factor affecting health care cost growth. One approach to providing incentives for Americans to be more cost conscious purchasers of medical services is to make available alternatives to low-deductible insurance such as medical savings accounts ("MSAs"). MSAs will give people more control over their health care dollars. Because MSAs afford people the opportunity to save unspent MSA funds for future health and long-term care needs, the Committee believes that people will be more prudent in their purchase of health care services.

Explanation of provision

In general

Under the bill, within limits, individuals covered by a high deductible health plan may make tax deductible contributions to an MSA. Similarly, within limits, contributions to an MSA are excludable from income (and wages for social security purposes) if made by the employer of an individual covered under a high deductible health plan. Earnings on amounts in an MSA are not currently taxable. Distributions from an MSA for medical expenses are not taxable. Distributions not used for medical expenses are taxable. In addition, distributions not used for medical expenses are subject to an additional 10-percent tax unless the distribution is made after age 59½, death, or disability.

Eligible individuals

An individual (including a self-employed individual) is eligible to make a deductible contribution to an MSA (or to have employer contributions made on his or her behalf) if the individual is covered under a high deductible health plan and is not covered under another health plan (other than a plan that provides certain permitted coverage).[2] An individual is not eligible to make contribu-

[2] An individual with other coverage in addition to a high deductible plan is still eligible for an MSA if such other coverage is certain permitted insurance or is coverage (whether provided through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term

tions to an MSA for a year if any employer contributions are made to an MSA or behalf of the individual for the year.

Tax treatment of and limits on contributions

Under the bill, individual contributions to an MSA are deductible (within limits) in determining AGI. Subject to the same limits, employer contributions to an MSA are excludable from gross income and wages for employment tax purposes, except that this exclusion does not apply to contributions made through a cafeteria plan. If the high deductible plan covers only the individual, the maximum amount of contributions that may be deducted or excluded for a year is equal to the lesser of (1) the deductible under the high deductible plan or (2) $2,000. If the high deductible plan covers the individual and a spouse or a dependent, the maximum that may be excluded or deducted for a year is the lesser of (1) the annual limit under the plan on the aggregate amount of deductibles required to be paid with respect to all individuals, and (2) $4,000. The annual limit is the sum of the limits determined separately for each month based on the individual's status as of the first day of the month. The maximum contribution limit to an MSA is determined separately for each spouse in a married couple. In no event may the maximum contribution limit for a year exceed $4,000 for a family. The dollar limits are indexed for medical inflation and rounded to the nearest multiple of $50.

Definition of high deductible plan

A high deductible health plan is a health insurance plan, whether self-insured or provided through commercial insurance, with a deductible of at least $1,500 in the case of single coverage and $3,000 in the case of coverage of more than one individual. These dollar limits are indexed for medical inflation, rounded to the nearest multiple of $50. A plan does not fail to be considered a high deductible plan merely because, under state law, the plan is required to provide that there is no deductible for preventive care. In the case of a self-insured plan, the plan must in fact be insurance (e.g., there must be appropriate risk shifting) and not merely a reimbursement arrangement.

Tax treatment of MSAs

MSAs are exempt from tax. Thus, earnings on amounts in an MSA are not currently includible in income.

Taxation of distributions

Under the bill, distributions from an MSA for the unreimbursed medical expenses of the individual (including a self-employed individual) and his or her spouse or dependents are excludable from income. The exclusion applies regardless of whether the payment is made directly from the MSA to the service provider, the MSA distribution reimburses the individual for expenses already incurred,

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care. Permitted insurance is: (1) Medicare supplemental insurance, (2) insurance if substantially all of the coverage provided under such insurance relates to (a) liabilities incurred under worker's compensation law, (b) tort liabilities, (c) liabilities relating to ownership or use of property (e.g., auto insurance), or (d) such other similar liabilities as the Secretary may prescribe by regulations; (3) insurance for a specified disease or illness; and (4) insurance that provides a fixed payment for hospitalization.

or the individual uses the MSA distribution to pay the service provider. The exclusion also applies regardless of whether the individual is eligible to make MSA contributions at the time of the distribution.

Medical expenses are defined as defined as under the rules relating to the itemized deduction for medical expenses, except that medical expenses for this purpose do not include insurance premiums other than (1) premiums for long-term care insurance; (2) premiums for health care continuation coverage under any Federal law; and (3) premiums while the individual is receiving unemployment compensation.[3] Thus, for example, amounts in an MSA can be used, at the account holder's discretion, for services performed by a variety of health care professionals either licensed, certified, or otherwise credentialed to provide health care services under State law (or under a State regulatory mechanism provided by State law, to the extent such services are treated as medical expenses under the rules relating to the itemized deduction for medical expenses.

Distributions that are not for medical expenses are included in income. In addition, such distributions are subject to an additional 10-percent tax unless made after age 59½, death, or disability.

Upon death, if the beneficiary of the MSA is the individual's surviving spouse, the spouse may continue the MSA as his or her own. If the beneficiary is not the surviving spouse, the beneficiary must include the MSA balance in income in the year of death. If there is no beneficiary, the MSA balance includible on the final return of the decedent. In all cases, no estate tax applies.

Definition of an MSA

In general, an MSA is a trust or custodial account created exclusively for the benefit of the account holder and is subject to rules similar to those applicable to individual retirement arrangements. An MSA trustee (or custodian) may be a bank, insurance company, or other person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with applicable requirements. The MSA trustee (or custodian) is required to make such reports as may be required by the Secretary. The acquisition expenses of an insurance company relating to the establishment of an MSA is not subject to the rules relating to the capitalization of policy acquisition costs.

Effective date

The provision is effective for taxable years beginning after December 31, 1996.

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[3] The long-term care provisions of the bill (see part D., below) provide that expenses for long-term care services are treated as medical expenses for purposes of the itemized deduction for medical expenses. Thus, an individual could use amounts in an MSA to pay expenses for long-term care insurance or services.

C. Deduction for Health Insurance Expenses of Self-Employed Individuals (sec. 311 of the bill and sec. 162(I) of the Code)

Present law

Under present law, self-employed individuals are entitled to deduct 30 percent of the amount paid for health insurance for the self-employed individual and the individual's spouse and dependents. The deduction is not available for any month in which the taxpayer is eligible to participate in a subsidized health plan maintained by the employer of the taxpayer or the taxpayer's spouse. The 30-percent deduction is available in the case of self insurance as well as commercial insurance. The self-insured plan must in fact be insurance (e.g., there must be appropriate risk shifting) and not merely a reimbursement arrangement.

Reasons for change

The Committee believes it appropriate to increase the deduction for health insurance expenses of self-employed individuals in order to reduce the disparity of treatment of such expenses and employer-provided health insurance and to help make health insurance more affordable for self-employed individuals.

Explanation of provision

Under the provision, the deduction for health insurance for self-employed individuals is phased up to 50 percent as follows: for taxable years beginning in 1998, the amount of the deduction is 35 percent of health insurance expenses; for taxable years beginning in 1999, 2000, and 2001, 40 percent; for taxable years beginning in 2002, 45 percent; and for taxable years beginning in 2003 and thereafter, 50 percent.

Effective date

The provision is effective for taxable years beginning after December 31, 1997.

D. Treatment of Long-Term Care Insurance and Services (secs. 321–328 of the bill, and secs. 106, 125, 213, 4980B of the Code, and new secs. 4980C, 6050Q, and 7702B of the Code)

Present law

In general

Present law generally does not provide explicit rules relating to the tax treatment of long-term care insurance contracts or long-term care services. Thus, the treatment of long-term care contracts and services is unclear. Present law does provide rules relating to medical expenses and accident or health insurance.

Itemized deduction for medical expenses

In determining taxable income for Federal income tax purposes, a taxpayer is allowed an itemized deduction for unreimbursed expenses that are paid by the taxpayer during the taxable year for medical care of the taxpayer, the taxpayer's spouse, or a dependent of the taxpayer, to the extent that such expenses exceed 7.5 percent of the adjusted gross income of the taxpayer for such year (sec.

213). For this purpose, expenses paid for medical care generally are defined as amounts paid: (1) for the diagnosis, cure, mitigation, treatment, or prevention of disease (including prescription medicines or drugs and insulin), or for the purpose of affecting any structure or function of the body (other than cosmetic surgery not related to disease, deformity, or accident); (2) for transportation primarily for, and essential to, medical care referred to in (1); (3) for insurance (including Part B Medicare premiums) covering medical care referred to in (1) and (2).

Exclusion for amounts received under accident or health insurance

Amounts received by a taxpayer under accident or health insurance for personal injuries or sickness generally are excluded from gross income to the extent that the amounts received are not attributable to medical expenses that were allowed as a deduction for a prior taxable year (sec. 104).

Treatment of accident or health plans maintained by employers

Contributions of an employer to an accident or health plan that provides compensation (through insurance or otherwise) to an employee for personal injuries or sickness of the employee, the employee's spouse, or a dependent of the employee, are excluded from the gross income of the employee (sec. 106). In addition, amounts received by an employee under such a plan generally are excluded from gross income to the extent that the amounts received are paid, directly or indirectly, to reimburse the employee for expenses for the medical care of the employee, the employee's spouse, or a dependent of the employee (sec. 105). For this purpose, expenses incurred for medical care are defined in the same manner as under the rules regarding the deduction for medical expenses.

A cafeteria plan is an employer-sponsored arrangement under which employees can elect among cash and certain employer-provided qualified benefits. No amount is included in the gross income of a participant in a cafeteria plan merely because the participant has the opportunity to make such an election (sec. 125). Employer-provided accident or health coverage is one of the benefits that may be offered under a cafeteria plan.

A flexible spending arrangement (FSA) is an arrangement under which an employee is reimbursed for medical expenses or other nontaxable employer-provided benefits, such as dependent care, and under which the maximum amount of reimbursement that is reasonably available to a participant for a period of coverage is not substantially in excess of the total premium (including both employee-paid and employer-paid portions of the premium) for such participant's coverage. Under proposed Treasury regulations, a maximum amount of reimbursement is not substantially in excess of the total premium if such maximum amount is less than 500 percent of the premium. An FSA may be part of a cafeteria plan or provided by an employer outside a cafeteria plan. FSAs are commonly used to reimburse employees for medical expenses not cov-

ered by insurance. If certain requirements are satisfied,[4] amounts reimbursed for nontaxable benefits from an FSA are excludable from income.

Health care continuation rules

The health care continuation rules require that an employer must provide qualified beneficiaries the opportunity to continue to participate for a specified period in the employer's health plan after the occurrence of certain events (such as termination of employment) that would have terminated such participation (sec. 4980B). Individuals electing continuation coverage can be required to pay for such coverage.

Reasons for change

The long-term care rules of the bill provide an incentive for individuals to take financial responsibility for their long-term care needs. The bill therefore generally provides favorable tax treatment with respect to long-term care insurance contracts and services meeting the bill's requirements.

Explanation of provision

Tax treatment and definition of long-term care insurance contracts and qualified long-term care services

Exclusion of long-term care proceeds

A long-term care insurance contract generally is treated as an accident and health insurance contract. Amounts (other than policyholder dividends or premium refunds) received under a long-term care insurance contract generally are excludable as amounts received for personal injuries and sickness, subject to a cap of $175 per day, or $63,875 annually, on per diem contracts only. If the aggregate payments under all per diem contracts with respect to any one insured exceed $175 per day, then the excess is not excludable from gross income. The dollar cap is indexed by the medical care cost component of the consumer price index.

Exclusion for employer-provided long-term care coverage

A plan of an employer providing coverage under a long-term care insurance contract generally is treated as an accident and health plan. Employer-provided coverage under a long-term care insurance contract is not, however, excludable by an employee if provided through a cafeteria plan; similarly, expenses for long-term care services cannot be reimbursed under an FSA.[5]

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[4] These requirements include a requirement that a health FSA can only provide reimbursement for medical expenses (as defined in sec. 213) and cannot provide reimbursement for premium payments for other health coverage and that the maximum amount of reimbursement under a health FSA must be available at all times during the period of coverage.

[5] The bill does not otherwise modify the requirements relating to FSAs. An FSA is defined as a benefit program providing employees with coverage under which specified incurred expenses may be reimbursed (subject to maximums and other reasonable conditions), and the maximum amount of reimbursement that is reasonably available to a participant is less than 500 percent of the value of the coverage.

Definition of long-term care insurance contract

A long-term care insurance contract is defined as any insurance contract that provides only coverage of qualified long-term care services and that meets other requirements. The other requirements are that (1) the contract is guaranteed renewable, (2) the contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged or borrowed, (3) refunds (other than refunds on the death of the insured or complete surrender or cancellation of the contract) and dividends under the contract may be used only to reduce future premiums or increase future benefits, and (4) the contract generally does not pay or reimburse expenses reimbursable under Medicare (except where Medicare is a secondary payor, or the contract makes per diem or other periodic payments without regard to expenses).

A contract does not fail to be treated as a long-term care insurance contract solely because it provides for payments on a per diem or other periodic basis without regard to expenses incurred during the period.

Medicare duplication rules

The bill provides that no provision of law shall be construed or applied so as to prohibit the offering of a long-term care insurance contract on the basis that the contract coordinates its benefits with those provided under Medicare. Thus, long-term care insurance contracts are not subject to the rules requiring duplication of Medicare benefits.

Definition of qualified long-term care services

Qualified long-term care services means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services, and maintenance or personal care services that are required by a chronically ill individual and that are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

A chronically ill individual is one who has been certified within the previous 12 months by a licensed health care practitioner as (1) being unable to perform (without substantial assistance) at least 2 activities of daily living for at least 90 days[6] due to a loss of functional capacity, (2) having a similar level of disability as determined by the Secretary of the Treasury in consultation with the Secretary of Health and Human Services, or (3) requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment. Activities of daily living are eating, toileting, transferring, bathing, dressing and continence.[7]

It is intended that an individual who is physically able but has a cognitive impairment such as Alzheimer's disease or another

[6] The 90-day period is not a waiting period. Thus, for example, an individual can be certified as chronically ill if the licensed health care practitioner certifies that the individual will be unable to perform at least 2 activities of daily living for at least 90 days.

[7] Nothing in the bill requires the contract to take into account all of the activities of daily living. For example, a contract could require that an individual be unable to perform (without substantial assistance) 2 out of any 5 such activities, or for another example, 3 out of the 6 activities.

form of irreversible loss of mental capacity be treated similarly to an individual who is unable to perform (without substantial assistance) at least 2 activities of daily living. Because of the concern that eligibility for the medical expense deduction not be diagnosis-driven, the provision requires the cognitive impairment to be severe. It is intended that severe cognitive impairment mean a deterioration or loss in intellectual capacity that is measured by clinical evidence and standardized tests which reliably measure impairment in: (1) short- or long-term memory; (2) orientation to people, places or time; and (3) deductive or abstract reasoning. In addition, it is intended that such deterioration or loss place the individual in jeopardy of harming self or others and therefore require substantial supervision by another individual.

A licensed health care practitioner is a physician (as defined in sec. 1861(r)(1) of the Social Security Act) and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary of the Treasury.

Expenses for long-term care services treated as medical expenses

Unreimbursed expenses for qualified long-term care services provided to the taxpayer or the taxpayer's spouse or dependent are treated as medical expenses for purposes of the itemized deduction for medical expenses (subject to the present-law floor of 7.5 percent of adjusted gross income). For this purpose, amounts received under a long-term care insurance contract (regardless of whether the contract reimburses expenses or pays benefits on a per diem or other periodic basis) are treated as reimbursement for expenses actually incurred for medical care.

For purposes for the deduction for medical expenses, qualified, long-term care services do not include services provided to an individual by a relative or spouse (directly, or through a partnership, corporation, or other entity), unless the relative is a licensed professional with respect to such services, or by a related corporation (within the meaning of Code section 267(b) or 707(b)).[8]

Long-term care insurance premiums treated as medical expenses

Long-term care insurance premiums that do not exceed specified dollar limits are treated as medical expenses for purposes of the itemized deduction for medical expenses.[9] The limits are as follows:

In the case of an individual with an attained age before the close of the taxable year of:	*The limitation on premiums paid for such taxable year is:*
Not more than 40	$200
More than 40 but not more than 50	375
More than 50 but not more than 60	750
More than 60 but not more than 70	2,000
More than 70	2,500

[8] The rule limiting such services provided by a relative or a related corporation does not apply for purposes of the exclusion for amounts received under a long term-care insurance contract, whether the contract is employer-provided or purchased by an individual. The limitation is unnecessary in such cases because it is anticipated that the insurer will monitor reimbursements to limit opportunities for fraud in connection with the performance of services by the taxpayer's relative or a related corporation.

[9] Similarly, within certain limits, in the case of a rider to a life insurance contract, charges against the life insurance contract's cash surrender value that are includible in income are treated as medical expenses (provided the rider constitutes a long-term care insurance contract).

For taxable years beginning after 1997, these dollar limits are indexed for increases in the medical care component of the consumer price index. The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, is directed to develop a more appropriate index to be applied in lieu of the foregoing. Such an alternative might appropriately be based on increases in skilled nursing facility and home health care costs. It is intended that the Treasury Secretary annually publish the indexed amount of the limits as early in the year as they can be calculated.

Deduction for long-term care insurance of self-employed individuals

The present-law 30 percent deduction for health insurance expenses of self-employed individuals is phased up to 50 percent under the bill. Because the bill treats payments of eligible long-term care insurance premiums in the same manner as medical insurance premiums, the self-employed health insurance deduction applies to eligible long-term care insurance premiums under the bill.

Long-term care riders on life insurance contracts

In the case of long-term care insurance coverage provided by a rider on or as part of a life insurance contract, the requirements applicable to long-term care insurance contracts apply as if the portion of the contract providing such coverage were a separate contract. The term ''portion'' means only the terms and benefits that are in addition to the terms and benefits under the life insurance contract without regard to long-term care coverage. As a result, if the applicable requirements are met by the long-term care portion of the contract, amounts received under the contract as provided by the rider are treated in the same manner as long-term insurance benefits, whether or not the payment of such amounts causes a reduction in the contract's death benefit or cash surrender value. The guideline premium limitation applicable under section 7702(c)(2) is increased by the sum of charges (but not premium payments) against the life insurance contract's cash surrender value, the imposition of which reduces premiums paid for the contract (within the meaning of sec. 7702(f)(1)). In addition, it is anticipated that Treasury regulations will provide for appropriate reduction in premiums paid (within the meaning of sec. 7702(f)(1)) to reflect the payment of benefits under the rider that reduce the cash surrender value of the life insurance contract. A similar rule should apply in the case of a contract governed by section 101(f) and in the case of the payments under a rider that are excludable under section 101(g) of the Code (as added by this bill).

Health care continuation rules

The health care continuation rules do not apply to coverage under a long-term care insurance contract.

Inclusion of excess long-term care benefits

In general, the bill provides that the maximum annual amount of long-term care benefits under a per diem type contract that is excludable from income with respect to an insured who is chron-

ically ill (not including amounts received by reason of the individual being terminally ill)[10] cannot exceed the equivalent of $175 per day for each day the individual is chronically ill. Thus, for per diem type contracts, the maximum annual exclusion for long-term care benefits with respect to any chronically ill individual (not including amounts received by reason of the individual being terminally ill) is $63,875 (for 1997). If payments under such contracts exceed the dollar limit, then the excess is excludable only to the extent the individual has incurred actual costs for long-term care services. If the insured is not the same as the holder of the contract, the insured may assign some or all of this limit to the contract holder at the time and manner prescribed by the Secretary.

This $175 per day limit is indexed for inflation after 1997 for increases in the medical care component of the consumer price index. The Treasury Secretary, in consultation with the Secretary of Health and Human Services, is directed to develop a more appropriate index, to be applied in lieu of the foregoing. Such an alternative might appropriately be based on increases in skilled nursing facility and home health care costs. It is intended that the Treasury Secretary annually publish the indexed amount of the limit as early in the year as it can be calculated.

A payor of long-term care benefits (defined for this purpose to include any amount paid under a product advertised, marketed or offered as long-term care insurance) is required to report to the IRS the aggregate amount of such benefits paid to any individual during any calendar year, and the name, address and taxpayer identification number of such individual. A copy of the report must be provided to the payee by January 31 following the year of payment, showing the name of the payor and the aggregate amount of benefits paid to the individual during the calendar year. Failure to file the report or provide the copy to the payee is subject to the generally applicable penalties for failure to file similar information reports.

Consumer protection provisions

Under the bill, long-term care insurance contracts, and issuers of contracts, are required to satisfy certain provisions of the long-term care insurance model Act and model regulations promulgated by the National Association of Insurance Commissioners (as adopted as of January 1993). The policy requirements relate to disclosure, nonforfeitability, guaranteed renewal or noncancellability, prohibitions on limitations and exclusions, extension of benefits, continuation or conversion of coverage, discontinuance and replacement of policies, unintentional lapse, post-claims underwriting, minimum standards, inflation protection, preexisting conditions, and prior hospitalization. The bill also provides disclosure and nonforfeiture requirements. The nonforfeiture provision gives consumers the option of selecting reduced paid-up insurance, extended term insurance, or a shortened benefit period in the event a policyholder who elects a nonforfeiture provision is unable to continue to pay pre-

[10] Terminally ill is defined as under the provision of the bill relating to accelerated death benefits. In general, under that provision, an individual is considered to be terminally ill if he or she is certified as having an illness or physical condition that reasonably can be expected to result in death within 24 months of the date of the certification.

miums. The requirements for issuers of long-term care insurance contracts relate to application forms, reporting requirements, marketing, appropriateness of purchase, format, delivering a shopper's guide, right to return, outline of coverage, group plans, policy summary, monthly reports on accelerated death benefits, and incontestability period. A tax is imposed equal to $100 per policy per day for failure to satisfy these requirements.

Nothing in the proposal prevents a State from establishing, implementing or continuing standards related to the protection of policyholders of long-term care insurance policies, if such standards are not inconsistent with standards established under the bill.

Effective date

The provisions defining long-term care insurance contracts and qualified long-term care services apply to contracts issued after December 31, 1996. Any contract issued before January 1, 1997, that met the long-term care insurance requirements in the State in which the policy was sitused at the time it was issued is treated as a long-term care insurance contract, and services provided under or reimbursed by the contract are treated as qualified long-term care services.

A contract providing for long-term care insurance may be exchanged for a long-term care insurance contract (or the former cancelled and the proceeds reinvested in the latter within 60 days) tax free between the date of enactment and January 1, 1998. Taxable gain would be recognized to the extent money or other property is received in the exchange.

The issuance or conformance of a rider to a life insurance contract providing long-term care insurance coverage is not treated as a modification or a material change for purposes of applying sections 101(f), 7702 and 7702A of the Code.

The provisions relating to treatment of eligible long-term care premiums and long-term care services as a medical expense generally are effective for taxable years beginning after December 31, 1996, however, amounts paid for long-term care services furnished in any taxable year beginning before January 1, 1998 are not deductible as medical expenses.

The provisions relating to the maximum exclusion for certain long-term care benefits and reporting are effective for taxable years beginning after December 31, 1996. Thus, the initial year in which reports will be filed with the IRS and copies provided to the payee will be 1988, with respect to long-term care benefits paid in 1997.

E. Tax Treatment of Accelerated Death Benefits Under Life Insurance Contracts (secs. 323 and 331–332 of the bill and secs. 101(g), 818(g), 605Q, and 7702B of the Code)

Present law

Treatment of amounts received under a life insurance contract

If a contract meets the definition of a life insurance contract, gross income does not include insurance proceeds that are paid pursuant to the contract by reason of the death of the insured (sec. 101(a)). In addition, the undistributed investment income ("inside

buildup") earned on premiums credited under the contract is not subject to current taxation to the owner of the contract. The exclusion under section 101 applies regardless of whether the death benefits are paid as a lump sum or otherwise.

Amounts received under a life insurance contract (other than a modified endowment contract) prior to the death of the insured are includible in the gross income of the recipient to the extent that the amount received constitutes cash value in excess of the taxpayer's investment in the contract (generally, the investment in the contract is the aggregate amount of premiums paid less amounts previously received that were excluded from gross income).

If a contract fails to be treated as a life insurance contract under section 7702(a), inside buildup on the contract is generally subject to tax (sec. 7702(g)).

Requirements for a life insurance contract

To qualify as a life insurance contract for Federal income tax purposes, a contract must be a life insurance contract under the applicable State or foreign law and must satisfy either of two alternative tests: (1) cash value accumulation test or (2) a test consisting of a guideline premium requirement and a cash value corridor requirement (sec. 7702(a)). A contract satisfies the cash value accumulation test if the cash surrender value of the contract may not at any time exceed the net single premium that would have to be paid at such time to fund future benefits under the contract. A contract satisfies the guideline premium and cash value corridor tests if the premiums paid under the contract do not at any time exceed the greater of the guideline single premium or the sum of the guideline level premiums, and if the death benefit under the contract is not less than a varying statutory percentage of the cash surrender value of the contract.

Proposed regulations on accelerated death benefits

The Treasury Department has issued proposed regulations[11] under which certain "qualified accelerated death benefits" paid by reason of the terminal illness of an insured would be treated as paid by reason of the death of the insured and therefore qualify for exclusion under section 101. In addition, the proposed regulations would permit an insurance contact that includes a qualified accelerated death benefit rider to qualify as a life insurance contract under section 7702. Thus, the proposed regulations provide that including this benefit would not cause an insurance contract to fail to meet the definition of a life insurance contract.

Under the proposed regulations, a benefit would qualify as a qualified accelerated death benefit only if it meets three requirements. First, the accelerated death benefit can be payable only if the insured becomes terminally ill. Second, the amount of the benefit must equal or exceed the present value of the reduction in the death benefit otherwise payable.[12] Third, the cash surrender value

[11] Prop. Treas. Reg. Secs. 1.108–8, 1.7702–0, 1.7702–2, and 1.7702A–1 (December 15, 1992).

[12] For purposes of determining the present value under the proposed regulations, the maximum permissible discount rate would be the greater of (1) the applicable Federal rate that applies under the discounting rules for property and casualty insurance loss reserves, and (2) the

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and the death benefit payable under the policy must be reduced proportionately as a result of the accelerated death benefit.

For purposes of the proposed regulations, an insured would be treated as terminally ill if he or she has an illness that, despite appropriate medical care, the insurer reasonably expects to result in death within twelve months from the payment of the accelerated death benefit. The proposed regulations would apply to viatical settlements.

Reasons for change

The Committee wishes to extend the present-law rule permitting an exclusion from income for amounts paid under a life insurance contract by reason of the death of the insured to accelerated death benefits paid with respect to certain terminally ill and chronically ill insured individuals. In addition, the Committee believes that this exclusion from income should be extended to certain sales or assignments of all or a portion of a life insurance contract to a viatical settlement provider. The Committee believes that a single set of rules should apply to benefit received with respect to a chronically ill individual. To provide parity in treatment, the same definition of a chronically ill individual applies for purposes of the rules under this provision and the rules governing long-term care insurance contracts. Further the $175 per day ($63,875 annual) limit on excludability of benefits under per diem type long-term care insurance contracts applies for chronically ill individuals.

Explanation of provision

The bill provides an exclusion from gross income as an amount paid by reason of the death of an insured for (1) amounts received under a life insurance contract and (2) amount received for the sale or assignment of a life insurance contract to a qualified viatical settlement provider, provided that the insured under the life insurance contract is either terminally ill or chronically ill.[13]

The provision does not apply in the case of an amount paid to any taxpayer other than the insured, if such taxpayer has an insurable interest by reason of the insured being a director, officer or employee of the taxpayer, or by reason of the insured being financially interested in any trade or business carried on by the taxpayer.

A terminally ill individual is defined as one who has been certified by a physician as having an illness or physical condition that reasonably can be expected to result in death within 24 months of the date of certification. A physician is defined for this purpose in the same manner as under the long-term care insurance rules of the bill.[14]

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interest rate applicable to policy loans under the contract. Also, the present value would be determined assuming that the death benefit would have been paid twelve months after payment of the accelerated death benefit.

[13] The exclusion for amounts received under a life insurance contract on the life of an insured who is chronically ill applies if the amount is received under a rider or other provision of the contract that is treated as a long-term care insurance contract under section 7702B (as added by the bill), and the amount is excludable as a payment for long-term care services under section 7702B.

[14] A physician is defined for these purposes as in section 1861(r)(1) of the Social Security Act, which provides that a physician means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (includ-

A chronically ill individual is defined under the long-term care provisions of the bill.[15] In the case of amounts received with respect to a chronically ill individual (but not amounts received by reason of the individual being terminally ill), the $175 per day ($63,875 annual) limitation on excludable benefits that applies for per diem type long-term care insurance contracts also limits amounts that are excludable with respect to such contracts under this provision. The payor of a payment with respect to an individual who is chronically ill is required to report to the IRS the aggregate amount of such benefits paid to any individual during any calendar year, and the name, address and taxpayer identification number of such individual. A copy of the report must be provided to the payee by January 31 following the year of payment, showing the name of the payer and the aggregate amount of such benefits paid to the individual during the calendar year. Failure to file the report or provide the copy to the payee is subject to the generally applicable penalties for failure to file similar information reports.

A qualified viatical settlement provider is any person that regularly purchases or takes assignments of life insurance contracts on the lives of the terminally ill individuals and either: (1) is licensed for such purposes in the State in which the insured resides; or (2) if the person is not required to be licensed by that State, meets the requirements of the sections 8 and 9 of the Viatical Settlements Model Act (issued by the National Association of Insurance Commissioners (NAIC)), and also meets the section of the NAIC Viatical Settlements Model Regulation relating to standards for evaluation of reasonable payments, including discount rates, in determining amounts paid by the viatical settlement provider.

For life insurance company tax purposes, the bill provides that a life insurance contract is treated as including a reference to a qualified accelerated death benefit rider to a life insurance contract (except in the case of any rider that is treated as a long-term care insurance contract under section 7702B, as added by the bill). A qualified accelerated death benefit rider is any rider on a life insurance contract that provides only for payments of a type that are excludable under this provision.

Effective date

The provision applies to amounts received after December 31, 1996. The provision treating a qualified accelerated death benefit rider as life insurance for life insurance company tax purposes takes effect on January 1, 1997. The issuance of qualified accelerated death benefit rider to a life insurance contract, or the addition of any provision required to conform an accelerated death benefit

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ing a physician within the meaning of section 1101(a)(7) of that Act). Section 1101(a)(7) of that Act provides that the term physician includes osteopathic practitioners within the scope of their practice as defined by State law.

[15] Thus, a chronically ill individual is one who has been certified within the previous 12 months by a licensed health care practitioner as (1) being unable to perform (without substantial assistance) at least 2 activities of daily living for at least 90 days due to a loss of functional capacity, (2) having a similar level of disability as determined by the Secretary of the Treasury in consultation with the Secretary of Health and Human Services, or (3) requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment. Activities of daily living are eating, toileting, transferring, bathing, dressing and continence. Nothing in the bill requires the contract to take into account all of the activities of daily living.

rider to these provisions, is not treated as a modification or material change of the contract (and is not intended to affect the issue date of any contract under section 101(f)).

F. Exemption From Income Tax for State-Sponsored Organizations Providing Health Coverage for High-Risk Individuals (sec. 341 of the bill and new section 501(c)(26) of the Code)

Present law

In general, the Internal Revenue Service ("IRS") takes the position that organizations that provide insurance for their members or other individuals are not considered to be engaged in a tax-exempt activity. The IRS maintains that such insurance activity is either (1) a regular business of a kind ordinarily carried on for profit, or (2) an economy or convenience in the conduct of members' businesses because it relieves the members from obtaining insurance on an individual basis.

Certain insurance risk pools have qualified for tax exemption under Code section 501(c)(6). In general, these organizations (1) assign any insurance policies and administrative functions to their member organizations (although they may reimburse their members for amounts paid and expenses); (2) serve an important common business interest of their members; and (3) must be membership organizations financed, at least in part, by membership dues.

State insurance risk pools may also qualify for tax exempt status under section 501(c)(4) as social welfare organizations or under section 115 as serving an essential governmental function of a State. In seeking qualification under section 501(c)(4), insurance organizations generally are constrained by the restrictions on the provision of "commercial-type insurance" contained in section 501(m). Section 115 generally provides that gross income does not include income derived from the exercise of any essential governmental function and accruing to a State or any political subdivision thereof. However, the IRS may be reluctant to rule that particular State risk-pooling entities satisfy the section 501(c)(4) or 115 requirements for tax-exempt status.

Reasons for change

The Committee believes that eliminating the uncertainty concerning the eligibility of certain State health insurance risk pools for tax-exempt status will assist States in providing medical care coverage for their uninsured high-risk residents.

Explanation of provision

The bill provides tax-exempt status to any membership organization that is established by a State exclusively to provide coverage for medical care on a nonprofit basis to certain high-risk individuals, provided certain criteria are satisfied.[16] The organization may provide coverage for medical care either by issuing insurance itself or by entering into an arrangement with a health maintenance organization ("HMO").

[16] No inference is intended as to the tax treatment of other types of State-sponsored organizations.

High-risk individuals eligible to receive medical care coverage from the organization must be residents of the State who, due to a pre-existing medical condition, are unable to obtain health coverage for such condition through insurance or an HMO, or are able to acquire such coverage only at a rate that is substantially higher than the rate charged for such coverage by the organization. The State must determine the composition of membership in the organization. For example, a State could mandate that all organizations that are subject to insurance regulation by the State must be members of the organization.

The bill further requires the State or members of the organization to fund the liabilities of the organization to the extent that premiums charged to eligible individuals are insufficient to cover such liabilities. Finally, no part of the net earnings of the organization can inure to the benefit of any private shareholder or individual.

Effective date

The provision applies to taxable years beginning after December 31, 1996.

G. Health Insurance Organizations Eligible for Benefits of Section 833 (sec. 351 of the bill and sec. 833 of the Code)

Present law

An organization described in sections 501(c)(3) or (4) of the Code is exempt from tax only if no substantial part of its activities consists of providing commercial-type insurance (sec. 501(m)). Special rules apply to certain eligible health insurance organizations. Eligible health insurance organizations are (1) Blue Cross and Blue Shield organizations existing on August 16, 1986, which have not experienced a material change in structure or operations since that date, and (2) other organizations that meet certain community-service-related requirements and substantially all of whose activities involve the providing of health insurance. Section 833 provides that eligible organizations are generally treated as stock property and casualty insurance companies.

Section 833 provides a special deduction for eligible organizations, equal to 25 percent of the claims and expenses incurred during the year, less the adjusted surplus at the beginning of the year. This deduction is calculated by computing surplus, taxable income, claims incurred, expenses incurred, tax-exempt income, net operating loss carryovers, and other items attributable to health business. The deduction may not exceed taxable income attributable to health business for the year (calculated without regard to this deduction).

In addition, section 833 eliminates, for eligible organizations, the 20 percent reduction in unearned premium reserves that applies generally to all property and casualty insurance companies.

Reasons for change

The Committee believes fairness dictates that the special rules benefitting Blue Cross and Blue Shield organizations under section 833 should apply to certain organizations that became taxable by

reason of the same provision of the Tax Reform Act of 1986 that made Blue Cross and Blue Shield organizations taxable, if such organizations are not Blue Cross or Blue Shield organizations, but otherwise meet the eligibility requirements.

Explanation of provision

The bill applies the special rules under section 833 to the same extent they are provided to certain existing Blue Cross or Blue Shield organizations, in the case of any organization that (1) is not a Blue Cross or Blue Shield organization existing on August 16, 1986, and (2) otherwise meets the requirements of section 833(c)(2) (including the requirement of no material change in operations or structure since August 16, 1986). Under the provision, an organization qualifies for this treatment only if (1) it is not a health maintenance organization and (2) it is organized under and governed by State laws which are specifically and exclusively applicable to not-for-profit health insurance or health service type organizations.

Effective date

The provision is effective for taxable years ending after December 31, 1996.

TITLE IV. REVENUE OFFSETS

A. Treatment of Bad Debt Deductions of Thrift Institutions (sec. 401 of the bill and sec. 593 of the Code)

Present law and background

Reserve method of accounting for bad debts of thrift institutions

Generally, a taxpayer engaged in a trade or business may deduct the amount of any debt that becomes wholly or partially worthless during the year (the ''specific charge-off'' method of sec. 166). Certain thrift institutions (building and loan associations, mutual savings banks, or cooperative banks) are allowed deductions for bad debts under rules more favorable than those granted to other taxpayers (and more favorable than the rules applicable to other financial institutions). Qualified thrift institutions may compute deductions for bad debts using either the specific charge-off method or the reserve method of section 593. To qualify for this reserve method, a thrift institution must meet an asset test, requiring that 60 percent of its assets consist of ''qualifying assets'' (generally cash, government obligations, and loans secured by residential real property). This percentage must be computed at the close of the taxable year, or at the option of the taxpayer, as the annual average of monthly, quarterly, or semiannual computations of similar percentages.

If a thrift institution uses the reserve method of accounting, it must establish and maintain a reserve for bad debts and charge actual losses against the reserve, and is allowed a deduction for annual additions to restore the reserve to its permitted balance. Under section 593, a thrift institution annually may elect to calculate its addition to its bad debt reserve under either (1) the ''percentage of taxable income'' method applicable only to thrift institu-

tions, or (2) the "experience" method that also is available to small banks.

Under the "percentage of taxable income" method, a thrift institution generally is allowed a deduction for an addition to its bad debt reserve equal to 8 percent of its taxable income (determined without regard to this deduction and with additional adjustments). Under the experience method, a thrift institution generally is allowed a deduction for an addition to its bad debt reserve equal to the greater of: (1) an amount based on its actual average experience for losses in the current and five preceding taxable years, or (2) an amount necessary to restore the reserve to its balance as of the close of the base year. For taxable years beginning before 1988, the "base year" was the last taxable year before the most recent adoption of the experience method (i.e., generally, the last year the taxpayer was on the percentage of taxable income method). For taxable years beginning after 1987, the base year is the last taxable year beginning before 1988. Prior to 1988, computing bad debts under a "base year" rule allowed a thrift institution to claim a deduction for bad debts for an amount at least equal to the institution's actual losses that were charged off during the taxable year.

Bad debt methods of commercial banks

A small commercial bank (i.e., one with adjusted bases of assets of $500 million or less) may use the experience method or the specific charge-off method for purposes of computing its deduction for bad debts. A large commercial bank only may use the specific charge-off method of section 166. If a small bank becomes a large bank, it must recapture its existing bad debt reserve (i.e., include the amount of the reserve in income) through one of two elective methods. Under the 4-year recapture method, the bank generally includes 10 percent of the reserve in income in the first taxable year 20 percent in the second year, 30 percent in the third year, and 40 percent in the fourth year. Under the cut-off method, the bank generally neither restores its bad debt reserve to income nor may it deduct losses relating to loans held by the bank as of the date of the required change in the method of accounting. Rather, the amount of such losses are charged against and reduce the existing bad debt reserve; any losses in excess of the reserve are deductible. Any reserve balance in excess of the balance of related loans is includable in income.

Recapture of bad debt reserves by thrift institutions

If a thrift institution becomes a commercial bank, or if the institution fails to satisfy the 60-percent qualified asset test, it is required to change its method of accounting for bad debts and, under proposed Treasury regulations,[17] is required to recapture its bad debt reserve. The percentage-of-taxable-income portion of the reserve generally is included in income ratably over a 6-taxable year period. The experience method portion of the reserve is not restored to income if the former thrift institution qualifies as a small bank. If the former thrift institution is treated as a large bank, the experience method portion of the reserve is restored to income ratably

[17] Prop. Treas. reg. sec. 1.593–13.

over a 6-taxable year period, or under the 4-year recapture method or the cut-off method described above.

In addition, a thrift institution may be subject to a form of reserve recapture even if the institution continues to qualify for the percentage of taxable income method. Specifically, if a thrift institution distributes to its shareholders an amount in excess of its post-1951 earnings and profits, such excess is deemed to be distributed from the nonexperience potion of the institution's bad debt reserve and is restored to income. In the case of any distribution in redemption of stock or in partial or complete liquidation of an institution, the distribution is treated as first coming from the nonexperience potion of the bad debt reserves of the institution (sec. 593(e)).

Financial accounting treatment of tax reserves of bad debts of thrift institutions

The recapture of a bad debt reserve for Federal income tax purposes may have significant financial and regulatory accounting implications for a thrift institution. In general, for financial accounting purposes, a corporation must record a deferred tax liability with respect to items that are deducted for tax purposes in a period earlier than they are expensed for book purposes. The deferred tax liability signifies that, although a corporation may be reducing its current tax expense because of the accelerated tax deduction, the corporation will become liable for tax in a future period when the timing item "reverses" (i.e., when the item is expensed for book purposes but for which the tax deduction had already been allowed). Under the applicable accounting standard (Accounting Principles Board Opinion 23), deferred tax liabilities generally were not required for pre-1988 tax deductions attributable to the bad debt reserve method of thrift institutions because the potential reversal of the bad debt reserve was indefinite (i.e., generally, a reversal only would occur by operation of sec. 593(e), a condition within the control of a thrift institution). However, the establishment of 1987 as a base year increased the likelihood of bad debt reserve reversals with respect to post-1987 additions to the reserve and it appears that thrift institutions generally have recorded additional deferred tax liabilities for these additions under the current generally accepted accounting principles.[18]

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[18] For taxable years beginning before 1988, the base year balance of a thrift institution was the reserve balance whenever the institution changed from one bad debt method to another (e.g., from the percentage of taxable income method to the experience method). How the establishment of 1987 as a permanent base year changed the nature of the bad reserves of thrift institutions between pre-1988 years and post-1987 years (which, in turn, contributed to the change in the financial accounting treatment of such reserves) can be illustrated by the following example.

Assume that thrift institution ("T") always had used the percentage of taxable income ("PTI") method to deduct bad debts through 1986 when its reserve balance was $10,000. Further assume that in 1987, T: (1) has insufficient taxable income to use the PTI method, (2) has actual bad debt losses of $1,000, and (3) under the six-year average formula of the experience method, would be allowed a deduction of $900. Under these facts, T would be allowed a bad debt deduction of $1,000 (rather than $900) in 1987 because $1,000 is the amount necessary to restore the reserve to its base year (PTI) level. Specifically, in 1987, T would charge the year-end 1986 reserve of $10,000 for the $1,000 actual loss and then add (and deduct) $1,000 to the reserve so that the balance of the reserve at year end 1987 is once again 10,000. Thus, T's former PTI deductions, which gave rise to the $10,000 reserve balance, generally would not be restored to income (unless subject to sec. 593(e)).

Further assume that in 1988, T has sufficient taxable income to be allowed a PTI deduction of $1,500, increasing the balance of the reserve to $11,500 at year-end 1988. Further assume

Under proposed Treasury regulations, if a thrift institution becomes a commercial bank (or is otherwise ineligible to use the bad debt reserve method of section 593), the institution would be required to recapture all or a portion of its bad debt reserve. As described in detail below, it appears that such recapture would require the institution immediately to record, for financial accounting purposes, a current or deferred tax liability for the amount of bad debt recapture for which liabilities previously had not be recorded (generally, with respect to the pre-1988 reserves), regardless of when such recapture is taken into account for Federal income tax purposes. To the extent regulatory accounting principles follow these financial accounting principles, the recording of this liability generally would decrease the regulatory capital of the institution.

Reasons for change

The Committee believes that the reserve method of bad debts accorded to qualified thrift institutions under present law results in a mismeasurement of economic income and provides those institutions with a tax benefit not provided to similarly-situated depository institutions.

The Committee also believes that whenever a taxpayer changes its method of accounting, it is appropriate to implement such change in a manner such that items of income or expense are not taken into account twice—once under the old method and again under the new method. Thus, under present law, most accounting method changes are implemented under section 481 which requires that calculation of an adjustment that reflects the cumulative effect of the method change and is restored to income over a specified period of time. Specifically, under present law, whenever a thrift institution no longer qualifies for the reserve method of accounting for bad debts, the bad debt reserve of the thrift institution must be restored to income.

The Committee believes that in order to further national banking policy, certain changes to the Internal Revenue Code are warranted. First, the Committee believes that, in order to provide similar treatment to similarly-situated depository institutions, the special bad debt reserve methods available to qualified thrift institutions should be repealed. However, the Committee understands that requiring full recapture of the bad debt reserves of thrift institutions in implementing this change in accounting method may impose significant financial accounting and regulatory capital burdens on institutions that have not recorded the appropriate amount of deferred tax liabilities with respect to such recapture. Thus, the Committee believes it is appropriate to provide relief from the re-

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that in 1989, T: (1) again has insufficient taxable income to use the PTI method, (2) has actual bad debts of $2,500, and (3) under the six-year average formula of the experience method would be allowed a deduction of $900. Under these facts, T would be allowed a deduction of $1,000 (i.e., the amount necessary to restore the reserve to its base year (year-end 1987) level). Specifically, T would charge the year-end 1988 reserve balance of $11,500 for the $2,500 actual loss and then add (and deduct) $1,000 to the reserve to restore the balance to the $10,000 base year amount. Thus, T's post-1987 PTI deduction of $1,500 is restored to income (i.e., T actually had losses of $2,500 in 1989, but only was allowed to deduct $1,000).

A thrift institution also may record a current or deferred tax liability in cases where the institution's deduction for bad debts may be limited under section 585(b)(2)(B)(ii) because the amount of institution's loans outstanding diminished from the close of the base year to the close of the current year.

capture of the portion of the bad debt reserves that arose prior to 1988. The Committee believes that this relief should not directly benefit the shareholders of the institutions in a manner similar to the way in which present-law section 593(e) provides a limitation on the direct enjoyment of the benefits of section 593 by shareholders of thrift institutions.

Further, the Committee is concerned that the repeal of section 593 may cause a change in thrift institutions' traditional roles as home mortgage lenders and may result in a temporary shortage in the availability of mortgage loans in some regions. The Committee bill addresses this issue by providing an incentive for institutions to continue to provide a level of residential mortgage financing for a period of time. The Committee recognizes that it may be appropriate to reexamine, in the future, this and other issues raised by the bill.

Explanation of provision

Repeal of section 593

The bill repeals the section 593 reserve method of accounting for bad debts by thrift institutions, effective for taxable years beginning after 1995. Thrift institutions that would be treated as "small banks" are allowed to utilize the experience method applicable to such institutions, while thrift institutions that are treated as "large banks" are required to use only the specific charge-off method.[19] Thus, the percentage of taxable income method of accounting for bad debts is no longer available for any financial institution. The bill also repeals the following present-law provisions that only apply to thrift institutions to which section 593 applies: (1) the denial of a portion of certain tax credits to a thrift institution (sec. 50(d)(1)); (2) the special rules with respect to the foreclosure of property securing loans of a thrift institution (sec. 595); (3) the reduction in the dividends received reduction of a thrift institution (sec. 596); and (4) the ability of a thrift institution to use a net operating loss to offset its income from a residual interest in a REMIC (sec. 860E(a)(2)).

Treatment of recapture of bad debt reserves

In general

A thrift institution required to change its method of computing reserves for bad debts will treat such change as a change in a method of accounting, initiated by the taxpayer, and having been made with the consent of the Secretary of the Treasury.[20] Any section 481(a) adjustment required to be taken into account with respect to such change generally will be determined solely with respect to the "applicable excess reserves" of the taxpayer. The amount of applicable excess reserves shall be taken into account

[19] Under present-law section 581, the definition of a "bank" includes a thrift institution. Whether an institution is a "large" or "small" bank is determined under section 585(c)(2).

[20] A thrift institution that uses a reserve method described in section 593 will be deemed to have changed its method of computing reserves for bad debts even though such institution will be allowed to use the reserve method of section 585. Similarly, a large thrift institution will be deemed to have changed its method of computing reserves for bad debts even though such institution used the experience-method portion of section 593 in lieu of the percentage-of-taxable-income method of section 593.

ratably over a six-taxable year period, beginning with the first taxable year beginning after 1995, subject to the residential loan requirement described below. In the case of a thrift institution that becomes a "large bank" (as determined under sec. 585(c)(2)), the amount of the institution's applicable excess reserves generally is the excess of (1) the balance of its reserves described in section 593(c)(1) other than its supplemental reserve for losses on loans (i.e., its reserve for losses on qualifying real property loans and its reserve for losses on nonqualifying loans) as of the close of its last taxable year beginning before January 1, 1996, over (2) the balance of such reserves (i.e., its reserve for losses on qualifying real property loans and its reserve for losses on nonqualifying loans) as of the close of its last taxable year beginning before January 1, 1988 (i.e., the "pre-1988 reserves").[21] Thus, a thrift institution that is treated as a large bank generally is required to recapture its post-1987 additions to its bad debt reserves, whether such additions are made pursuant to the percentage of taxable income method or the experience method. The timing of this recapture may be delayed for a two-year period to the extent the residential loan requirement described below applies.

In the case of a thrift institution that becomes a "small bank" (as determined under sec. 582(c)(2)), the amount of the institution's excess reserves will be the excess of (1) the balance of its reserves described in section 593(c)(1) as of the close of its last taxable year beginning before January 1, 1996, over (2) the greater of the balance of: (a) its pre-1988 reserves or (b) what the institution's reserves would have been at the close of its last taxable year beginning before January 1, 1996, has the institution always used the experience method described in section 585(b)(2)(A) (i.e., the six-year average method). For purposes of the future application of section 585, the beginning balance of the small bank's reserve for its first taxable year beginning after December 31, 1995, will be the greater of the two amounts described in (2) in the preceding sentence, and the balance of the reserve at the close of the base year (for purposes of sec. 585(b)(2)(B)) will be the amount of its pre-1988 reserves. The residential loan requirement described below also applies to small banks. If such small bank later becomes a large bank, any section 481(a) adjustment amount required to be taken into account under section 585(c)(3) will not include any portion of the bank's pre-1988 reserve. Similarly, if the bank elects the cut-off method to implement its conversion to large bank status, the amount of the reserve against which the bank charges its actual losses will not include any portion of the bank's pre-1988 reserve and the amount by which the pre-1988 reserve exceeds actual losses will not be included in gross income.

The balance of the pre-1988 reserves is subject to the provisions of present-law section 593(e) (requiring recapture in the case of certain excess distributions to, and redemptions of, shareholders). Thus, section 593(e) will continue to apply to an institution regard-

[21] The balance of a taxpayer's pre-1988 reserves is reduced if the taxpayer's loan portfolio had decreased since 1988. The permitted balance of a taxpayer's pre-1988 reserves is reduced by multiplying such balance by the ratio of the balance of the taxpayer's loans outstanding at the close of the last taxable beginning before 1996, to the balance of the taxpayer's loans outstanding at the close of the last taxable beginning before 1988. This reduction is required for both large and small banks.

less of whether the institution becomes a commercial bank or remain a thrift institution. In addition, the balances of the pre-1988 reserve and the supplemental reserve will be treated as tax attributes to which section 381 applies. The Committee expects that Treasury regulations will provide rules for the continued application of section 593(e) in the case of mergers, acquisitions, spin-offs, and other reorganizations of thrift and other institutions. The Committee believes that any such regulations should provide that, if the stock of an institution with a pre-1988 reserve is acquired by another depository institution, the pre-1988 reserve will not be restored to income by reason of the acquisition. Similarly, if an institution with a pre-1988 reserve is merged or liquidated tax-free into a commercial bank that never was a thrift institution, the pre-1988 reserve should not be restored to income by reason of the merger or liquidation.[22] Rather, the surviving institution will inherit the pre-1988 reserve and the post-1951 earnings and profits of the former thrift institution and section 593(e) will apply to the surviving institution as if it were a thrift institution. That is, the pre-1988 reserve will be restored into income in the case of any distribution in redemption of the stock of the surviving institution or in partial or complete liquidation of the institution following the merger or liquidation. In the case of any other distribution, the pre-1988 reserve will not be restored to income unless the distribution is in excess of the sum of the post-1951 earnings and profits inherited from the thrift institution and the post-1913 earnings and profits of the acquiring bank.[22] The Committee expects that Treasury regulations will address the case where the shareholders of an institution with a pre-1988 reserve are "cashed out" in a taxable merger of the institution and a commercial bank. Such regulations may provide that the pre-1988 reserve may be restored to income if such redemption represents a concealed distribution from the former thrift institution. For example, cash received by former thrift shareholders pursuant to a taxable reverse merger may represent a concealed distribution if, immediately preceding the merger, the acquiring bank had no available resources to distribute and its existing debt structure, indenture restrictions, financial condition, or regulatory capital requirements precluded it from borrowing money for purposes of making the cash payment to the former thrift shareholders. No inference is intended by the Committee as to the application of section 593(e) to these and similar transactions under present law.

Further, if a taxpayer no longer qualifies as a bank (as defined by sec. 581), the balances of the taxpayer's pre-1988 reserve and supplement reserves are restored to income ratably over a six-year period, beginning in the taxable year the taxpayer no longer qualifies as a bank.

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[22] The issue of whether section 593(e) applies in cases where a thrift institution is merged into a bank generally does not arise under present law because such merger results in a charter change and, under proposed Treasury regulations, requires full bad debt reserve recapture.

[23] If the acquiring bank is a former thrift institution itself and the pre-1988 reserves of neither institution are restored to income pursuant to the merger, the Committee expects that the pre-1988 reserves and the post-1951 earnings and profits of the two institutions will be combined for purposes of the continued application of section 593(e) with respect to the combined institution.

Residential loan requirement

Under a special rule, if the taxpayer meets the "residential loan requirement" for a taxable year, the recapture of the applicable excess reserves otherwise required to be taken into account as a section 481(a) adjustment for such year will be suspended. A taxpayer meets the residential loan requirement if, for the taxable year, the principal amount of residential loans made by the taxpayer during the year is not less than its base amount. The residential loan requirement is applicable only for taxable years that begin after December 31, 1995, and before January 1, 1998, and must be applied separately with respect to each such year. Thus, all taxpayers are required to recapture their applicable excess reserves within six, seven, or eight years after the effective date of the provision.

The "base amount" of a taxpayer means the average of the principal amounts of the residential loans made by the taxpayer during the six most recent taxable years beginning before January 1, 1996. At the election of the taxpayer, the base amount may be computed by disregarding the taxable years within that six-year period in which the principal amounts of loans made during such years were highest and lowest. This election must be made for the first taxable year beginning after December 31, 1995, and applies to the succeeding taxable year unless revoked with the consent of the Secretary of the Treasury or his delegate.

For purposes of the residential loan requirement, a loan will be deemed to be "made" by a financial institution to the extent the institution is, in fact, the principal source of the loan financing. Thus, any loan only can be "made" once. The Committee expects that loans "made" by a financial institution may include, but are not limited to, loans (1) originated directly by the institution through its place of business or its employees, (2) closed in the name of the institution, (3) originated by a broker that acts as an agent for the institution, and (4) originated by another person (other than a financial institution) and that are acquired by the institution pursuant to a pre-existing, enforceable agreement to acquire such loans. In addition, Treasury regulations also may provide that loans "made" by a financial institution may include loans originated by another person (other than a financial institution) acquired by the institution soon after origination if such acquisition is pursuant to a customary practice of acquiring such loans from such person. A loan acquired by a financial institution from another financial institution generally will be considered to be made by the transferor rather than the transferee of the loan; however, such loan may be completely disregarded if a principal purpose of the transfer was to allow the transferor to meet the residential loan requirement. A loan may be considered to be made by a financial institution even if such institution has an arrangement to transfer such loan to the Federal National Mortgage Association or the Federal Home Loan Mortgage Corporation.

For purposes of the residential loan requirement, a "residential loan" is a loan described in section 7701(a)(19)(C)(v) (generally, loans secured by residential real and church property and certain

mobile homes),[24] but only to the extent the loan is made to the owner of the property to acquire, construct, or improve the property. Thus, mortgage refinancings and home equity loans are not considered to be residential loans, except to the extent the proceeds of the loan are used to acquire, construct, or improve qualified residential real property. The Committee understands that pursuant to the Home Mortgage Disclosure Act, financial institutions are required to disclose the purpose for which loans are made. The Committee further understands that for purposes of this disclosure, institutions are required to classify loans as home purchase loans, home improvement loans, refinancings, and multifamily dwelling loans (whether for purchase, improvement or refinancing of such property). The Committee expects that taxpayers (and the Secretary of the Treasury in promulgating guidance) may take such reporting into account, and make such adjustments as are appropriate,[25] in determining: (1) whether or not a loan qualifies as a "residential loan" and (2) whether the institution "made" the loan. A taxpayer must use consistent standards for determining whether loans qualify as residential loans made by the institution both for purposes of determining its base amount and for purposes of determining whether it met the residential loan requirement for a taxable year.

The residential loan requirement is determined on a controlled group basis. Thus, for example, if a controlled group consists of two thrift institutions with applicable excess reserves that are wholly-owned by a bank, the residential loan requirement will be met (or not met) with respect to both thrift institutions by comparing the principal amount of the residential loans made by all three members of the group during the taxable year to the group's base amount. The group's base amount will be the average principal amount of residential loans made by all three members of the group during the base period. The election to disregard the high and low taxable years during the 6-year base period also would be applied on a controlled group basis (i.e., generally by treating the members of the group as one taxpayer so that all members of the group must join in the election, and the same corresponding years of each member would be so disregarded).

Treasury regulations may provide rules for the application of the residential loan requirement in the case of mergers, acquisitions, and other reorganizations of thrift and other institutions. The Committee expects that the balance of a taxpayer's applicable excess reserve will be treated as a tax attribute to which section 381 applies. Thus, if an institution with an applicable excess reserve is acquired in a tax-free reorganization, the balance of such reserve will not be immediately restored to income but will continue to be subject to the residential loan requirement in the hands of the

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[24] For this purpose, as under present law, if a multifamily structure securing a loan is used in part for nonresidential purposes, the entire loan will be deemed a residential real property loan if the planned residential use exceeds 80 percent of the property's planned use (determined as of the time the loan is made). In addition, loans made to finance the acquisition or development of land will be deemed to be loans secured by an interest in residential real property if, under regulations prescribed by the Secretary of the Treasury, there is a reasonable assurance that the property will become residential real property within a period of three years from the date of acquisition of the land.

[25] For example, adjustments will be required with respect to the reporting of multifamily dwellings in order to distinguish home purchase, home improvement, and refinancing loans.

acquirer. The Committees further expect that if a financial institution joins or merges into (or leaves) a group of financial institutions, the base amount of the acquiring (or remaining) group will be appropriately adjusted to reflect the base amount of the acquired (or departing) institution for purposes of determining whether the group meets the residential loan requirement for the year of the acquisition (or departure) and subsequent years. Similarly, if a controlled group of institutions had made an election to disregard its high and low years in computing its base amount, it is anticipated that such election shall be binding on any institution that subsequently joins the group and the election shall be applied to the new member by disregarding the high and low years of the new member even if such years do not correspond to the years applicable to the other members of the group.

Treatment of conversions to credit unions

The bill provides that if a thrift institution to which the repeal of section 593 applies becomes a credit union, the credit union will be treated as an institution that is not a bank and any section 481(a) adjustment required to be included in gross income will be treated as derived from an unrelated trade or business. Thus, if a thrift institution becomes a credit union in its first taxable year beginning after December 31, 1995, the entire balance of the institution's bad debt reserve will be included in income, and subject to tax, over a six-year period beginning with such taxable year. No inference is intended as to the Federal income tax treatment of any other aspect of the conversion of a financial institution to a credit union.

Effective date

The repeal of section 593 is effective for taxable years beginning after December 31, 1995. The repeal of section 595 is effective for property acquired in taxable years beginning after December 31, 1995. The amendment to section 860E does not apply to any residual interest in a REMIC held by the taxpayer on October 31, 1995, and at all times thereafter.

The amendments to section 593(e) do not apply to any distributions with respect to preferred stock if (1) such stock is issued and outstanding on October 31, 1995, and at all times thereafter before the distribution and (2) such distribution is made within the later of (a) one year after the date of enactment of this Act or (b) if the stock is redeemable by the issuer or a related party, 30 days after the date such stock first may be redeemed. For this purpose, the first date a preferred stock may be redeemed is the day upon which the issuer or a related party has the right to call the stock, regardless of the amount of call premium.

B. Earned Income Credit Provisions (sec. 411 of the bill and secs. 32 and 6213(g)(2) of the Code)

Present law

In general

Certain eligible low-income workers are entitled to claim a refundable credit on their income tax return. The amount of the cred-

it an eligible taxpayer may claim depends upon whether the taxpayer has one, more than one, or no qualifying children and is determined by multiplying the credit rate by the taxpayer's earned income up to an earned income threshold. The maximum amount of the credit is the product of the credit rate and the earned income threshold. For taxpayers with earned income (or adjusted gross income (AGI), if greater) in excess of the phaseout threshold, the maximum credit amount is reduced by the phaseout rate multiplied by the amount of earned income (or AGI, if greater) in excess of the phaseout threshold. For taxpayers with earned income (or AGI, if greater) in excess of the phaseout limit, no credit is allowed.

The parameters for the credit depend upon the number of qualifying children the taxpayer claims. For 1996, the parameters are given in the following table:

	Two or more qualifying children	One qualifying child	No qualifying children
Credit rate	40.00%	34.00%	7.65%
Phaseout rate	21.06%	15.98%	7.65%
Earned income threshold	$8,890	$6,330	$4,220
Maximum credit	3,556	2,152	323
Phaseout threshold	11,610	11,610	5,280
Phaseout limit	28,495	25,078	9,500

For years after 1996, the credit rates and the phaseout rates will be the same as in the preceding table. The earned income threshold and the phaseout threshold are indexed for inflation; because the phaseout limit will also increase if there is inflation.

In order to claim the credit, a taxpayer must either have an qualifying child or meet other requirements. A qualifying child must meet a relationship test, an age test, an indentification test, and a residence test. In order to claim the credit without a qualifyng child, a taxpayer must not be a dependent and must be over age 24 and under age 65.

To satisfy the identification test, taxpayers must include on their tax return the name and age of each qualifying child. For returns filed with respect to tax year 1996, taxpayers must provide a taxpayer identification number (TIN) for all qualifying children born on or before November 30, 1996. For returns filed with respect to tax year 1997 and all subsequent years, taxpayers must provide TINs for all qualifying children, regardless of their age. A taxpayer's TIN is generally that taxpayer's social security number.

Mathematical errors

The Internal Revenue Service may summarily assess additional tax due as a result of a mathematical error without sending the taxpayer a notice of deficiency and giving the taxpayer an opportunity to petition the Tax Court. Where the IRS uses the summary assessment procedure for mathematical or clerical errors, the taxpayer must be given an explanation of the asserted error and a period of 60 days to request that the IRS abate its assessment. The IRS may not proceed to collect the amount of the assessment until the taxpayer has agreed to it or has allowed the 60-day period for objecting to expire. If the taxpayer files a request for abatement of the assessment specified in the notice, the IRS must abate the as-

sessment. Any reassessment of the abated amount is subject to the ordinary deficiency procedures. The request for abatement of the assessment is the only procedure a taxpayer may use prior to paying the assessed amount in order to contest an assessment arising out of a mathematical or clerical error. Once the assessment is satisfied, however, the taxpayer may file a claim for refund if he believes the assessment was made in error.

Reasons for change

The Committee does not believe that individuals who are not authorized to work in the United States should be able to claim the credit. To enforce the requiremnt that credit claimants and their qualifying children have proper social security numbers and to insure that credit claimants have paid self-employment taxes on any self=employment income used to qualify for the credit, the Committee believes the IRS should be able to use the streamlined procedures it currently uses for mathematical and clerical errors.

Explanation of provision

Deny credit to individuals not authorized to be employed in the United States

Under the bill, taxpayers are not eligible for the credit if they do not include their taxpayer identification number (and, if married, their spouse's taxpayer identification number on their tax return. Solely for these purposes and for purposes of the present-law identification test for a qualifying child, a taxpayer identification number is defined as a social security number issued to an individual by the Social Security Administration other than a number issued under section 205(c)(2)(B)(i)(II) (or that portion of sec. 205(c)(2)(B)(i)(III) relating to it) of the Social Security Act (regarding the issuance of a number to an individual applying for or receiving Federally funded benefits).

Use mathematical error procedures for certain omissions

If a taxpayer fails to provide a correct taxpayer identification number, such omission will be treated as a mathematical or clerical error. If a taxpayer who claims the credit with respect to net earnings from self-employment fails to pay the proper amount of self-employment tax on such net earnings, the failure will be treated as a mathematical or clerical error. Thus, any notification that the taxpayer owes additional tax because of these omissions will not be treated as a notice of deficiency.

Effective date

The provision is effective for taxable years beginning after December 31, 1995.

C. Revision of Expatriation Tax Rules (secs. 421–322 of the bill and secs. 877, 2107, 2501 and new sec. 6039F of the Code)

Present law

1. Taxation of United States citizens, residents, and nonresidents

a. Individual income taxation.

Income taxation of U.S. citizens and residents

In general

A United States citizen generally is subject to the U.S. individual income tax on his or her worldwide taxable income.[26] All income earned by a U.S. citizen, from sources inside and outside the United States, is taxable, whether or not the individual lives within the United States. A non-U.S. citizen who resides in the United States generally is taxed in the same manner as a U.S. citizen if the individual meets the definition of a "resident alien," described below.

The taxable income of a U.S. citizen or resident is equal to the taxpayer's total income less certain exclusions, exemptions, and deductions. The appropriate tax rates are then applied to a taxpayer's taxable income to determine his or her individual income tax liability. A taxpayer may reduce his or her income tax liability by any applicable tax credits. When an individual disposes of property, any gain or loss on the disposition is determined by reference to the taxpayer's cost basis in the property, regardless of whether the property was acquired during the period in which the taxpayer was a citizen or resident of the United States.

If a U.S. citizen or resident earns income from sources outside the United States, and that income is subject to foreign income taxes, the individual generally is permitted a foreign tax credit against his or her U.S. income tax liability to the extent of foreign income taxes paid on that income.[27] In addition, a United States citizen who lives and works in a foreign country generally is permitted to exclude up to $70,000 of annual compensation from being subject to U.S. income taxes, and is permitted an exclusion or deduction for certain housing expenses.[28]

Resident aliens

In general, a non-U.S. citizen is considered a resident of the United States if the individual (1) has entered the United States as a lawful permanent U.S. resident (the "green card test"); or (2) is present in the United States for 31 or more days during the current calendar year and has been present in the United States for a substantial period of time—183 or more days during a 3-year period weighted toward the present year (the "substantial presence test").[29]

If an individual is present in the United States for fewer than 183 days during the calendar year, and if the individual establishes that he or she has a closer connection with a foreign country than with the United States and has a tax home in that country for the year, the individual generally is not subject to U.S. tax as a resident on account of the substantial presence test. If an individual

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[26] The determination of who is a U.S. citizen for tax purposes, and when such citizenship is lost, is governed by the provisions of the Immigration and Nationality Act, 8 U.S.C. section 1401, et seq. See Treas. Reg. section 1.1–1(c).

[27] See sections 901–907.

[28] Section 911.

[29] The definitions of resident and nonresident aliens are set forth in section 7701(b). The substantial presence test will compare 183 days to the sum of (1) the days present during the current calendar year, (2) one-third of the days present during the preceding calendar year, and (3) one-sixth of the days present during the second preceding calendar year. Presence for 122 days (or more) per year over the 3-year period would constitute substantial presence under the test.

is present for as many as 183 days during a calendar year, this closer connections/tax home exception is not available. An alien who has an application pending to change his or her status to permanent resident or who has taken other steps to apply for status as a lawful permanent U.S. resident is not eligible for the closer connections/tax home exception.

For purposes of applying the substantial presence test, any days that an individual is present as an "exempt individual" are not counted. Except individuals include certain foreign government-related individuals, teachers, trainees, students, and professional athletes temporarily in the United States to complete in charitable sports events. In addition, the substantial presence test does not count days of presence of an individual who is physically unable to leave the United States because of a medical condition that arose while he or she was present in the United States, if the individual can establish to the satisfaction of the Secretary of the Treasury that he or she qualifies for this special medical exception.

In some circumstances, an individual who meets the definition of a U.S. resident (as described above) could also be defined as a resident of another country under the internal laws of that country. In order to avoid the double taxation of such individuals, most income tax treaties include a set of "tie-breaker" rules to determine the individual's country of residence for income tax purposes. In general, a dual resident is deemed to be a resident of the country in which such person has a permanent home. If the individual has a permanent home available in both countries, the individual's residence is deemed to be the country with which his or her personal and economic relations are closer (i.e., the "center of vital interests.") If the country in which such individual has his or her center or vital interests cannot be determined, or if such individual does not have a permanent home available in either country, he or she is deemed to be a resident of the country in which he or she has an habitual abode. If the individual has an habitual abode in both countries or in neither country, he or she is deemed to be a resident of the country of which he or she is a citizen. If each country considers the person to be its citizen or if he or she is a citizen of neither country, the competent authorities of the countries are to settle the question of residence by mutual agreement.

Income taxation of nonresident aliens

Non-U.S. citizens who do not meet the definition of "resident aliens" are considered to be nonresident aliens for tax purposes. Nonresident aliens are subject to U.S. tax only to the extent their income is from U.S. sources or is effectively connected with the conduct of a trade or business within the United States. Bilateral income tax treaties may modify the U.S. taxation of a nonresident alien.

A nonresident alien is taxed at regular graduated rates on net profits derived from a U.S. business.[30] Nonresident aliens also are taxed at a flat rate of 30 percent on certain types of passive income derived from U.S. sources, although a lower rate may be provided by treaty (e.g., dividends are frequently taxed at a reduced rate of

[30] Section 871.

15 percent). Such passive income includes interest, dividends, rents, salaries, wages, premiums, annuities, compensations, remunerations, emoluments, and other fixed or determinable annual or periodical gains, profits and income. There is no U.S. tax imposed, however, on interest earned by nonresident aliens with respect to deposits with U.S. banks and certain types of portfolio debt investments.[31] Gains on the sale of stocks or securities issued by U.S. persons generally are not taxable to a nonresident alien because they are considered to be foreign source income.[32]

Nonresident aliens are subject to U.S. income taxation on any gain recognized on the disposition of an interest in U.S. real property.[33] Such gains generally are subject to tax at the same rates that apply to similar income received by U.S. persons. If a U.S. real property interest is acquired from a foreign person, the purchaser generally is required to withhold 10 percent of the amount realized (gross sales price). Alternatively, either party may request that the Internal Revenue Service ("IRS") determine the transferor's maximum tax liability and issue a certificate prescribing a reduced amount of withholding (not to exceed the transferor's maximum tax liability).[34]

b. Estate and gift taxation.

The United States imposes a gift tax on any transfer of property by gift made by a U.S. citizen or resident,[35] whether made directly or indirectly and whether made in trust or otherwise. Nonresident aliens are subject to the gift tax with respect to transfers of tangible real or personal property where the property is located in the United States at the time of the gift. No gift tax is imposed, however, on gifts made by nonresident aliens of intangible property having a situs within the United States (e.g., stocks and bonds).[36]

The United States also imposes an estate tax on the worldwide "gross estate" of any person who was a citizen or resident of the United States at the time of death, and on certain property belonging to a nonresident of the United States that is located in the United States at the time of death.[37]

Since 1976, the gift tax and the estate tax have been unified so that a single graduated rate schedule applies to cumulative taxable transfers made by a U.S. citizen or resident during his or her lifetime and at death. Under this rate schedule, the unified estate and gift tax rates begin at 18 percent on the first $10,000 in cumulative taxable transfers and reach 55 percent on cumulative taxable

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[31] See sections 871(h) and 871(i)(3).

[32] Section 865(a).

[33] Sections 897, 1445, 6039C, and 6652(f), known as the Foreign Investment in Real Property Tax Act ("FIRPTA"). Under the FIRPTA, provisions, tax is imposed on gains from the disposition of an interest (other than an interest solely as a creditor) in real property (including an interest in a mine, well, or other natural deposit) located in the United States or the U.S. Virgin Islands. Also included in the definition of a U.S. real property interest in any interest (other than an interest solely as a creditor) in any domestic corporation unless the taxpayer establishes that the corporation was not a U.S. real property holding corporation ("USRPHC") at any time during the five-year period ending on the date of the disposition of the interest (sec. 897(c)(1)(A)(ii). A USRPHC is any corporation, the fair market value of whose U.S. real property interests equals or exceeds 50 percent of the sum of the fair market values of (1) its U.S. real property interests, (2) its interests in foreign real property, plus (3) any other of its assets which are used or held for use in a trade or business (sec. 897(c)(2)).

[34] Section 1445.

[35] Section 2501.

[36] Section 2501(a)(2).

[37] Sections 2001, 2031, 2101, and 2103.

transfers over $3 million.[38] A unified credit of $192,800 is available with respect to taxable transfers by gift and at death. The unified credit effectively exempts a total of $600,000 in cumulative taxable transfers from the estate and gift tax.

Residency for purposes of estate and gift taxation is determined under different rules than those applicable for income tax purposes. In general, an individual is considered to be a resident of the United States for estate and gift tax purposes if the individual is "domiciled" in the United States. An individual is domiciled in the United States if the individual (a) is living in the United States and has the intention to remain in the United States indefinitely; or (b) has lived in the United States with such an intention and has not formed the intention to remain indefinitely in another country. In the case of a U.S. citizen who resided in a U.S. possession at the time of death, if the individual acquired U.S. citizenship solely on account of his birth or residence in a U.S. possession, that individual is not treated as a U.S. citizen or resident for estate tax purposes.[39]

In addition to the estate and gift taxes, a separate transfer tax is imposed on certain "generation-skipping" transfers.

2. Special tax rules with respect to the movement of persons and property into or out of the United States

Individuals who relinquish U.S. citizenship with a principal purpose of avoiding U.S. tax

An individual who relinquishes his or her U.S. citizenship with a principal purpose of avoiding U.S. taxes is subject to an alternative method of income taxation for 10 years after expatriation under section 877.[40] Under this provision, if the Treasury Department establishes that it is reasonable to believe that the expatriate's loss of U.S. citizenship would, but for the application of this provision, result in a substantial reduction in U.S. tax based on the expatriate's probable income for the taxable year, then the expatriate has the burden of proving that the loss of citizenship did not have as one of its principal purposes the avoidance of U.S. income, estate or gift taxes. Section 877 does *not* apply to resident aliens who terminate their U.S. residency.

The alternative method modifies the rules generally applicable to the taxation of nonresident aliens in two ways. First, the expatriate is subject to tax on his or her U.S. source income at the rates applicable to U.S. citizens rather than the rates applicable to other nonresident aliens. (Unlike U.S. citizens, however, individuals subject to section 877 are not taxed on any foreign source income.) Second, the scope of items treated as U.S. source income for section 877 purposes is broader than those items generally considered to be

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[38] Section 2001(c).

[39] Section 2209.

[40] Treasury regulations provide that an individual's citizenship status is governed by the provisions of the Immigration and Nationality Act, specifically referring to the "rules governing loss of citizenship [set forth in] sections 349 to 357, inclusive, of such Act (8 U.S.C. 1481–1489)." Treas. Reg. section 1.1–1(c). Under the Immigration and Nationality Act, an individual is generally considered to lose U.S. citizenship on the date that an expatriating act is committed. The present-law rules governing the loss of citizenship, and a description of the types of expatriating acts that lead to a loss of citizenship, are discussed more fully below.

U.S. source income under the Code. For example, gains on the sale of personal property located in the United States and gains on the sale or exchange of stocks and securities issued by U.S. persons, generally are not considered to be U.S. source income under the Code. However, if an individual is subject to the alternative taxing method of section 877, such gains are treated as U.S. source income with respect to that individual. The alternative method applies only if it results in a higher U.S. tax liability than would otherwise be determined if the individual were taxed as a nonresident alien.

Because section 877 alters the sourcing rules generally used to determine the country having primary taxing jurisdiction over certain items of income, there is an increased potential for such items to be subject to double taxation. For example, a former U.S. citizen subject to the section 877 rules may have capital gains derived from stock in a U.S. corporation. Under section 877, such gains are treated as U.S. source income, and are, therefore, subject to U.S. tax. Under the internal laws of the individual's new country of residence, however, that country may provide that all capital gains realized by a resident of that country are subject to taxation in that country, and thus the individual's gain from the sale of U.S. stock also would be taxable in his or her country of residence. If the individual's new country of residence has an income tax treaty with the United States, the treaty may provide for the amelioration of this potential double tax.

Similar rules apply in the context of estate and gift taxation if the transferor relinquished U.S. citizenship with a principal purpose of avoiding U.S. taxes within the 10-year period ending on the date of the transfer. A special rule is applied to the estate tax treatment of any decedent who relinquished his or her U.S. citizenship within 10 years of death, if the decedent's loss of U.S. citizenship had as one of its principal purposes a tax avoidance motive.[41] Once the Secretary of the Treasury establishes a reasonable belief that the expatriate's loss of U.S. citizenship would result in a substantial reduction in estate, inheritance, legacy and succession taxes, the burden of proving that one of the principal purposes of the loss of U.S. citizenship was not avoidance of U.S. income or estate tax is on the executor of the decedent's estate.

In general, the estates of individuals who have relinquished U.S. citizenship are taxed in accordance with the rules generally applicable to the estates of nonresident aliens (i.e., the gross estate includes all U.S.-situs property held by the decedent at death, is subject to U.S. estate tax at the rates generally applicable to the estates of U.S. citizens, and is allowed a unified credit of $13,000, as well as credits for State death taxes, gift taxes, and prior transfers). However, a special rule provides that the individual's gross estate also includes his or her pro-rata share of any U.S.-situs property held through a foreign corporation in which the decedent had a 10-percent or greater voting interest, provided that the decedent and related parties together owned more than 50 percent of the voting power of the corporation. Similarly, gifts of intangible property having a situs within the United States (e.g., stocks and bonds) made by a nonresident alien who relinquished his or her

[41] Section 2107.

U.S. citizenship within the 10-year period ending on the date of transfer are subject to U.S. gift tax, if the loss of U.S. citizenship had as one of its principal purposes a tax avoidance motive.[42]

Aliens having a break in residency status

A special rule applies in the case of an individual who has been treated as a resident of the United States for at least three consecutive years, if the individual becomes a nonresident but regains residency status within a three-year period.[43] In such cases, the individual is subject to U.S. tax for all intermediate years under the section 877 rules described above (i.e., the individual is taxed in the same manner as a U.S. citizen who renounced U.S. citizenship with a principal purpose of avoiding U.S. taxes). The special rule for a break in residency status applies regardless of the subjective intent of the individual.

Transfers to foreign corporations

Certain transfers of property by shareholders to a controlled corporation are generally tax-free if the persons transferring the property own at least 80 percent of the corporation after the transfer.[44] Also, in certain corporate reorganizations, including qualifying acquisitions and dispositions, shareholders of one corporation may exchange their stock or securities for stock or securities of another corporation that is a party to the reorganization without a taxable event except to the extent they receive cash or other property that is not permitted stock or securities. In addition, a corporation may transfer property to another corporation that is a party to the reorganization without a taxable event, except to the extent certain non-permitted consideration is received.[45] A liquidation of an 80-percent owned corporate subsidiary into its parent corporation is also generally tax-free.[46]

Under the rules applicable to these types of transfers, property transferred to a corporation retains its basis, to the extent the transfer was tax-free, so that any appreciation (i.e., built-in gain) will be subject to tax if the property is subsequently sold by the recipient corporation. Similarly, a shareholder who exchanges stock of one corporation for stock of another retains his or her original basis so that a subsequent sale of the acquired stock can produce a taxable gain.

Section 367 applies special rules, however, if property is transferred by a U.S. person to a foreign corporation in a transaction that would otherwise be tax-free under these provisions. These special rules are generally directed at situations where property is transferred to a foreign corporation, outside of the U.S. taxing jurisdiction, so that a subsequent sale by that corporation could escape U.S. tax notwithstanding the carryover basis of the asset. In some instances, such a transfer causes an immediate taxable event so that the generally applicable tax-free rules are overridden. In other instances, the taxpayer may escape immediate tax by enter-

[42] Section 2501(a)(3).
[43] Section 7701(b)(10).
[44] Section 351.
[45] Sections 368, 354, 356, and 361. (See also sec. 355.)
[46] Section 332.

ing a gain recognition agreement ("GRA") obligating the taxpayer to pay tax if the property is disposed of within a specified time period after the transfer. The GRA rules generally require the taxpayer to agree to file an amended return for the year of the original transfer if the property is disposed of by the transferee (including payment of interest from the due date of the return for the year of the original transfer to the time the additional tax under the agreement is actually paid following the disposition).

Section 367 also imposes rules directed at situations where a U.S. person has an interest in a foreign corporation, such as a controlled foreign corporation ("CFC") meeting the specific U.S. shareholder ownership requirements, that could result in the U.S. person being taxed on its share of certain foreign corporate earnings. These rules are designed to prevent the avoidance of tax in circumstances where a reorganization or other nonrecognition transaction restructures the stock or asset ownership of the foreign corporation so that the technical requirements for imposition of U.S. tax on foreign earnings under the CFC or other rules are no longer met and there is therefore potential for removing the earnings of the original CFC from current or future U.S. tax, or changing the character of the earnings for U.S. tax purposes (e.g., from dividend to capital gain).

The rules of section 367 do not generally apply unless there is a transfer by a U.S. person to a foreign corporation, or unless a foreign corporation of which a U.S. person is a shareholder engages in certain transactions. Because an individual who expatriates is no longer a U.S. person, section 367 has no effect on actions taken by such individuals after expatriation. The Treasury Department has considerable regulatory authority under section 367 to address situations that may result in U.S. tax avoidance. For example, section 367(b) provides that any of certain tax-free corporate transactions that do not involve a transfer of property from a U.S. person (described in section 367(a)(1)) can be recharacterized as taxable "to the extent provided in regulations prescribed by the Secretary which are necessary or appropriate to prevent the avoidance of Federal income taxes." The legislative history of this provision suggests that it was directed principally at situations involving avoidance of U.S. tax on foreign earnings and profits;[47] however, the statutory language is quite broad and was provided in conjunction with the general rules taxing certain transfers by U.S. persons.

Under the existing section 367 regulations and the relevant expatriation sections of the Code, a U.S. person who expatriates, even for a principal purpose of avoiding U.S. tax, may subsequently engage in transactions that involve the transfer of property to a foreign corporation without any adverse consequences under section 367, since expatriation (even for a principal purpose of tax avoidance) is not an event covered by section 367 or the current regulations under that section. Similarly, a U.S. person who has expatriated is not considered a U.S. shareholder for purposes of applying the rules that address restructurings of foreign corporations with

[47] See, e.g., H. Rept. No. 94–658, pp. 239–248 (94th Cong. 1st Sess, 1975); S. Rept. No. 94–938, pp. 261–271 (94th Cong., 2d Sess, 1976); H. Rept. No. 94–1515, p. 463 (94th Cong., 2d Sess., 1976)

U.S. shareholders. By engaging in such a transaction, a taxpayer that has expatriated could transfer assets that would otherwise generate income which would be subject to tax under section 877 into a foreign corporation, thus transforming the income into non-U.S. source income not subject to tax under section 877. For example, under section 877, if a principal purpose of tax avoidance existed, an expatriate would be taxed for 10 years on any sale of U.S. corporate stock. However, after expatriation, the person would no longer be a U.S. person for purposes of section 367, and thus could transfer U.S. corporate stock to a foreign corporation controlled by the expatriate under section 351 without any section 367 effect. The foreign corporation could then sell the U.S. corporate stock within the 10-year period, but the gain would not be subject to U.S. tax.

In addition, the IRS or Treasury might encounter difficulties enforcing a gain recognition agreement if a U.S. person who has entered into such an agreement to pay tax on a later disposition of an asset subject to the agreement and then expatriates. The GRA regulations contain provisions requiring security arrangements if a U.S. natural person who has entered an agreement dies (or if a U.S. entity goes out of existence) but these provisions do not apply if a U.S. natural person expatriates.[48]

Even if an individual is subject to the alternative taxing method of section 877 (because the person expatriated with a principal purpose of avoiding U.S. tax), section 877 does not impose a tax on foreign source income. Thus, such an individual could expatriate and subsequently transfer appreciated property to a foreign corporation or other entity beyond the U.S. taxing jurisdiction, without any U.S. tax being imposed on the appreciation under section 877.

Similar issues exist under section 1491 of the Code. Section 1491 imposes a 35-percent tax on otherwise untaxed appreciation when appreciated property is transferred by a U.S. citizen or resident, or by a domestic corporation, partnership, estate or trust, to certain foreign entities in a transaction not covered by section 367. In some cases, taxpayers may elect to enter into a gain recognition agreement (rather than pay immediate tax) pursuant to section 1492.[49] As in the case of section 367, an individual who has expatriated is no longer a U.S. citizen and may also no longer be a U.S. resident, thus a transfer by such a person would be unaffected by section 1491.

3. Requirements for United States citizenship, immigration, and visas

United States citizenship

An individual may acquire U.S. citizenship in one of three ways: (1) being born within the geographical boundaries of the United States; (2) being born outside the United States to at least one U.S. citizen parent (as long as that parent had previously been resident in the United States for a requisite period of time); or (3) through the naturalization process. All U.S. citizens are required to pay U.S. income taxes on their worldwide income. The State Depart-

[48] See, e.g., Temp. Reg. section 1.367(a)–3T(g)(9) and (10), Notice 87–85, 1987–2 C.B. 395.
[49] See, e.g., PLR 9103033.

ment estimates that there are approximately 3 million U.S. citizens living abroad, although thousands of these individuals may not even know that they are U.S. citizens.

A U.S. Citizen may voluntarily give up his or her U.S. citizenship at any time by performing one of the following acts ("expatriating acts") with the intention of relinquishing U.S. nationality: (1) becoming naturalized in another country; (2) formally declaring allegiance to another country; (3) serving in a foreign army; (4) serving in certain types of foreign government employment; (5) making a formal renunciation of nationality before a U.S. diplomatic or consular officer in a foreign country; (6) making a formal renunciation of nationality in the United States during a time of war; or (7) committing an act of treason.[50] An individual who wishes formally to renounce citizenship (item (5), above) must execute an Oath of Renunciation before a consular officer, and the individual's loss of citizenship is effective on the date the oath is executed. In all other cases, the loss of citizenship is effective on the date that the expatriating act is committed, even though the loss may not be documented until a later date. The State Department generally documents loss in such cases when the individual acknowledges to a consular officer that the act was taken with the requisite intent. In all cases, the consular officer abroad submits a certificate of loss of nationality ("CLN") to the State Department in Washington, D.C. for approval.[51] Upon approval, a copy of the CLN is issued to the affected individual. However, the date upon which the CLN is approved is not the effective date for loss of citizenship.

Before a CLN is issued, the State Department reviews the individual's files to confirm that: (1) the individual was a U.S. citizen; (2) an expatriating act was committed; (3) the act was undertaken voluntarily; and (4) the individual had the intent of relinquishing citizenship when the expatriating act was committed. If the expatriating act involved an action of a foreign government (for example, if the individual was naturalized in a foreign country or joined a foreign army), the State Department will not issue a CLN until it has obtained an official statement from the foreign government confirming the expatriating act. If a CLN is not issued because the State Department does not believe that an expatriating act has occurred (for example, if the requisite intent appears to be lacking), the issue is likely to be resolved through litigation. Whenever the loss of U.S. nationality is put in issue, the burden of proof is on the person or party claiming that a loss of citizenship has occurred to establish, by a preponderance of the evidence, that the loss occurred.[52] Similarly, if a CLN has been issued, but the State Department later discovers that such issuance was improper (for example, because fraudulent documentation was submitted, or the requisite intent appears to be lacking), the State Department could initiate proceedings to revoke the CLN. If the recipient is unable to establish beyond a preponderance of the evidence that citizenship was lost on the date claimed, the CLN would be revoked. To the extent that the IRS believes a CLN was improperly issued, the IRS could present such evidence to the State Department and re-

[50] 8 U.S.C. section 1481.
[51] 8 U.S.C. section 1501.
[52] 8 U.S.C. sec. 1481(b).

quest that revocation proceedings be commenced. If it is determined that the individual has indeed committed an expatriating act, the date for loss of citizenship will be the date of the expatriating act.

A child under the age of 18 cannot lose U.S. citizenship by naturalizing in a foreign state or by taking an oath of allegiance to a foreign state. A child under 18 can, however, lose U.S. citizenship by serving in a foreign military or by formally renouncing citizenship, but such individuals my regain their citizenship by asserting a claim of citizenship before reaching the age of eighteen years and six months.

A naturalized U.S. citizen can have his or her citizenship involuntarily revoked if a U.S. court determines that the certificate of naturalization was illegally procured, or was procured by concealment of a material fact or by willful misrepresentation (for example, if the individual concealed the fact that he served as a concentration camp guard during World Ware II).[53] In such cases, the individual's certificate of naturalization is cancelled, effective as of the original date of the certificate; in other words, it is as if the individual were never a U.S. citizen at all.

United States immigration and visas

In general, a non-U.S. citizen who enters the United States is required to obtain a visa.[54] An immigrant visa (also known as a "green card") is issued to an individual who intends to relocate to the United States permanently. Various types of nonimmigrant visas are issued to individuals who come to the United States on a temporary basis and intend to return home after a certain period of time. The type of nonimmigrant visa issued to such individuals is dependent upon the purpose of the visit and its duration. An individual holding a nonimmigrant visa is prohibited from engaging in activities that are inconsistent with the purpose of the visa (for example, an individual holding a tourist visa is not permitted to obtain employment in the United States).

Foreign business people and investors often obtain "E" visas to come into the United States. Generally an "E" visa is initially granted for a one-year period, but it can be routinely extended for additional two-year periods. There is no overall limit on the amount of time an individual may retain an "E" visa. There are two types of "E" visas: an "E–1" visa, for "treaty traders" and an "E–2" visa, for "treaty investors."

Relinquishment of green cards

There are several ways in which a green card can be relinquished. First, an individual who wishes to terminate his or her permanent residency may simply mails his or her green card back to the INS. Second, an individual may be involuntarily deported from the United States (through a judicial or administrative pro-

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[53] See Section 340(a) of the Immigration and Nationality Act, 8 U.S.C. section 1451(a). See also, *U.S.* v. *Demjanjuk*, 680 F.2d 32, *cert. denied*, 459 U.S. 1036 (1982).

[54] Under the Visa Waiver Pilot Program, nationals of most European countries are not required to obtain a visa to enter the United States if they are coming as tourists and staying a maximum of 90 days. Also, citizen of Canada, Mexico, and certain islands in close proximity to the United States do not need visas to enter the United States, although other types of travel documents may be required.

ceeding), and the green card must be relinquished at that time. Third, a green card holder who leaves the United States and attempts to re-enter more than a year later may have his or her green card taken away by the INS border examiner, although the individual may appeal to an immigration judge to have the green card reinstated. A green-card holder may permanently leave the United States without relinquishing his or her green card, although such individuals would continue to be taxed as U.S. residents.[55]

Reasons for change

The Committee has been informed that a small number of very wealthy individuals each year relinquish their U.S. citizenship for the purpose of avoiding U.S. income, estate, and gift tax. By so doing, such individuals may reduce their annual U.S. income tax liability and their eventual U.S. estate tax liability.

The Committee recognizes that citizens of the United States clearly have a basic right under both U.S. and international law not only to leave the United States to live elsewhere, but also to relinquish their U.S. citizenship. The Committee does not believe that the Internal Revenue Code should be used to stop U.S. citizens or residents from expatriating; however, the Committee also does not believe that the Code should provide a tax incentive for expatriating.

The Committee is concerned that present law, which bases the application of the alternative method of taxation under sections 877, 2107 and 2501(a)(3) ("expatriation tax provisions") to former citizens on proof of a tax-avoidance purpose, may be difficult to administer. Thus, the bill generally subjects certain former citizens to the expatriation tax provisions without inquiry as to their motive for losing their U.S. citizenship, but allows certain individuals to request a ruling from the Secretary of Treasury as to whether the loss of citizenship had a principal purpose of tax avoidance. The Committee believes that long-term permanent residents of the United States (i.e., green-card holders) should similarly be taxed under the expatriation tax provisions for 10 years after their U.S. residency is terminated.

The Committee is aware that taxpayers may circumvent present-laws section 877 by converting U.S. source income to foreign source income. To eliminate taxpayers' ability to escape U.S. tax by such conversions, the bill substantially expands the scope of section 877 to apply to foreign property acquired in nonrecognition transactions. In addition, for purposes of determining the tax liability under section 877, the 10-year period is suspended with respect to any property during the period in which the individual's risk of loss with respect to such property is substantially diminished.

The Committee further believes that it is appropriate to tax amounts earned by formed U.S. citizens and residents through certain controlled foreign corporations where the taxation of such amounts have been deferred during the period of U.S. citizenship or residency. Therefore, income or gains derived from stock in a for-

[55] Section 7701(b)(6)(B) provides that an individual who has obtained the status of residing permanently in the United States as an immigrant (i.e., an individual who has obtained a green card) will continue to be taxed as a lawful permanent resident of the United States until such status is revoked, or is administratively or judicially determined to have been abandoned.

eign corporation that is more than 50-percent owned by a former citizen or resident is taxable under the bill to the extent of the earnings and profits attributable to such stock if the income or gains are realized within the 10-year period after the relinquishment of U.S. citizenship or termination of U.S. residency. This rule applies to earnings and profits attributable to such stock but only to the extent earned during the pre-expatiation period.

The Committee understands that amounts taxed under the expatriation tax provisions could be subject to double taxation (e.g., taxed by both the United States and the country of residence of the expatriate). Therefore, the bill provides relief from double taxation in circumstances where another country also taxes the same items that is subject to tax under the expatriation tax provisions.

The Committee is also aware that certain existing U.S. Income tax treaties may not permit the Untied States to assert its taxing jurisdiction on former citizens or long-term residents who are residents of such countries. the Committee believes that the modified expatriation tax provisions are generally consistent with the underlying principles of income tax treaties to the extent the bill provides a foreign tax credit for items that are taxed by another country, thus ceding primary taxing jurisdiction to the foreign country. To the extent that the modified expatriation provisions do conflict with the provisions of tax treaties, the Committees expects that the Treasury Department will renegotiate those treaties to eliminate any such conflicts. In the interim, the new provisions take precedence over the treaties for a period of 10 years.

In order to enhance compliance with the expatriation tax provisions, and to assist the IRS in identifying former U.S. citizens and residents who are subject to the expatriation tax provisions, the bill imposes an information reporting obligation on former citizens and long-term residents at the time of expatriation and requires the State Department and other governmental entities to share certain information with the IRS with respect to such individuals.

Explanation of provision

Overview

The bill expands and substantially strengthens in several ways the present-law provisions that subject U.S. citizens who lose their citizenship for tax avoidance purposes to special tax rules for 10 years after such loss of citizenship (secs. 877, 2107, and 2501(a)(3)). First, the bill extends the expatriation tax provisions to apply not only to U.S. citizens who lose their citizenship but also to certain long-term residents of the United States whose U.S. residency is terminated. Second, the bill subjects certain individuals to the expatriation tax provisions without inquiry as to their motive for losing their U.S. citizenship or residency, but allows certain categories of citizens to show an absence of tax-avoidance motives if they request a ruling from the Secretary of the Treasury as to whether the loss of citizenship had a principal purpose of tax avoidance. Third, the bill expands the categories of income and gains that are treated as U.S. source (and therefore subject to U.S. income tax under section 877) if earned by an individual who is subject to the expatriation tax provisions and includes provisions designed to eliminate

the ability to engage in certain transactions that under current law partially or completely circumvent the 10-year reach of section 877. Further, the bill provides relief from double taxation in circumstances where another country imposes tax on items that would be subject to U.S. tax under the expatriation tax provisions.

The bill also contains provisions to enhance compliance with the expatriation tax provisions. The bill imposes information reporting obligations on U.S. citizens who lose their citizenship and long-term residents whose U.S. residency is terminated at the time of expatriation. In addition, the bill directs the Treasury Department to undertake a study regarding compliance by individuals living abroad with their U.S. tax reporting obligations and to make recommendations with respect to improving such compliance.

Individuals covered

The present-law expatriation tax provisions apply only to certain U.S. citizens who lose their citizenship. The bill extends these expatriation tax provisions to apply also to long-term residents of the United States whose U.S. residency is terminated. For this purpose, a long-term resident is any individual who was a lawful permanent resident of the United States for at least 8 out of the 15 taxable years ending with the year in which such termination occurs. In applying this 8-year test, an individual is not considered to be a lawful permanent resident for any year in which the individual is taxed as a resident of another country under a treaty tie-breaker rule. An individual's U.S. residency is considered to be terminated when either the individual ceases to be a lawful permanent resident pursuant to section 7701(b)(6) (i.e., the individual loses his or her green-card status) or the individual is treated as a resident of another country under a tie-breaker provision of a tax treaty (and the individual does not elect to waive the benefits of such treaty). Furthermore, a long-term resident may elect to use the fair market value basis of property on the date the individual became a U.S. resident (rather than the property's historical basis) to determine the amount of gain subject to the expatriation tax provision if the asset is sold within the 10-year period.

Under the present law, the expatriation tax provisions are applicable to a U.S. citizen who loses his or her citizenship unless such loss did not have as a principal purpose the avoidance of taxes. Under the bill, U.S. citizens who lose their citizenship and long-term residents whose U.S. residency is terminated are generally treated as having lost such citizenship or terminated such residency with a principal purpose of the avoidance of taxes if either: (1) the individual's average annual U.S. Federal income tax liability for the 5 taxable years ending before the date of such loss or termination is greater than $100,000 (the ''tax liability test''), or (2) the individual's net worth as of the date of such loss of termination is $500,000 or more (the ''net worth test''). The dollar amount thresholds contained in the tax liability test and the net worth test are indexed for inflation in the case of a loss of citizenship or termination of residency occurring in any calendar year of 1996. An individual who falls below the thresholds specified in both the tax liability test and the net worth test is subject to the expatriation tax provisions unless the individual's loss of citizenship or termination

of residency did not have as a principal purpose the avoidance of tax (as under present law in the case of U.S. citizens).

A U.S. citizen, who loses his or her citizenship and who satisfies either the tax liability test or the net worth test, is not subject to the expatriation tax provisions if such individual can demonstrate that he or she did not have a principal purpose of tax avoidance and the individual is within one of the following categories: (1) the individual was born with dual citizenship and retains only the non-U.S. citizenship; (2) the individual becomes a citizen of the country in which the individual, the individual's spouse, or one of the individual's parents, was born; (3) the individual was present in the United States for no more than 30 days during any year in the 10-year period immediately preceding the date of his or her loss of citizenship; (4) the individual relinquishes his of her citizenship before reaching age 18–½; or (5) any other category of individuals prescribed by Treasury regulations. In all of these situations, the individual would have been subject to tax on his or her worldwide income (as are all U.S. citizens) until the time of expatriation. In order to qualify for one of these exceptions, the former U.S. citizen must, within one year from the date of loss of citizenship, submit a ruling request for a determination by the Secretary of the Treasury as to whether such loss had as one of its principal purposes the avoidance of taxes. A former U.S. citizen who submits such a ruling request is entitled to challenge an adverse determination by the Secretary of the Treasury. However, a former U.S. citizen who fails to submit a timely ruling request is not eligible for these exceptions. It is expected that in making a determination as to the presence of a principal purpose of tax avoidance, the Secretary of the Treasury will take into account factors such as the substantiality of the former citizen's ties to the United States (including ownership of U.S. assets) prior to expatriation, the retention of U.S. citizenship by the former citizen's spouse, and the extent to which the former citizen resides in a country that imposes little or no tax.

The foregoing exception are not available to long-term residents whose U.S. residency is terminated. However, the bill authorizes the Secretary of the Treasury to prescribe regulations to exempt certain categories of long-term residents from the bill's provisions.

Items subject to section 877

Under section 877, an individual covered by the expatriation tax is subject to tax on U.S. source income and gains for a 10-year period after expatriation at the graduated rates applicable to U.S. citizens.[56] The tax under section 877 applies to U.S. source income and gains of the individual for the 10-year period, without regard to whether the property giving rise to such income or gains was acquired before or after the date the individual became subject to the expatriation tax provisions. For example, a U.S. citizen who inher-

[56] Under present law, all nonresident aliens (including expatriates) are subject to U.S. income tax at graduated rates on certain types of income. Such income includes income effectively connected with a U.S. trade or business and gains from the disposition of interests in U.S. real property. For example, compensation (including deferred compensation) paid with respect to services performed in the United States is subject to such tax. Thus, under current law, a U.S. citizen who earns a stock option while employed in the United States and delays the exercise of such option until after such individual loses his or her citizenship is subject to U.S. tax on the compensation income recognized upon exercise of the stock option (even if the stock received upon the exercise is stock in a foreign corporation).

its an appreciated asset immediately before losing citizenship and disposes of the asset immediately after such loss would not recognize any taxable gain on such disposition (because of the date of death fair market value basis accorded to inherited assets), but the individual would continue to be subject to tax under section 877 on the income or gain derived from any U.S. property acquired with the proceeds from such disposition.

In addition, section 877 currently recharacterizes as U.S. source income certain gains of individuals who are subject to the expatriation tax provisions, thereby subjecting such individuals to U.S. income tax on such gains. Under this rule, gain on the sale or exchange of stock of a U.S. corporation or debt of a U.S. person is treated as U.S. source income. In this regard, under current law, the substitution of a foreign obligor for a U.S. obligor is generally treated as a taxable exchange of the debt instrument, and therefore any gain on such exchange is subject to tax under section 877. The bill extends this recharacterization to income and gains derived from property obtained in certain transactions on which gain or loss is not recognized under present law. An individual covered by section 877 who exchanges property that would produce U.S. source income for property that would produce foreign source income is required to recognize immediately as U.S. source income any gain on such exchange (determined as if the property had been sold for its fair market value on such date). To the extent gain is recognized under this provision, the property would be accorded the step-up in basis provided under current law. This rule requiring immediate gain recognition does not apply if the individual enters into an agreement with the Secretary of the Treasury specifying that any income or gains derived from the property received in the exchange during the 10-year period after the loss of citizenship (or termination of U.S. residency, as applicable) would be treated as U.S. source income. Such a gain recognition agreement terminates if the property transferred in the exchange is disposed of by the acquiror, and any gain that had not been recognized by reason of such agreement is recognized as U.S. source as of such date. It is expected that a gain recognition agreement would be entered into not later than the due date for the tax return for the year of the exchange. In this regard, the Secretary of the Treasury is authorized to issue regulations providing similar treatment for nonrecognition transactions that occur within 5 years immediately prior to the date of loss of citizenship (or termination of U.S. residency, as applicable).

The Secretary of Treasury is authorized to issue regulations to treat removal of tangible personal property from the United States, and other circumstances that result in a conversion of U.S. source income to foreign source income without recognition of any unrealized gain, as exchanges for purposes of computing gain subject to section 877. The taxpayer may defer the recognition of the gain if he or she enters into a gain recognition agreement as described above. For example, a former citizen who removes appreciated artwork that he or she owns from the United States could be subject to immediate tax on the appreciation under this provision unless the individual enters into a gain recognition agreement.

The foregoing rules regarding the treatment under section 877 of nonrecognition transactions are illustrated by the following exam-

ples: Ms. A loses her U.S. citizenship on January 1, 1996, and is subject to section 877. On June 30, 1997, Ms. A transfers the stock she owns in a U.S. corporation, USCo, to a wholly-owned foreign corporation, FCo, in a transaction that qualifies for tax-free treatment under section 351. At the time of such transfer, A's basis in the stock of USCo is $100,000 and the fair market value of the stock is $150,000. Under present law, Ms. A would not be subject to U.S. tax on the $50,000 of gain realized on the exchange. Moreover, Ms. A would not be subject to U.S. tax on any distribution of the proceeds from a subsequent disposition of the USCo stock by FCo. Under the bill, if Ms. A does not enter into a gain recognition agreement with the Secretary of the Treasury, Ms. A would be deemed to have sold the USCo stock for $150,000 on the date of the transfer, and would be subject to U.S. tax in 1997 on the $50,000 of gain realized. Alternatively, if Ms. A enters into a gain recognition agreement, she would not be required to recognize for U.S. tax purposes in 1997 the $50,000 of gain realized upon the transfer of the USCo stock to FCo. However, under the gain recognition agreement, for the 10-year period ending on December 31, 2005, any income (e.g., dividends) or gain with respect to the FCo stock would be treated as U.S. source, and therefore Ms. A would be subject to tax on such income or gain under section 877. If FCo disposes of the USCo stock on January 1, 2002, Ms. A's gain recognition agreement would terminate on such date, and Ms. A would be required to recognize as U.S. source income at that time the $50,000 of gain that she previously deferred under the gain recognition agreement. (The amount of gain required to be recognized by Ms. A in this situation would not be affected by any changes in the value of the USCo stock since her June 30, 1997 transfer of such stock to FCo.)

The bill also extends the recharacterization rules of section 877 to treat as U.S. source any income and gains derived from stock in a foreign corporation if the individual losing citizenship or terminating residency owns, directly or indirectly, more than 50 percent of the vote or value of the stock of the corporation on the date of such loss or termination or at any time during the 2 years preceding such date. Such income and gains are recharacterized as U.S. source only to the extent of the amount of earnings and profits attributable to such stock earned or accumulated prior to the date of loss of citizenship (or termination of residency, as applicable) and while such ownership requirement is satisfied.

The following example illustrates this rule: Mr. B loses his U.S. citizenship on July 1, 1996 and is subject to section 877. Mr. B has owned all of the stock of a foreign corporation, FCo, since its incorporation in 1991. As of FCo's December 31, 1995 year-end, FCo has accumulated earnings and profits of $500,000. FCo has earnings and profits of $100,000 for 1996 and does not have any subpart F income (as defined in sec. 952). FCo makes a $100,000 distribution to Mr. B in each of 1997 and 1998. On January 1, 1999, Mr. B disposes of all his stock of FCo and realizes $400,000 of gain. Under present law, neither the distributions from FCo nor the gain on the disposition of the FCo stock would be subject to U.S. tax. Under the bill, the distributions from FCo and the gain on the sale of the stock of FCo would be treated as U.S. source income and would be

taxed to Mr. B under section 877, subject to the earnings and profits limitation. For this purpose, the amount of FCo's earnings and profits for 1996 is prorated based on the number of days during 1996 that Mr. B is a U.S. citizen. Thus, the amount of FCo's earnings and profits earned or accumulated before Mr. B's loss of citizenship is $550,000. Accordingly, the $100,000 distributions from FCo in 1997 and 1998 would be treated as U.S. source income taxable to Mr. B under section 877 in such years. In addition, $350,000 of the gain realized from the sale of the stock of FCo in 1999 would be treated as U.S. source income taxable to Mr. B under section 877 in that year.

Special rule for shift in risks of ownership

Section 877 applies to income and gains for the 10-year period following the loss of citizenship (or termination of residency, as applicable). For purposes of applying section 877, the bill suspends this 10-year period for gains derived from a particular property during any period in which the individual's risk of loss with respect to such property is substantially diminished. For example, Ms. C loses her citizenship on January 1, 1996 and is subject to section 877. On that date Ms. C owns 10,000 shares of stock of a U.S. corporation, USCo, with a value of $1 million. On the same date Ms. C enters into an equity swap with respect to such USCo stock with a 5-year term. Under the transaction, Ms. C will transfer to the counter-party an amount equal to the dividends on the USCo stock and any increase in the value of the USCo stock for the 5-year period. The counter-party will transfer to Ms. C an amount equal to a market rate of interest on $1 million and any decrease in the value of the USCo stock for the same period. Ms. C's risk of loss with respect to the USCo stock is substantially diminished during the 5-year period in which the equity swap is in effect, and therefore, under the bill, the 10-year period under section 877 is suspended during such period. Accordingly, under the bill, if Ms. C sells her USCo stock for a gain on January 1, 2010, such gain would be treated as U.S. source income taxable to Ms. C under section 877. Such gain would not be subject to U.S. tax under present law.

Double tax relief

In order to avoid the double taxation of individuals subject to the expatriation tax provisions, the bill provides a credit against the U.S. tax imposed under such provisions for any foreign income, gift, estate or similar taxes paid with respect to the items subject to such taxation. This credit is available only against the tax imposed solely as a result of the expatriation tax provisions, and is not available to be used to offset any other U.S. tax liability. For example, Mr. D loses his citizenship on January 1, 1996 and is subject to section 877. Mr. D becomes a resident of Country X. During 1996, Mr. D recognizes a $100,000 gain upon the sale of stock a U.S. corporation, USCo. Country X imposes $20,000 tax on this capital gain. But for the double tax relief provision, Mr. D would be subject to tax of $28,000 on this gain under section 877. However, Mr. D's U.S. tax under section 877 would be reduced by the

$20,000 of foreign tax paid, and Mr. D's resulting U.S. tax on this gain would be $8,000.

Effect on tax treaties

While it is believed that the expatriation tax provisions, as amended by the bill, are generally consistent with the underlying principles of income tax treaties to the extent the bill provides a foreign tax credit for items taxed by another country, it is intended that the purpose of the expatriation tax provisions, as amended, not be defeated by any treaty provision. The Treasury Department is expected to review all outstanding treaties to determine whether the expatriation tax provisions, as revised, potentially conflict with treaty provisions and to eliminate any such potential conflicts through renegotiation of the affected treaties as necessary. Beginning on the tenth anniversary of the enactment of the bill, any conflicting treaty provisions that remain in force would take precedence over the expatriation tax provisions as revised.

Required information reporting and sharing

Under the bill, a U.S. citizen who loses his or her citizenship is required to provide a statement to the State Department (or other designated government entity) which includes the individual's social security number, forwarding foreign address, new country of residence and citizenship and, in the case of individuals with a net worth of at least $500,000, a balance sheet. The entity to which such statement is to be provided is required to provide to the Secretary of the Treasury copies of all statements received and the names of individuals who refuse to provide such statements. A long-term resident whose U.S. residency is terminated is required to attach a similar statement to his or her U.S. income tax return for the year of such termination. An individual's failure to provide the required statement results in the imposition of a penalty for each year the failure continues equal to the greater of (1) 5 percent of the individual's expatriation tax liability for such year, or (2) $1,000.

The bill requires the State Department to provide the Secretary of the Treasury with a copy of each certificate of loss of nationality (CLN) approved by the State Department. Similarly, the bill requires the agency administering the immigration laws to provide the Secretary of the Treasury with the name of each individual whose status as a lawful permanent resident has been revoked or has been determined to have been abandoned.

Further, the bill requires the Secretary of the Treasury to publish in the Federal Register the names of all former U.S. citizens from whom it receives the required statements or whose names it receives under the foregoing information-sharing provisions.

Treasury report on tax compliance by U.S. citizens and residents living abroad

The Treasury Department is directed to undertake a study on the tax compliance of U.S. citizens and green-card holders residing outside the United States and to make recommendations regarding the improvement of such compliance. The findings of such study and such recommendations are required to be reported to the house

Committee on Ways and Means and the Senate Committee on Finance within 90 days of the date of enactment.

During the course of the 1995 Joint Committee on Taxation staff study on expatriation (see Joint Committee on Taxation, *Issues Presented by proposals to Modify the Tax Treatment of Expatriation* (JCS–17–95), June 1, 1995), a specific issue was identified regarding the difficulty in determining when a U.S. citizen has committed an expatriating act with the requisite intent, and thus no longer has the obligation to continue to pay U.S. taxes on his or her worldwide income due to the fact that the individual is no longer a U.S. citizen. Neither the Immigration and Nationality Act nor any other Federal law requires an individual to request a CLN within a specified amount of time after an expatriating act has been committed, even though the expatriating act terminates the status of the individual as a U.S. citizen for all purposes, including the status of being subject to U.S. tax on worldwide income. Accordingly, it is anticipated that the Treasury report, in evaluating whether improved coordination between executive branch agencies could improve compliance with the requirements of the Internal Revenue Code, will review the process through which the State Department determines when citizenship has been lost, and make recommendations regarding changes to such process to recognize the importance of such date for tax purposes. In particular, it is anticipated that the Treasury Department will explore ways of working with the State Department to insure that the State Department will not issue a CLN confirming the commission of an expatriating act with the requisite intent necessary to terminate citizenship in the absence of adequate evidence of both the occurrence of the expatriating act (e.g., the joining of a foreign army) and the existence of the requisite intent.

Effective date

The expatriation tax provisions as modified by the bill generally apply to any individual who loses U.S. citizenship, and any long-term resident whose U.S. residency is terminated, on or after February 6, 1995. For citizens, the determination of the date of loss of citizenship remains the same as under present law (i.e., the date of loss of citizenship is the date of the expatriating act). However, a special transition rule applies to individuals who committed an expatriating act within one year prior to February 6, 1995, but had not applied for a CLN as of such date. Such an individual is subject to the expatriation tax provisions as amended by the bill as of the date of application for the CLN, but is *not* retroactively liable for U.S. income taxes on his or her worldwide income. In order to qualify for the exceptions provided for individuals who fall within one of the specified categories, such individual is required to submit a ruling request within 1 year after the date of enactment of the bill.

The special transition rule is illustrated by the following example. Mr. E joined a foreign army on October 1, 1994 with the intent to relinquish his U.S. citizenship, but Mr. E does not apply for a CLN until October 1, 1995. Mr. E would be subject to the expatriation tax provisions (as amended) for the 10-year period beginning on October 1, 1995. Moreover, if Mr. E falls within one of the specified categories (i.e., Mr. E is age 18 when he joins the foreign

army), in order to qualify for the exception provided for such individuals, Mr. E would be required to submit his ruling request within 1 year after the date of enactment of the bill. Mr. E would not, however, be liable for U.S. income taxes on his worldwide income for any period after October 1, 1994.

III. VOTES OF THE COMMITTEE

In compliance with clause 2(l)(2)(B) of Rule XI of the Rules of the House of Representatives, the following statement is made concerning the roll call votes of the Committee in its consideration of the bill, H.R. 3103.

Motion to Report the Bill

The bill, as amended, was ordered favorably reported on March 19, 1996, by a roll call vote of 25 yeas and 11 nays, with a quorum present.

The roll call vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer	X			Mr. Gibbons		X	
Mr. Crane	X			Mr. Rangel			
Mr. Thomas	X			Mr. Stark		X	
Mr. Shaw	X			Mr. Jacobs	X		
Mrs. Johnson	X			Mr. Ford		X	
Mr. Bunning	X			Mr. Matsui		X	
Mr. Houghton	X			Mrs. Kennelly		X	
Mr. Herger	X			Mr. Coyne		X	
Mr. McCrery	X			Mr. Levin		X	
Mr. Hancock	X			Mr. Cardin	X		
Mr.Camp	X			Mr. McDermott		X	
Mr. Ramstad	X			Mr. Kleczka	X		
Mr. Zimmer	X			Mr. Lewis		X	
Mr. Nussle	X			Mr. Payne	X		
Mr. Johnson	X			Mr. Neal		X	
Ms. Dunn	X			Mr. McNulty		X	
Mr. Collins	X						
Mr. Portman	X						
Mr. Hayes							
Mr. Laughlin							
Mr. English	X						
Mr. Ensign	X						
Mr. Christensen	X						

Votes on Amendments

Roll call votes were conducted on the following amendments to the Chairman's substitute markup amendment.

An amendment by Mr. Rangel to Title II on duplication and coordination of Medicare plans, which would modify the anti-duplication provisions contained in the 1990 Medigap law, was defeated by a roll call vote of 18 yeas to 19 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer		X		Mr. Gibbons	X		
Mr. Crane		X		Mr. Rangel	X		
Mr. Thomas		X		Mr. Stark	X		
Mr. Shaw		X		Mr. Jacobs	X		
Mrs. Johnson		X		Mr. Ford	X		
Mr. Bunning		X		Mr. Matsui	X		
Mr. Houghton	X			Mrs. Kennelly	X		

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Herger		X		Mr. Coyne	X		
Mr. McCrery		X		Mr. Levin	X		
Mr. Hancock		X		Mr. Cardin	X		
Mr.Camp		X		Mr. McDermott	X		
Mr. Ramstad	X			Mr. Kleczka	X		
Mr. Zimmer		X		Mr. Lewis	X		
Mr. Nussle		X		Mr. Payne	X		
Mr. Johnson		X		Mr. Neal	X		
Ms. Dunn		X		Mr. McNulty	X		
Mr. Collins		X					
Mr. Portman		X					
Mr. Hayes							
Mr. Laughlin							
Mr. English		X					
Mr. Ensign		X					
Mr. Christensen		X					

An amendment by Mr. Collins to Title II to add a new Subtitle G on duplication and coordination of Medicare-related plans was approved by a roll call vote of 28 yeas to 9 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer	X			Mr. Gibbons		X	
Mr. Crane	X			Mr. Rangel	X		
Mr. Thomas	X			Mr. Stark		X	
Mr. Shaw	X			Mr. Jacobs	X		
Mrs. Johnson	X			Mr. Ford		X	
Mr. Bunning	X			Mr. Matsui		X	
Mr. Houghton	X			Mrs. Kennelly	X		
Mr. Herger	X			Mr. Coyne		X	
Mr. McCrery	X			Mr. Levin		X	
Mr. Hancock	X			Mr Cardin		X	
Mr. Camp	X			Mr. McDermott		X	
Mr. Ramstad	X			Mr. Kleczka		X	
Mr. Zimmer	X			Mr. Lewis	X		
Mr. Nussle	X			Mr. Payne	X		
Mr. Johnson	X			Mr. Neal	X		
Ms. Dunn	X			Mr. McNulty	X		
Mr. Collins	X						
Mr. Portman	X						
Mr. Hayes							
Mr. Laughlin							
Mr. English	X						
Mr. Ensign	X						
Mr. Christensen	X						

An amendment by Mr. Cardin to Title II to strike Section 205 on advisory opinions was defeated by a roll call vote of 16 yeas to 21 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer		X		Mr. Gibbons	X		
Mr. Crane		X		Mr. Rangel	X		
Mr. Thomas		X		Mr. Stark	X		
Mr. Shaw		X		Mr. Jacobs	X		
Mrs. Johnson		X		Mr. Ford	X		
Mr. Bunning		X		Mr. Matsui	X		
Mr. Houghton		X		Mrs. Kennelly	X		
Mr. Herger		X		Mr. Coyne	X		
Mr. McCrery		X		Mr. Levin	X		
Mr. Hancock		X		Mr Cardin	X		
Mr. Camp		X		Mr. McDermott	X		

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Ramstad		X		Mr. Kleczka	X		
Mr. Zimmer		X		Mr. Lewis	X		
Mr. Nussle		X		Mr. Payne	X		
Mr. Johnson		X		Mr. Neal	X		
Ms. Dunn		X		Mr. McNulty	X		
Mr. Collins		X					
Mr. Portman		X					
Mr. Hayes							
Mr. Laughlin							
Mr. English		X					
Mr. Ensign		X					
Mr. Christensen		X					

An amendment by Mr. Levin to Title II to strike Section 232 on the clarification of level of intent required for imposition of sanctions was defeated by a roll call vote of 15 yeas to 21 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer		X		Mr. Gibbons	X		
Mr. Crane		X		Mr. Rangel	X		
Mr. Thomas		X		Mr. Stark	X		
Mr. Shaw		X		Mr. Jacobs			
Mrs. Johnson		X		Mr. Ford	X		
Mr. Bunning		X		Mr. Matsui	X		
Mr. Houghton		X		Mrs. Kennelly	X		
Mr. Herger		X		Mr. Coyne	X		
Mr. McCrery		X		Mr. Levin	X		
Mr. Hancock		X		Mr. Cardin	X		
Mr. Camp		X		Mr. McDermott	X		
Mr. Ramstad		X		Mr. Kleczka	X		
Mr. Zimmer		X		Mr. Lewis	X		
Mr. Nussle		X		Mr. Payne	X		
Mr. Johnson		X		Mr. Neal	X		
Ms. Dunn		X		Mr. McNulty	X		
Mr. Collins		X					
Mr. Portman		X					
Mr. Hayes							
Mr. Laughlin							
Mr. English		X					
Mr. Ensign		X					
Mr. Christensen		X					

A substitute amendment to the Chairman's amendment, in the nature of a substitute, by Mr. Gibbons was defeated by a roll call vote of 15 yeas to 21 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer		X		Mr. Gibbons	X		
Mr. Crane		X		Mr. Rangel			
Mr. Thomas		X		Mr. Stark	X		
Mr. Shaw		X		Mr. Jacobs	X		
Mrs. Johnson		X		Mr. Ford	X		
Mr. Bunning		X		Mr. Matsui	X		
Mr. Houghton		X		Mrs. Kennelly	X		
Mr. Herger		X		Mr. Coyne	X		
Mr. McCrery		X		Mr. Levin	X		
Mr. Hancock		X		Mr. Cardin	X		
Mr. Camp		X		Mr. McDermott	X		
Mr. Ramstad		X		Mr. Kleczka	X		
Mr. Zimmer		X		Mr. Lewis	X		
Mr. Nussle		X		Mr. Payne	X		
Mr. Johnson		X		Mr. Neal	X		

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Ms. Dunn		X		Mr. McNulty	X		
Mr. Collins		X					
Mr. Portman		X					
Mr. Hayes							
Mr. Laughlin							
Mr. English		X					
Mr. Ensign		X					
Mr. Christensen		X					

IV. BUDGET EFFECTS OF THE BILL

A. Committee Estimate of Budgetary Effects

In compliance with clause 7(a) of Rule XIII of the Rules of the House of Representatives, the following statement is made concerning the effects on the budget of the bill, H.R. 3103, as reported.

The bill, as amended, is estimated to have the following effects on the budget for fiscal years 1996–2002:

ESTIMATED REVENUE EFFECTS OF PROVISIONS CONTAINED IN H.R. 3103 AS APPROVED BY THE COMMITTEE ON WAYS AND MEANS

[Millions of Dollars]

Provision	Effective	Fiscal years								
		1996	1997	1998	1999	2000	2001	2002	1996 to 2000	1996 to 2002
1. COBRA tax penalties	1/1/98	Negligible Revenue Effect								
2. Medical savings accounts: (a) maximum contribution limit ($2,000 single and $4,000 family); (b) tax-free build up of earnings; (c) definition of qualified medical expenses; (d) post-death distribution rules; and (e) clarification relating to capitalization of policy acquisition costs.	tyba 12/31/96	.....	−134	−246	−290	−340	−369	−399	−1,010	−1,778
3. Increase the self-employed health insurance deduction (35% in 1998; 40% in 1999 through 2001; 45% in 2002; and 50% in 2003 and thereafter.	tyba 12/31/97	.....	.....	−36	−153	−250	−272	−347	−439	−1,058
4. Long-term care provisions: (a) deduction for long-term care premiums; (b) exclude employer contributions for long-term care insurance from gross income; and (c) allow long-term care premiums to be deducted subject to the self-employed health care rules.	tyba 12/13/96	.....	−35	−227	−266	−305	−341	−377	−833	−1,551
5. Deduction for long-term care expenses	tyba 12/31/97	.....	.....	−78	−265	−291	−326	−363	−634	−1,323
6. Tax treatment of accelerated death benefits under life insurance contracts.	tyba 12/31/96	.....	−10	−107	−166	−214	−265	−316	−497	−1,077
7. Exemption from income tax for State-sponsored organizations providing health coverage for high-risk individuals.	tyba 12/31/96	.....	−1	−1	−1	−2	−2	−2	−5	−8
8. Health insurance organizations eligible for benefits of section 833.	tyea 12/31/96	.....	−1	−1	−1	−1	−1	−1	−4	−7
9. Repeal bad debt reserve deduction for thrift institutions, with residential loan test for 1996 and 1997.	tyba 12/31/95	63	95	216	280	277	272	260	931	1,462
10. Earned income credit (“EIC”) provisions:										
a. Require Social Security numbers for primary and secondary taxpayers, treat omission of a correct Social Security number as a math error:.										
Revenue	tyba 12/31/95	1	24	24	25	25	25	26	99	150
Outlay reduction	tyba 12/31/95	10	195	203	205	210	212	217	823	1,251

ESTIMATED REVENUE EFFECTS OF PROVISIONS CONTAINED IN H.R. 3103 AS APPROVED BY THE COMMITTEE ON WAYS AND MEANS—Continued

[Millions of Dollars]

Provision	Effective	Fiscal years								
		1996	1997	1998	1999	2000	2001	2002	1996 to 2000	1996 to 2002
b. Treat omission of the proper self-employment tax by an EIC recipient with self-employment income as a math error:.										
Revenue	tyba 12/31/95	[1]	4	4	5	5	5	5	18	28
Outlay reduction	tyba 12/31/95	1	28	30	31	31	33	35	122	190
11. Expatriation tax provisions	2/6/95	52	97	146	199	254	289	304	748	1,341
TOTAL REVENUE EFFECT		127	262	−73	−397	−600	−740	−958	−681	−2,380

Note: Details may not add to totals due to rounding.
Legend for "Effective" column: tyba=taxable years beginning after; tyea=taxable years ending after.
[1] Gain of less than $500,000.

B. Statement Regarding New Budget Authority and Tax Expenditures

In compliance with subdivision (B) of clause 2(l)(3) of Rule XI of the Rules of the House of Representatives, the Committee makes the following statements concerning budget authority and tax expenditures.

Budget authority

The Committee states that Titles I and II of the bill (relating to availability and portability of health insurance coverage, prevention of health care fraud and abuse, and administrative simplification) are estimated to reduce budget authority (outlays) by $2.2 billion over the fiscal year period 1996–2002. (See Part IV.C., above). Also, the outlay reduction portions of the earned income credit changes in Title IV involve reduced budget authority (reduction in outlays).

Tax expenditures

The Committee states that the revenue-reducing provisions of Title III involve increased tax expenditures. (For amounts for fiscal years 1996–2002, see table in Part IV.A., above.) The deduction for health insurance expenses of self-employed individuals involves an increase in an existing tax expenditure, while the other revenue-reducing provisions involve new tax expenditures (except for the COBRA tax penalty provision, which is not a tax expenditure provision).

The revenue offset provisions (in Title IV) relating to bad debt deductions of thrift institutions and the earned income credit (revenue-increase portion) involve reductions in existing tax expenditures. The expatriation tax provisions (in Title IV) do not affect tax expenditures during the fiscal year 1996–2002 period.

C. Cost Estimate Prepared by the Congressional Budget Office

In compliance with subdivision (C) of clause 2(l)(3) of Rule XI of the Rules of the House of Representatives, requiring a cost estimate prepared by the Congressional Budget Office (CBO), the following statement by CBO is provided.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, March 25, 1996.

Hon. BILL ARCHER,
Chairman, Committee on Ways and Means
Washington, D.C. 20515

DEAR MR. CHAIRMAN: The Congressional Budget Office (CBO) has reviewed H.R. 3103, the Health Coverage Availability and Affordability Act of 1996, as ordered reported by the House Committee on Ways and Means on March 19, 1996. Enclosed are CBO's federal cost estimate and estimates of the costs of intergovernmental and private sector mandates.

If you wish further details on these estimates, we will be pleased to provide them. The CBO staff contacts are identified in the separate estimates.

Sincerely,

JUNE E. O'NEILL,
Director.

CONGRESSIONAL BUDGET OFFICE FEDERAL COST ESTIMATE

1. Bill number: H.R. 3103.

2. Bill title: Health Coverage Availability and Affordability Act of 1996.

3. Bill status: As ordered reported by the House Committee Ways and Means on March 19, 1996.

4. Bill purpose: Title I would make it easier for people who change jobs to maintain health insurance coverage by limiting exclusions for preexisting conditions and increasing portability of coverage.

Title II would prevent health care fraud and abuse and would simplify the administration of health insurance.

Titles III and IV would change the tax treatment of Medical Savings Accounts (MSAs), increase the deductibility of health insurance costs of self-employed individuals, and make other changes to the tax code.

5. Estimated cost to the Federal Government: CBO and the Joint Committee on Taxation (JCT) estimate that H.R. 3103 would increase the federal deficit by about $300 million over seven years, with outlays falling by $2.2 billion and revenues falling by $2.5 billion over the period (see the attached table).

CBO estimates that title I, concerning portability of group health coverage, would increase private group health premiums by a small amount, resulting in a slight increase in employer-paid premiums. A portion of this increase would be passed on to employees as reduced wages and salaries. Federal income and payroll taxes, therefore, would be reduced slightly as well. CBO and JCT estimate that revenues would be reduced by $0.2 billion over seven years as a result of this section.

CBO estimates that title II, concerning the prevention of fraud and abuse and other matters, would reduce Federal outlays for Medicare by approximately $2.2 billion over seven years.

JCT estimates that the tax changes in titles III and IV would reduce revenues by $2.4 billion over seven years. The provision to increase tax deductions for MSAs would reduce revenues by $1,778 million; the provision to increase the deduction for health costs of the self-employed would reduce revenues by $1,058 million; and other tax changes would increase revenues by $457 million over the period.

6. Basis of the estimate:

TITLE I, GROUP INSURANCE PORTABILITY

H.R. 3103 addresses health insurance purchased in large and small groups—usually by employers and employees. The bill does not regulate individually-purchased insurance or state and local government employers.

The bill would create uniform national standards to govern the portability of private group health insurance policies. For example, these standards would allow workers with employment-based policies to continue their coverage more easily when changing or leaving jobs. Because private insurance plans often require a waiting period before new employees become eligible for coverage, especially for those with preexisting medical conditions, workers with chronic conditions or other potential health risks may face gaps in their coverage when they change jobs. Alternatively, such workers may be hesitant to change jobs because they fear the temporary loss of coverage—a situation know as job-lock.

H.R. 3103 would reduce the effective length of exclusions for preexisting conditions by crediting enrollees for continuous coverage by a previous insurer. Plans would be prohibited from denying coverage based on an employee's health status. The bill would allow workers to change their enrollment status under certain conditions without being subject to penalties for late enrollment. To the extent that states have not already implemented similar rules, these changes would clarify the insurance situation for many people.

Because the bill would not regulate the premiums that plans could charge, the number of people covered by health insurance and the premiums that they pay would continue to be influenced primarily by market forces. Although this provision would make insurance more portable for some people, it would not dramatically increase the availability of insurance in general.

Budgetary impact

Title I could affect the federal budget in two ways. First, if the bill changed the amount of employer-paid health premiums, total federal tax revenues could change. For example, if the total amount employers paid for premiums fell, cash wages would rise, thereby increasing income and payroll tax revenues. Second, if the bill caused people insured by government health programs to obtain private coverage, then federal outlays for those programs could change.

Impact on federal revenues

According to the General Accounting Office (GAO), 38 states have enacted legislation to improve the portability and renewability of health plans among small employers. State laws do not apply to employees of firms with self-funded insurance plans, although large employer plans—those most likely to self-insure—generally have fewer long exclusions for preexisting conditions than smaller firms. Health maintenance organizations and other health plans that use organized networks of health providers use few exclusions for preexisting conditions within their networks. Most group insurance is now provided through these managed care networks. The new standards for insurance portability created by H.R. 3103 would increase the price of health insurance for group plans, with a corresponding reduction in coverage. Because many insurance reforms have already been implemented by the states, however, and because most health plans tend not to use long exclusions for preexisting conditions, these changes would be relatively small.

CBO estimates that the portability requirements of H.R. 3103 would initially increase group premiums by approximately $300 million a year, beginning in 1998. This increase would consist of $200 million from shortening exclusions for preexisting conditions to 12 months and $100 from the crediting of coverage in a previous group. Employers and employees would react to these costs by reducing health benefits or other fringe benefits or by lowering cash wages. CBO assumes that cash wages would fall by about $100 million, one-third of the initial $300 million cost increase. JCT estimates that income and payroll tax revenues would fall by about $35 million a year and by $164 million over seven years.

Impact on federal outlays

CBO assumes that federal outlays for Medicaid would not change because any persons eligible for free coverage from Medicaid under current law would still seek Medicaid coverage if H.R. 3103 was enacted. CBO also estimates that the bill would cause no appreciable changes to federal outlays for Medicare, Federal Employees Health Benefits,or other government programs.

TITLE II, LIMITING FRAUD AND ABUSE AND ADMINISTRATIVE SIMPLIFICATION

Limiting fraud and abuse

The proposal includes several proposals to limit fraud and abuse in Medicare.

Payment safeguards and enforcement

The bill would establish mandatory appropriations for Medicare payment safeguards and for the anti-fraud activities of the Inspector General (IG) of the Department of Health and Human Services (HHS) and the Federal Bureau of Investigation (FBI). It would also increase the resources devoted to these two activities. After a few years, reduced Medicare spending and additional fines and penalties would more than offset the added administrative costs. Over the 1996–2002 period, the net savings would total $2,900 million.

CBO's estimate attributes savings only to the projected increase in resources, not to the base level itself. The estimate assumes that the Health Care Financing Administration (HCFA), the IG, and the FBI could productively use only limited additional resources each year, and that additional resources would be subject to diminishing marginal returns. Based on studies by the General Accounting Office and HCFA, the estimate assumes that an additional dollar devoted to HCFA payment safeguard activities would at first return eight dollars in lower benefit payments. Data from the IG indicate that an additional dollar devoted to its enforcement efforts would initially return seven dollars in recoveries. The estimate assumes that the marginal benefit-to-cost ratio in each case would decline to approximately four-to-one by 2002. Data on recoveries from the FBI's Health Care Fraud Unit indicate an initial nine-to-one ratio of recoveries to cost. As with HHS, the estimate assumes that the ratio at the margin would decay over time to seven-to-one by 2002. If this proposal is adopted, CBO expects that the savings would be documented and subject to an independent audit. These docu-

mented savings would then be used to make any estimates of new proposals and provide a basis for updating projections of spending under current law.

Additional health care fraud and abuse guidance

The bill would require the Secretary to create a program enabling providers of health care to seek advisory opinions regarding the application of health care fraud and abuse sanctions. According to the IG, such a provision would substantially hinder its ability to prosecute fraud and abuse cases successfully. It would also require the IG to hire additional legal staff. Based on data provided by the IG, CBO estimates that this provision would cost $390 million in lost recoveries and additional staff over the 1996–2002 period.

New and increased civil monetary penalties

The bill would increase current law civil monetary penalties for fraudulent claims for reimbursement under Medicare and Medicaid and apply these penalties to all federal health care programs. New civil monetary penalties would apply to individuals who retained control of a provider entity while they were excluded from Medicare or a State health care program, coded billed procedures incorrectly, prescribed services that were not medically necessary, offered kickbacks for using particular providers, or falsely certified home health services, and to Medicare health maintenance organizations (HMOs) that failed to fulfill their contracts. Based on an analysis of the recoveries generated by the IG's current caseload and expectations of the impact of the new penalties, CBO estimates that these provisions would generate $320 million in savings over the 1996–2002 period.

Additional exclusion authorities

The bill would require the Secretary of HHS to exclude providers from program participation for three years following felony convictions for fraud, obstructing an investigation, and controlled substance violations. Providers would be excluded for one year following the provision of substandard or unnecessary services and for the term of a provider's loss of license for violations of state law. The Secretary could also exclude individuals in control of a sanctioned entity. CBO estimates that these provisions would result in $190 million in fraud avoided over six years. The estimate is based on the IG's data on program savings resulting from provider convictions and expectations for additional successful actions.

Criminal provisions

The bill would make certain offenses involving health care fraud federal crimes. The bill would also grant the Attorney General the authority to subpoena information relating to suspected health care fraud. Based on conversations with officials of the Department of Justice, CBO assumes that these provisions would modestly increase successful prosecutions and result in recovery of $70 million in fraudulent Medicare payments over the next seven years.

In addition, the bill would create an additional exception to anti-kickback penalties for discounting and managed care arrangements. Based on recoveries data and conversations with the IG,

CBO estimates that this would result in $580 million lost in anti-kickback recoveries.

Other items

The bill would require the Secretary of HHS to establish a fraud and abuse data collection program to report the final settlements from adverse actions against health care providers, suppliers, or practitioners. The bill would also require the Secretary to establish a hotline and provide incentives for beneficiaries to report suspected fraud and to provide suggestions to improve the Medicare program. Based on an examination of a similar program operated by the Department of Defense, CBO estimates that this program would produce a net benefit of $30 million from additional recoveries over six years.

Administrative simplification

This provision would require the Secretary to adopt uniform standards and data elements for the electronic transmission of health information and claims. The Secretary would adopt standards developed by standard-setting organizations, or a modification of these standards, with the goal of reducing administrative costs. A Health Information Advisory Committee would assist the Secretary with this task and would make recommendations regarding standards and electronic data exchange. The proposal would also require the Secretary to take measures to protect the privacy and security of electronically transmitted health information. CBO estimates that this provision would cost the federal government $60 million over seven years. Because this spending would require appropriations action, these costs are not included in the attached table.

These new standards would apply to health plans, claims clearinghouses, and providers transmitting health information electronically, and would supersede existing state laws and regulations. Large health plans, clearinghouses and providers must conform to these standards within 24 months of their adoption, while small plans would have 36 months to comply. Penalties would be levied against those who violated the standards or improperly used or distributed individually identifiable health information. However, these penalties would be waived if violators demonstrated reasonable cause of diligence.

Laboratory services

The provision relating to laboratory services would cost the federal government approximately $330 million over seven years. This provision would mandate that, within a year of the enactment of H.R. 3063, the Secretary develop standardized coverage, payment, and administrative policies for clinical laboratory tests reimbursed under Medicare Part B. The Secretary would select medical directors from various carriers to develop recommendations regarding these policies, in consultation with affected groups. The purpose of these recommendations would be to simplify the processes of reporting beneficiary information, filing claims, and record keeping.

The bill would also excuse labs from documenting the medical necessity of tests unless reviews indicate aberrant utilization pat-

terns. In fiscal year 1995, 17 Medicare carriers saved $41 million through localized policies requiring labs to document medical necessity. Therefore, repealing the requirement would cost a similar amount. These costs would not accrue immediately because the bill prohibits intermediaries and carriers from implementing new requirements for claims submission for lab tests pending the implementation of the uniform policies retroactive to January 1996. Since most carriers' local policies regarding the documentation of medical necessity were established by 1995, these policies could remain in place until the uniform policies were fully implemented. Thus, this proposal would cost the federal government about $240 million over seven years.

An independent lab would also be allowed to select a single carrier to process its Medicare claims under this proposal; currently, labs use multiple carriers to process claims. This provision would increase costs to the federal government for independent lab services, although the magnitude of these costs is difficult to estimate. If independent labs were permitted to select a single carrier, carriers would face incentives to adopt more lenient policies to attract a higher volume of business. Also, the carrier processing lab test claims for a beneficiary might not be the same carrier handling other claims for that person. This fragmentation could make it more difficult for the Health Care Financing Administration to determine the medical necessity of tests performed by independent labs. If this provision were to increase Medicare costs for independent lab services by one-half of one percent annually, it would cost the federal government an additional $90 million over seven years.

TITLES III AND IV, TAX PROVISIONS

Medical savings accounts (MSAs)

Under the legislation, individuals covered by high-deductible health insurance plans could make deductible contributions to MSAs, or their employers could make contributions on their behalf that would be excluded from earnings for income and payroll tax purposes. Investment earnings of amounts in the MSA would also be excluded from taxable income in the year earned. Withdrawals from MSAs for medical expenses would be tax-free, but withdrawals for other purposes would be included in taxable income and subject to an additional tax of 10 percent. The additional tax would be waived if the account holder were over age 59½, disabled, or had died.

High-deductible insurance would be defined as insurance having a deductible of at least $1,500 per person covered, and a deductible of at least $3,000 per family. Contributions would be limited to the lesser of the deductible of the insurance plan or $2,000 for individual coverage and $4,000 for family coverage. To be eligible for an MSA, individuals and families could not have other insurance policies that covered the deductible of the high-deductible policy. Allowable medical expenses would be those permitted under the itemized deduction for medical expenses, except for certain insurance premiums. Expenses for long-term care would also qualify as medical expenses.

The proposal would be effective for taxable years beginning after December 31, 1996, and is projected by the Joint Committee on Taxation to reduce income tax revenues by $1.778 billion in 1997–2002.

Deduction for health insurance expenses of self-employed individuals

Under current law, self-employed individuals are allowed to deduct 30 percent of the cost of health insurance premiums they pay for coverage of themselves, their spouse, and dependents, as long as they are not eligible for insurance provided by an employer. The proposal would increase the fraction deductible to 50 percent in the following steps: 35 percent for 1998; 40 percent for 1999, 2000, and 2001; 45 percent for 2002; and 50 percent for 2003 and years thereafter.

The Joint Committee on Taxation estimates that this proposal would reduce revenue by $1.058 billion between fiscal years 1998 and 2002.

Other tax provisions

The Joint Committee on Taxation estimates that the combined effect of other provisions in Titles III and IV of H.R. 3103 would increase revenues by $457 million over seven years.

7. Pay-as-you-go considerations: The Balanced Budget and Emergency Deficit Control Act of 1985 sets up pay-as-you-go procedures for legislation affecting direct spending or receipts through 1998. The bill would have the following pay-as-you-go impact:

[by fiscal year, in millions of dollars]

	1996	1997	1998
Change in Outlays	0	340	−40
Change in Revenues	127	262	−97

8. Previous CBO estimate: CBO has prepared cost estimates for several health care reform bills—S. 1028 as reported by the Senate Committee on Labor and Human Resources, H.R. 995 as reported by the House Committee on Economic and Educational Opportunities, H.R. 3070 as reported by the House Committee on Commerce, and H.R. 3103 as reported by the House Committee on Ways and Means. All four bills contain provisions restricting preexisting conditions and increasing portability of health insurance. In addition, H.R. 3070 and H.R. 3103 contain provisions designed to reduce fraud and abuse in Medicare and simplify the administration of health insurance.

9. Estimate prepared by: Jeff Lemieux (insurance reform), Anne Hunt (administrative simplification), Cynthia Dudzinski (fraud and abuse).

10. Estimate approved by: Paul N. Van de Water, Assistant Director for Budget Analysis.

ESTIMATED BUDGETARY EFFECTS OF H.R. 3103

[By fiscal year, in billions of dollars]

	1996	1997	1998	1999	2000	2001	2002	Total
				DIRECT SPENDING				
Title I	0	0	0	0	0	0	0	0
Title II:								
Fraud and Abuse:								
A. Recoveries from Payment Safeguards and Law Enforcement	0	330	−110	−490	−780	−890	−960	−2,900
B. Cost of Additional Health Care Fraud and Abuse Guidance	0	60	60	60	70	70	70	390
C. New and Increased Civil Monetary Penalties	0	−30	−50	−50	−60	−60	−70	−320
D. Additional Exclusion Authorities	0	−10	−10	−40	−40	−50	−50	−190
E. Criminal Provisions	0	−10	10	40	90	190	190	510
F. Other Items	0	(1)	(1)	(1)	(1)	(1)	(1)	−30
Total, Fraud and Abuse	0	330	−100	−480	−730	−740	−810	−2,540
Administrative Simplification:								
A. Administrative Simplification Standards[2]	0	0	0	0	0	0	0	0
B. Administrative Simplification for Labs	0	10	60	60	60	70	70	330
Total, Administrative Simplification	0	10	60	60	60	70	70	330
Total, Title II	0	340	−40	−420	−670	−670	−740	−2,200
Titles III and IV	0	0	0	0	0	0	0	0
Total, Outlays	0	340	−40	−420	−670	−670	−740	−2,200
				REVENUES				
Title I	0	0	−24	−35	−35	−35	−35	−164
Title II	0	0	0	0	0	0	0	0
Titles III and IV:								
A. Medical Savings Accounts	0	−134	−246	−290	−340	−369	−399	−1,778
B. Deduction for the Self-Employed	0	0	−36	−153	−250	−272	−347	−1,058
C. Other	127	396	209	46	−10	−99	−212	457
Total, Titles III and IV	127	262	−73	−397	−600	−740	−958	−2,379
Total, Revenues	127	262	−97	−432	−635	−775	−993	−2,543
				DEFICIT				
Total	−127	78	57	12	−35	105	253	343

[1] Savings or cost of less than $10 million.
[2] Costs of about $10 million per year for this provision would be discretionary spending.

Note: Estimate based on CBO December 1995 baseline assumptions.

CONGRESSIONAL BUDGET OFFICE ESTIMATE OF COSTS OF INTERGOVERNMENTAL MANDATES

1. Bill number: H.R. 3103.

2. Bill title: Health Coverage Availability and Affordability Act of 1996.

3. Bill status: As ordered reported by the House Committee on Ways and Means on March 19, 1996.

4. Bill purpose: Title I would make it easier for people who change jobs to maintain adequate coverage by limiting preexisting

condition exclusions and increasing portability of coverage. State and local governments could elect to be exempt from these requirements.

Title II would require the Secretary of Health and Human Services and the Attorney General to establish a program to control health care fraud. The program would include a national data base of criminal actions, civil actions, and license revocations against health care providers, practitioners, and suppliers. State and local governments would be required to provide this information for the data base.

Title II would also require the Secretary of Health and Human Services to establish national standards for health care transactions, such as claims and eligibility, that are transmitted electronically. Health care plans would be required to have the capability of receiving and transmitting this information three and one-half years after enactment.

Title III and Title IV would make numerous changes to federal tax law, many of which deal with health care.

5. Intergovernmental mandates contained in bill: H.R. 3103 contains various mandates, two of which have budgetary implications. First, state and local agencies would be required to report criminal and civil actions and license revocations against health care providers, practitioners, and suppliers. Second, state and local governments, as providers of health insurance or health care, would have to transmit health care transactions under new national standards.

6. Estimated Direct Costs to State, Local, and Tribal Governments:

(a) *Is the $50 Million Threshold Exceeded?* No

(b) *Total Direct Costs of Mandates:* Not significant.

(c) *Estimate of Necessary Budget Authority:* None

7. Basis of estimate:

Reporting requirements. State and local agencies would be required to report criminal and civil actions and license revocations against health care providers, practitioners, and suppliers. Based on the information from the National Association of Attorneys General and the National Health Care Anti-Fraud Association, CBO expects that this requirement would not impose a significant administrative burden on state and local governments. Most health care fraud cases carried out by states deal with Medicaid. Under current law, states are already required to report criminal and civil actions relating to Medicaid to the Department of Health and Human Services.

National standards. The bill would require state and local governments, as providers of health insurance to their employees, to have the capability to receive and transmit transactions electronically under the national standards. Such transactions include enrollment, eligibility, and claims. Because the Secretary of Health and Human services would be required to adopt standards only if they reduce the administrative costs of providing and paying for health care, this mandate should save states and local governments money in the long run. Some state and local governments would face one-time costs as they purchase computer hardware and software and reconfigure their computer systems. Because many of these health plans already have the hardware to transmit informa-

tion electronically and many more will acquire the hardware over the next the three and one-half years under current law, however, additional costs would be negligible.

The national standards would also apply to state and local government agencies that provide health care, for example, through public hospitals or clinics, and that transmit any health information electronically. CBO estimates that the additional costs faced by these providers would be negligible.

8. Appropriation or other Federal financial assistance provided in bill to cover mandate costs: None

9. Other impacts on State, local, and tribal governments:

National standards. The capability to transmit health information electronically would also apply to the Medicaid program. States are already in the forefront in administering the Medicaid program electronically; the only costs—which should not be significant—would involve bringing the software and computer systems for the Medicaid programs into compliance with the new standards. Moreover, under Public Law 104–4 increases in requirements for large entitlement programs are not considered mandates if the states have the programmatic flexibility to reduce their financial responsibilities. States have the ability to reduce their coverage of optional services or benefits.

Preexisting condition and portability. H.R. 3103 also would require state and local governments, as providers of health coverage to their employees, to comply with the preexisting condition and portability requirements unless they specifically opt out in a form and manner determined by the Secretary of Health and Human Services. If state and local governments decide to comply with these requirements, they would face an increase in health care costs of less than $50 million, a 0.1 percent increase in such costs. CBO estimates that state and local governments spend about $40 billion annually on health insurance for their employees. CBO assumes that state and local governments would pass these costs onto their employees in the form of adjustments to pay or other benefits.

Enforcement. States would have the option of enforcing the requirements of H.R. 3103 on issuers of group health insurance. If a state decides not to enforce the new requirements, the federal government would do so. States currently regulate the group insurance market, and CBO does not expect any state to give up this authority and responsibility. States would thus incur additional costs as they enforce the new requirements. In 1995, according to the National Association of Insurance Commissioners, states spent $650 million regulating all form of insurance (health and others). CBO expects that H.R. 3103 would increase these costs only marginally.

Other impacts. H.R. 3103 would also require state and local governments to pay a fee if they want to access information from the national data base of health care fraud; these costs would not be significant. In addition, to the extent that the private sector mandates result in an increase in health care premiums collected by insurance companies and health maintenance organizations, state premium taxes would increase. Such increases would be offset by lower income tax revenues if higher premiums are passed onto em-

ployees in the form of lower wages. The net effect of the premium tax increase and income tax decrease should be no more than a few million dollars. Finally, to the extent that state and local governments piggyback their income tax systems on the federal tax system, they would face changes in revenue as result of the changes to federal tax law contained in this bill. CBO is unable to determine the net effect of these changes.

10. Previous CBO estimate: CBO has prepared cost estimates of various other health care reform bills—S. 1028 as reported by the Senate Committee on Labor and Human Resources on October 12, 1995, H.R. 995 as ordered reported by the House Committee on Economic and Educational Opportunities on March 6, 1995, and H.R. 3070 as ordered reported by the House Committee on Commerce on March 20, 1996. All three bills have preexisting condition and portability provisions similar to those in H.R. 3103, but only under S. 1028 do these provisions constitute a mandate on state and local governments. The House bills allow state and local governments to opt out of these requirements. All for bills differ with respect to other provisions, but H.R. 3103 and H.R. 3070 would impose similar data reporting and electronic transmission requirements on state and local governments.

11. Estimate prepared by: John Patterson.

12. Estimate approved by: Paul N. Van de Water, Assistant Director for Budget Analysis.

CONGRESSIONAL BUDGET OFFICE ESTIMATE OF COSTS OF PRIVATE SECTOR MANDATES

1. Bill number: H.R. 3103.

2. Bill title: The Health Coverage Availability and Affordability Act of 1996.

3. Bill status: As ordered reported by the House Committee on Ways and Means on March 19, 1996.

4. Bill purpose: The purpose of H.R. 3103 is to improve portability of health insurance coverage, to simplify administration of health insurance, to reduce waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, and to improve access to long-term care coverage. It would also modify certain provisions of the Internal Revenue Code.

5. Private sector mandates contained in the bill: H.R. 3103 contains several private sector mandates as defined in P.L. 104–4. Provisions in Title I would affect the private group and employer-sponsored health insurance industry. They would apply both to sellers of group insurance and to employee health benefit plans that are "self-insured" by firms.

The bill would limit the use of pre-existing condition exclusions—clauses that exempt the plan from paying for expenses related to a medical condition that already existed when an enrollee first joined the plan. Under its provisions, twelve months would be the maximum allowable duration of a pre-existing condition exclusion (eighteen months for employees who did not join the plan at their first enrollment opportunity). In addition, month-for-month credit against that exclusion would have to be given to enrollees for continuous coverage (as specified in the bill) that they had prior to

joining a new plan. A break in coverage of 60 days or less would not be counted against the prior continuous coverage requirement. (Insurers and health benefit plans would be required to disclose information that would facilitate the administration of those "portability" requirements.) In addition, pregnancy could not be excluded by a pre-existing condition clause, and children who were signed up with a plan within thirty days of birth could not have any existing conditions excluded from coverage. (A similar provision applies for adopted children.)

Health maintenance organizations would be allowed to use "eligibility" periods, in which new enrollees would not be eligible for benefits, as long as pre-existing condition exclusions were not part of the plan. However, such periods would be limited to sixty days (ninety days for late enrollees).

Finally, a health plan could not exclude an employee or his or her beneficiary from the plan on the basis of health status. The bill would require that group health plans offer special enrollment periods during which enrollment in at least one benefit option would be possible for participants or family members, for various changes in family or employment status that resulted in a loss of insurance coverage.

Title II of the bill would impose a mandate on all private sector insurers and those providers who submit claims electronically. It would require that certain specified health-related electronic transmittals conform to standards adopted by the Secretary of Health and Human Services. The bill states that any standards adopted must reduce the administrative costs of providing and paying for health care. Title II would also establish a health care fraud and abuse data collection program, with a mandate on each government agency and private health plan to report any final adverse action taken against a health care provider, supplier, or practitioner.

Title IV includes revenue provisions that would raise private-sector costs. Those provisions would repeal the bad debt reserve method for thrift savings associations, modify eligibility for the earned income credit, and revise tax provisions relating to individuals who give up U.S. citizenship.

In addition to these mandates, Title III includes provisions that would reduce tax payments. Those provisions would establish or amend tax rules for medical savings accounts, long-term care insurance, accelerated death benefits under life insurance contracts, and some health insurance organizations. They would also increase the percentage of health insurance costs that can be deducted by self-employed individuals.

6. Estimated direct cost to the private sector: This section provides estimates of the direct private-sector costs of the non-tax and tax mandates in the bill. It also provides information on tax reductions the bill contains. CBO estimated the cost of the non-tax provisions, while the Joint Committee on Taxation (JCT) estimated the effects of the other provisions (See the attached letter for more details on the JCT estimates.)

CBO estimates that the direct cost of the main non-tax private sector mandates in H.R. 3103 would total about $300 million in each full year that the provisions would be effective, as shown below:

[By fiscal year, in millions of dollars]

	1996	1997	1998	1999	2000	2001	2002
Direct cost of non-tax mandates	.....	.....	225	300	300	300	300

The specific mandates examined in this estimate are contained in Title I of the bill, and include: (1) limiting the length of time employer-sponsored and group insurance plans could withhold coverage for pre-existing conditions, and (2) requiring that periods of continuous prior health plan coverage be credited against pre-existing condition exclusions of a new plan.

The $300 million annual direct cost is approximately 0.2 percent of the total premium payments in the group and employer-sponsored market, although their distribution among health insurance plans would be uneven. (Plans that cover public sector employees are not included in this analysis.) This estimate is subject to considerable uncertainty because a number of underlying assumptions rely on limited data or judgements about future changes in health insurance markets.

CBO estimates that the direct cost of the mandates in Title II of the bill would be negligible. Health plans (and those providers who choose to submit claims electronically) would be required to modify their computer software to incorporate new standards as they are adopted or modified, but modifications could not be made more frequently than once every six months. Uniform standards would generate offsetting savings for plans and providers by simplifying the claims process and coordination of benefits. Data reporting requirements for the health care fraud and abuse data collection program would be negligible.

The JCT estimates that the direct mandate cost of tax increases in H.R. 3103 would total $116 million in 1996, growing to $590 million in 2002, as shown below:

[By fiscal year, in millions of dollars]

	1996	1997	1998	1999	2000	2001	2002
Direct cost of tax increases	116	216	386	504	556	586	590

These tax increases are contained in Title IV of the bill.

In addition to these mandates, the bill also provides for reductions in taxes. At this point, it is unclear to CBO whether these tax reductions should be viewed as offsets to the direct costs of the mandates in the bill in determining whether the $100 million threshold in P.L. 104–4 is exceeded. JCT estimates that the saving associated with the tax reductions in H.R. 3103 would total about $180 million in 1997, growing to about $1.8 billion in 2002, as shown below:

[By fiscal year, in millions of dollars]

	1996	1997	1998	1999	2000	2001	2002
Reductions in taxes	.....	−181	−696	−1142	−1403	−1576	−1805

These tax reductions are contained in Title III of the bill.

Basis of the estimate: The remainder of this analysis discusses the basis for CBO's estimate of the direct cost of the main non-tax private sector mandates in H.R. 3103. The direct costs of those

mandates consist of the additional health expenses that would be covered by insurance as a direct result of their implementation. Expenses for pre-existing conditions that would have to be paid by insurers under the bill but would not have been insured under current law, for example, are included in aggregate direct costs. In contrast, insured expenses that would be transferred among different insurers bases of the bill are not included in aggregate direct costs.

In making this estimate, CBO did not attempt to value any social benefits that might result from expansions in insurance coverage. That is, the estimate accounts only for the additional insurance costs of the mandates, not the value of additional insurance coverage to beneficiaries. Nor was there an attempt to quantify any indirect costs or benefits. Such indirect effects could include, for example, loss of coverage if an employer ceases to offer group coverage when premiums rise, or increases in worker mobility (or reduced "job lock") with greater portability of benefits. It would be important to weigh all such factors in considering the bill, but only estimates of the direct costs of the mandates in the bill are required by P.L. 104–4, the Unfunded Mandates Reform Act.

Limiting the maximum length of an exclusion

The mandate to limit exclusions for pre-existing conditions to 12 months (18 months for late enrollees) is estimated to have a direct private-sector cost of about $200 million per year. This estimate is based on two components: (1) the number of people who would have more of their medical expenses covered by insurance if exclusions were limited to one year or less, and (2) the average cost to insurers of that newly insured medical care.

CBO used data from the Survey of Employee Benefits in the April 1993 Current Population Survey (CPS) to estimate the number of people with conditions that are not now covered because of a pre-existing condition exclusion of more than one year. The survey asks respondents whether they or a family member have a medical condition that their employment-based plan is not covering because of a pre-existing condition exclusion. It also asks respondents how long they have been with their present firm. For people with medical conditions excluded by a pre-existing condition clause, responses to the second question are used to estimate whether the exclusion period exceeds one year.

A number of adjustments were made to the data. In particular, CBO's estimate of the number of people affected by H.R. 3103 excluded people who said they were limited by a pre-existing restriction but who also had other health insurance coverage, because the other insurance plan might have covered their pre-existing condition. Under those circumstances, the limitation imposed on employment-based plans by H.R. 3103 would not raise their aggregate costs.

The second modification to the CPS data adjusted for changes in the insurance market that have occurred since the survey date of 1993. In particular, since that time, about 40 states have implemented laws affecting the small group insurance market that would limit pre-existing condition exclusions to one year or less and require that previous coverage be credited against those exclusions.

Those laws generally apply to groups of 50 or fewer employees and do not include self-funded health benefit plans. Because plans covered by such state laws would not have to change their provisions as a result of H.R. 3103, CBO lowered its initial estimate of the number of people affected by the bill.

CBO's analysis led to the conclusion that approximately 300,000 people would gain coverage under H.R. 3103 for some condition that would otherwise be excluded by a long (more than one year) pre-existing condition clause. This estimate represents less than 0.3 percent of people with private employment-based coverage.

The other component of the estimated private-sector cost is the average cost of the coverage that would become available under H.R. 3103. A recent monograph from the American Academy of Actuaries (referred to as the academy) indicated a surge in claims costs of 40 to 60 percent when a pre-existing condition exclusion period expired for a sample of people with high expected medical costs.[1] That range is consistent with information from Spencer and Associates indicating that the costs of policies for former employees who have chosen to take extended COBRA coverage are 55 percent higher than those of active employees.[2] Applying those percentages to the average premium cost in the employer-sponsored market yields additional costs of about $900 a year per person who would gain coverage under H.R. 3103.

Crediting prior coverage against current exclusions

Another provision in H.R. 3103 would require insurers under certain circumstances to credit previous continuous health insurance coverage against pre-existing condition periods. That provision is estimated to have a private sector cost of about $100 million per year. The key components of this estimate are: (1) the number of people who would receive some added coverage, and (2) the additional full-year cost of coverage, adjusted to reflect the estimated number of months of that coverage.

CPS data were used to estimate the number of people who would receive some added coverage under this mandate. These are people who would otherwise face some denial of coverage under a pre-existing condition exclusion period of one year or less, and who would qualify for a shortened exclusion period based on prior continuous coverage. CBO estimates that about 100,000 people would receive some added coverage under this provision of the bill. The relatively small size of this estimate is due largely to the difficulty of meeting the restrictive eligibility criteria for the reduction in the exclusion period—particularly the requirement that at most a 60-day gap separate prior periods of insurance coverage from the enrollment in the new plan.

The average number of months of coverage these people would gain is constraint by the one-year limit on the exclusion period that would be required under the bill. Based on information from a 1995

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[1] See American Academy of Actuaries, "Providing Universal Access in a Voluntary Private-Sector Market," February 1996.

[2] Charles D. Spencer and Associates, Inc. "1995 COBRA Survey: Almost One in Five Elect Coverage, Cost is 155% of Actives' Cost," Spencer's Research Reports (August 25, 1995).

study by KPMG Peat Marwick, CBO estimates that people who would qualify would gain coverage for an average of 10 months.[3]

CBO's estimates of the additional insured costs per person is based on evidence from the Academy, which suggested that people with pre-existing condition exclusions may not seek treatment during the exclusion period but have rapid increases in expenses when that period expire. That behavior would reduce the effectiveness of exclusion periods in protecting insurers from treatment costs. The shorter the exclusion period, the less effective the pre-existing exclusion is at reducing the insurer's costs. CBO consequently assumed that full-year insured costs of people getting coverage for pre-existing conditions under this provision would rise by less than 40 percent.

Other considerations

The estimated direct cost of the mandate to limit the length of pre-existing condition exclusions is about $200 million annually, and the cost of the mandate to credit previous coverage against pre-existing condition exclusions is about $100 million. Together, those mandate costs amount to about 0.2 percent of total premium payments in the group and employer-sponsored market.

Those estimates are subject to considerable uncertainty for several reasons. First, they are based on individual's responses to surveys, which should be treated with caution. In addition, unforeseen changes in health insurance markets could result in the estimates being too low or too high. Larger than expected increases in medical costs would result in higher direct costs than estimated. On the other hand, the growth of managed care plans would lower the direct costs of the bill. The magnitude of this effect would depend on the relative growth of HMOs, which generally do not use pre-existing conditions, as compared to PPO and POS plans, many of which do use pre-existing condition exclusions.

The distribution of the direct costs of the mandates would be uneven across health plans. Only plans that currently use pre-existing condition exclusion of more than 12 months would face the $200 million direct cost of the first mandate. Data from the Peat Marwick survey indicate that 2.5 percent of employees are in such heath plans. Consequently, the costs to health plans that use long pre-existing exclusions would be about 4.5 percent of their premium costs. Likewise, only health plans that use pre-existing condition exclusions would face the direct cost of the mandate to credit previous coverage against the pre-existing exclusion. The data indicate that almost half of employees are in such plans—implying that the plans directly affected by this mandate would have direct costs equal to about one-tenth of one percent of their premiums under current law.

Employers could respond in a number of ways to the additional insured costs that would arise under these provisions of the bill. They could reduce other insurance benefits, increase employees' premium contributions, or reduce other components of employee compensation. Employers would be likely to respond in different

[3] Based on unpublished tabulations from KPMG Peat Marwick, LLP, *Survey of Employer-Sponsored Benefits, 1995.*

ways, and these changes could take time. Some employers that currently offer health insurance to their employees might drop that coverage if the costs became too large, although the magnitude of such a reaction would probably be modest. These employer responses, which would offset the costs of the mandates, are indirect effects and do not enter into our estimates of the direct costs to the private sector of the insurance mandates.

7. Appropriations or other Federal financial assistance: None.

8. Previous CBO estimate: CBO has prepared cost estimates of various other health care reform bills—S. 1028 as reported by the Senate Committee on Labor and Human Resources on October 12, 1995, and H.R. 3070 as reported by the House Committee on Commerce on March 20, 1996. All three bills have similar pre-existing conditions and portability provisions affecting the group health insurance market, but they differ in other respects. For example, the Senate and Commerce Committee bills both include provisions for group-to-individual portability, HR 3103 does not have. In addition, S. 1028 includes provisions to guarantee the availability of insurance to employers, and H.R. 3070 has provisions to guarantee availability in the small group market only. The Ways and Means Committee bill, by contrast, has no provisions to guarantee availability. It is also the only one of the three bills to include provisions promoting the use of medical savings accounts and modifying the Internal Revenue Code in various other ways.

9. Estimate prepared by: James Baumgardner (non-tax items) and Rick Kasten (tax items).

10. Estimate approved by: Joseph Antos, Assistance Director for Health and Human Resources.

V. OTHER MATTERS TO BE DISCUSSED UNDER THE RULES OF THE HOUSE

A. Committee Oversight Findings and Recommendations

With respect to subdivision (A) of clause 2(l)(3) of rule XI of the Rules of the House of Representatives (relating to oversight findings), the Committee advises that it was a result of the Committee's oversight activities concerning improved availability and portability of health insurance coverage, prevention of health care fraud and abuse, health care administrative simplification, certain tax-related health provisions to improve health care accessibility and coverage, and certain revenue offsets needed to pay for the other provisions in the bill that the Committee concluded that it is appropriate to enact the provisions contained in the bill as amended.

B. Summary of Findings and Recommendations of the Committee on Government Reform Oversight

With respect to subdivision (D) of clause 2(l)(3) of rule XI of the Rules of the House of Representatives, the Committee advises that no oversight findings or recommendations have been submitted to this Committee by the Committee on Government Reform and Oversight with respect to the provisions of the bill.

C. Inflationary Impact Statement

In compliance with clause 2(l)(4) of rule XI of the Rules of the House of Representatives, the Committee states that the provisions of the bill are not expected to have an overall inflationary impact on prices and costs in the operation of the national economy.

D. Information Relating to Unfunded Mandates

This information is provided in accordance with section 423 of the Unfunded Mandates Reform Act of 1995 (Public Law 104–4).

Non-revenue provisions

The Committee has determined that the following provisions of the bill contain Federal mandates on the private sector: (1) limiting the length of time employer-sponsored and group insurance plans could withhold coverage for pre-existing conditions, and (2) requiring that periods of continuous prior health plan coverage be credited against pre-existing condition exclusions of a new plan, (3) imposing a mandate on all private sector insurers and those providers who submit claims electronically by requiring that certain specified health-related electronic transmittals conform to standards adopted by the Secretary of Health and Human Services (the bill states that any standards adopted must reduce the administrative costs of providing and paying for health care), and (4) requiring the establishment of a health care fraud and abuse data collection program, with a mandate on each Government agency and private health plan to report any final adverse action taken against a health care provider, supplier, or practitioner.

The direct cost of the administrative simplification and fraud and abuse provisions (items #3 and #4 above) are negligible. Benefits from the administrative simplification provisions include improved administration and reduced costs for the millions of health care claims and other related informational transactions in the health care system. Data reporting requirements for the health care fraud and abuse data collection program would be negligible and benefit the entire system by contributing to the identification of fraudulent behavior and enforcement actions taken to address such behavior.

The provisions limiting pre-existing condition exclusions and requiring crediting of prior qualified coverage (items #1 and #2 above) have important social benefits because they expand the availability of health insurance and increase the value of insurance coverage to beneficiaries. In addition, by improving portability of health insurance benefits from one group health plan to another, the bill's provisions promote mobility of workers by easing "job-lock", which in turn could create more efficient employment markets. Finally, since all group health plans would be required to comply with these standards, the bill's provisions help level the field because no employer or insurer gains a competitive advantage from a cost standpoint, attributable to restricting benefits through lengthy pre-existing condition exclusions.

Separately, the Committee has determined that the following provisions of the bill contain Federal mandates on the public sector. First, State and local agencies would be required to report criminal and civil actions and license revocations against health

care providers, practitioners, and suppliers. Second, State and local governments, as providers of health insurance or health care, would have to transmit health care transactions under new national standards. The national standards would also apply to State and local government agencies that provide health care, for example, through public hospitals or clinics, and that transmit any health information electronically. Third, the bill's provisions also would require State and local governments, as providers of health coverage to their employees, to comply with the pre-existing condition and portability requirements unless they specifically opt out in a form and manner determined by the Secretary of Health and Human Services.

The Committee has determined that the direct costs of all of these provisions are negligible. As in the private sector, the national standards would improve administration and reduce the costs of informational transactions in the public sector. Second, the reporting of criminal and civil actions, and license revocations against entities guilty of fraudulent actions has the broad social benefit of aiding in reducing fraud and abuse and the excessive costs such actions create in the health care sector. Although state and local governments could choose to opt out of the pre-existing condition and portability requirements, the application of those requirements would ensure that public sector workers enjoy the same protections and opportunities for career mobility as workers in the private sector.

The non-revenue provisions of the bill uniformly affect activities engaged in by both the private and public sectors. Therefore, they do not affect the competitive balance between state, local or tribal governments and the private sector.

Revenue provisions

The Committee has determined that three of the revenue provisions of the bill contain Federal mandates on the private sector: (1) the provision relating to treatment of bad debt deductions of thrift institutions (repeal of Internal Revenue Code section 593); (2) the earned income credit ("EIC") compliance provision; and (3) the provision relating to expatriation.[57] In general, the first provision repeals a special rule regarding the treatment of bad debt reserves by thrift institutions and conforms the treatment of such reserves to the manner in which such reserves are required to be treated by banks. The provision relating to EIC compliance denies the EIC to individuals not authorized to be employed in the United States. The provision relating to expatriation expands and substantially strengthens the present-law provisions that subject U.S. citizens who relinquish their citizenship for tax avoidance purposes to special tax rules. These provisions will increase the Federal tax liabilities of certain taxpayers.

The cost required to comply with each mandate generally is no greater than the revenue estimate for the provision. Benefits from the provisions include improved administration of the Federal income tax laws and greater availability of and more affordable

[57] The bill also amends the so-called COBRA tax sanctions. These provisions are integrally related to the effects of the health care provisions, and the discussion of the mandates in the health care provisions takes into account the additional COBRA tax sanctions.

health care insurance. The Committee believes that the benefits of the provisions are greater than the cost required to comply with the mandates.

The provision relating to bad debt reserves of thrift institutions corrects a present-law provision that results in a mismeasurement of economic income and provides thrift institutions with a tax benefit not provided to similarly situated depository institutions. It also facilitates national banking policy. The provision relating to the EIC will in effect reduce Federal tax expenditures by denying the credit to individuals who are not legally working in the United States. The expatriation provision helps to ensure that the Federal tax laws do not provide individuals with an incentive to expatriate.

These revenue-raising provisions offset the revenue loss of the tax provisions in the bill relating to health care, including provisions relating to long-term care, medical savings accounts, and an increase in the deduction for health insurance costs of self-employed individuals. These latter provisions will help make health care insurance more affordable, will encourage individuals to take control of their health care expenses and reward individuals for reducing health costs, and encourage individuals to provide for their long-term care needs. The revenue offsets are critical to achieving these goals.

The revenue provisions of the bill do not contain any intergovernmental mandates.

The revenue provisions of the bill affect activities that are only engaged in by the private sector and thus do not affect the competitive balance between State, local, or tribal governments and the private sector.

E. Applicability of Federal Advisory Committee Act

Pursuant to the Federal Advisory Committee Act (5 U.S.C., App., section 5(b)), the Committee states that any advisory bodies created by the bill, such as the Health Information Advisory Committee created by section 1179, are consciously created, and are deemed appropriate and necessary to carry out the purposes of the bill. It is the view of the Committee that the functions of any such advisory bodies are not being and could not be performed by one or more agencies or by an advisory committee already in existence, or by enlarging the mandate of an existing advisory committee under the Social Security Act.

VI. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, existing law in which no change is proposed is shown in roman):

INTERNAL REVENUE CODE OF 1986

* * * * * * *

Subtitle A—Income Taxes

CHAPTER 1—NORMAL TAXES AND SURTAXES

Subchapter A—Determination of Tax Liability

* * * * * * *

PART IV—CREDITS AGAINST TAXES

* * * * * * *

Subpart C—Refundable Credits

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SEC. 32. EARNED INCOME.

(a) * * *

* * * * * * *

(c) DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

(1) ELIGIBLE INDIVIDUAL.—

(A) * * *

* * * * * * *

(F) IDENTIFICATION NUMBER REQUIREMENT.—The term "eligible individual" does not include any individual who does not include on the return of tax for the taxable year—

(i) such individual's taxpayer identification number, and

(ii) if the individual is married (within the meaning of section 7703), the taxpayer identification number of such individual's spouse.

* * * * * * *

(l) IDENTIFICATION NUMBERS.—Solely for purposes of subsections (c)(1)(F) and (c)(3)(D), a taxpayer identification number means a social security number issued to an individual by the Social Security Administration (other than a social security number issued pursuant to clause (II) (or that portion of clause (III) that relates to clause (II)) of section 205(c)(2)(B)(i) of the Social Security Act).

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Subpart E—Rules for Computing Investment Credit

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SEC. 50. OTHER SPECIAL RULES.

(a) * * *

* * * * * * *

(d) CERTAIN RULES MADE APPLICABLE.—For purposes of this subpart, rules similar to the rules of the following provisions (as in effect of the day before the date of the enactment of the Revenue Reconciliation Act of 1990) shall apply:

(1) Section 46(e) (relating to limitations with respect to certain persons).

(2) Section 46(f) (relating to limitation in case of certain regulated companies).

(3) Section 46(h) (relating to special rules for cooperatives).

(4) Paragraphs (2) and (3) of section 48(b) (relating to special rule for sale-leasebacks).

(5) Section 48(d) (relating to certain leased property).

(6) Section 48(f) (relating to estates and trusts).

(7) Section 48(r) (relating to certain 501(d) organizations.

Paragraphs (1)(A), (2)(A), and (4) of the section 46(e) referred to in paragraph (1) of this subsection shall not apply to any taxable year beginning after December 31, 1995.

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Subpart F—Rules for Computing Targeted Jobs Credit

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SEC. 52. SPECIAL RULES.

(a) * * *

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(e) LIMITATIONS WITH RESPECT TO CERTAIN PERSONS.—Under regulations prescribed by the Secretary, in the case of—

[(1) an organization to which section 593 (relating to reserves for losses on loans) applies,

[(2)**]** *(1)* a regulated investment company or a real estate investment trust subject to taxation under subchapter M (section 851 and following), and

[(3)**]** *(2)* a cooperative organization described in section 1381(a),

rules similar to the rules provided in subsections (e) and (h) of section 46 (as in effect on the day before the date of the enactment of the Revenue Reconciliation Act of 1990) shall apply in determining the amount of the credit under this subpart.

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PART VI—ALTERNATIVE MINIMUM TAX

* * * * * * *

SEC. 57. ITEMS OF TAX PREFERENCE.

(a) GENERAL RULE.—For purposes of this part, the items of tax preference determined under this section are—

(1) * * *

* * * * * * *

[(4) RESERVES FOR LOSSES ON BAD DEBTS OF FINANCIAL INSTITUTIONS.—In the case of a financial institution to which section 593 applies, the amount by which the deduction allowable for the taxable year for a reasonable addition to a reserve for bad debts exceeds the amount that would have been allowable had the institution maintained its bad debt reserve for all taxable years on the basis of actual experience.**]**

* * * * * * *

Subchapter B—Computation of Taxable Income

PART I—DEFINITION OF GROSS INCOME, ADJUSTED GROSS INCOME, TAXABLE INCOME, ETC.

* * * * * * *

SEC. 62. ADJUSTED GROSS INCOME DEFINED.

(a) GENERAL RULE.—For purposes of this subtitle, the term "adjusted gross income" means, in the case of an individual, gross income minus the following deductions:

(1) * * *

* * * * * * *

(16) MEDICAL SAVINGS ACCOUNTS.—The deduction allowed by section 220.

* * * * * * *

PART III—ITEMS SPECIFICALLY EXCLUDED FROM GROSS INCOME

* * * * * * *

SEC. 101. CERTAIN DEATH BENEFITS.

(a) * * *

* * * * * * *

(g) TREATMENT OF CERTAIN ACCELERATED DEATH BENEFITS.—

(1) IN GENERAL.—For purposes of this section, the following amounts shall be treated as an amount paid by reason of the death of an insured:

(A) Any amount received under a life insurance contract on the life of an insured who is a terminally ill individual.

(B) Any amount received under a life insurance contract on the life of an insured who is a chronically ill individual (as defined in section 7702B(c)(2)) but only if such amount is received under a rider or other provision of such contract which is treated as a qualified long-term care insurance contract under section 7702B and such amount is treated under section 7702B (after the application of subsection (d) thereof) as a payment for qualified long-term care services (as defined in such section).

(2) TREATMENT OF VIATICAL SETTLEMENTS.—

(A) IN GENERAL.—In the case of a life insurance contract on the life of an insured described in paragraph (1), if—

(i) any portion of such contract is sold to any viatical settlement provider, or

(ii) any portion of the death benefit is assigned to such a provider,

the amount paid for such sale or assignment shall be treated as an amount paid under the life insurance contract by reason of the death of such insured.

(B) VIATICAL SETTLEMENT PROVIDER.—The term "viatical settlement provider" means any person regularly engaged in the trade or business of purchasing, or taking assignments of, life insurance contracts on the lives of insureds described in paragraph (1) if—

(i) such person is licensed for such purposes in the State in which the insured resides, or

(ii) in the case of an insured who resides in a State not requiring the licensing of such persons for such purposes—

(I) such person meets the requirements of sections 8 and 9 of the Viatical Settlements Model Act of the National Association of Insurance Commissioners, and

(II) meets the requirements of the Model Regulations of the National Association of Insurance Commissioners (relating to standards for evaluation of reasonable payments) in determining amounts paid by such person in connection with such purchases or assignments.

(3) DEFINITIONS.—For purposes of this subsection—

(A) TERMINALLY ILL INDIVIDUAL.—The term "terminally ill individual" means an individual who has been certified by a physician as having an illness or physical condition which can reasonably be expected to result in death in 24 months or less after the date of the certification.

(B) PHYSICIAN.—The term "physician" has the meaning given to such term by section 1861(r)(1) of the Social Security Act (42 U.S.C. 1395x(r)(1)).

(4) EXCEPTION FOR BUSINESS-RELATED POLICIES.—This subsection shall not apply in the case of any amount paid to any taxpayer other than the insured if such taxpayer has an insurable interest with respect to the life of the insured by reason of the insured being a director, officer, or employee of the taxpayer or by reason of the insured being financially interested in any trade or business carried on by the taxpayer.

* * * * * * *

SEC. 106. CONTRIBUTIONS BY EMPLOYER TO ACCIDENT AND HEALTH PLANS.

[Gross income of an employee does not include employer-provided coverage under an accident or health plan.**]**

(a) GENERAL RULE.—Except as otherwise provided in this section, gross income of an employee does not include employer-provided coverage under an accident or health plan.

(b) CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—In the case of an employee who is an eligible individual, gross income does not include amounts contributed by such employee's employer to any medical savings account of such employee.

(2) COORDINATION WITH DEDUCTION LIMITATION.—The amount excluded from the gross income of an employee under this subsection for any taxable year shall not exceed the limitation under section 220(b)(1) (determined without regard to this subsection) which is applicable to such employee for such taxable year.

(3) NO CONSTRUCTIVE RECEIPT.—No amount shall be included in the gross income of any employee solely because the employee may choose between the contributions referred to in

paragraph (1) and employer contributions to another health plan of the employer.

(4) SPECIAL RULE FOR DEDUCTION OF EMPLOYER CONTRIBUTIONS.—Any employer contribution to a medical savings account, if otherwise allowable as a deduction under this chapter, shall be allowed only for the taxable year in which paid.

(5) DEFINITIONS.—For purposes of this subsection, the terms "eligible individual" and "medical savings account" have the respective meanings given to such terms by section 220.

(c) INCLUSION OF LONG-TERM CARE BENEFITS PROVIDED THROUGH FLEXIBLE SPENDING ARRANGEMENTS.—

(1) IN GENERAL.—Effective on and after January 1, 1997, gross income of an employee shall include employer-provided coverage for qualified long-term care services (as defined in section 7702B(c)) to the extent that such coverage is provided through a flexible spending or similar arrangement.

(2) FLEXIBLE SPENDING ARRANGEMENT.—For purposes of this subsection, a flexible spending arrangement is a benefit program which provides employees with coverage under which—

(A) specified incurred expenses may be reimbursed (subject to reimbursement maximums and other reasonable conditions), and

(B) the maximum amount of reimbursement which is reasonably available to a participant for such coverage is less than 500 percent of the value of such coverage.

In the case of an insured plan, the maximum amount reasonably available shall be determined on the basis of the underlying coverage.

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SEC. 125. CAFETERIA PLANS.

(a) * * *

* * * * * * *

(f) QUALIFIED BENEFITS DEFINED.—For purposes of this section, the term "qualified benefit" means any benefit which, with the application of subsection (a), is not includible in the gross income of the employee by reason of an express provision of this chapter (other than section *106(b)*, 117, 127, or 132). Such term includes any group term life insurance which is includible in gross income only because it exceeds the dollar limitation of section 79 and such term includes any other benefit permitted under regulations. *Such term shall not include any long-term care insurance contract (as defined in section 4980C).*

* * * * * * *

PART VI—ITEMIZED DEDUCTIONS FOR INDIVIDUALS AND CORPORATIONS

* * * * * * *

SEC. 162. TRADE OR BUSINESS EXPENSES.

(a) * * *

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(l) SPECIAL RULES FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.—

[(1) IN GENERAL.—In the case of an individual who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an amount equal to 30 percent of the amount paid during the taxable year for insurance which constitutes medical care for the taxpayer, his spouse, and dependents.]

(1) ALLOWANCE OF DEDUCTION.—

(A) IN GENERAL.—In the case of an individual who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an amount equal to the applicable percentage of the amount paid during the taxable year for insurance which constitutes medical care for the taxpayer, his spouse, and dependents.

(B) APPLICABLE PERCENTAGE.—For purposes of subparagraph (A), the applicable percentage shall be determined under the following table:

For taxable years beginning in calendar year—	*The applicable percentage is—*
1998	*35 percent*
1999, 2000, or 2001	*40 percent*
2002	*45 percent*
2003 or thereafter	*50 percent.*

* * * * * * *

PART VII—ADDITIONAL ITEMIZED DEDUCTIONS FOR INDIVIDUALS

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SEC. 213. MEDICAL, DENTAL, ETC., EXPENSES.

(a) * * *

* * * * * * *

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

(1) The term "medical care" means amounts paid—

(A) for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body,

(B) for transportation primarily for and essential to medical care referred to in subparagraph (A), [or]

(C) for qualified long-term care services (as defined in section 7702B(c)), or

[(C)] *(D)* for insurance (including amounts paid as premiums under part B of title XVIII of the Social Security Act, relating to supplementary medical insurance for the aged) covering medical care referred to in subparagraphs

(A) and (B) *or for any qualified long-term care insurance contract (as defined in section 7702B(b)).*

In the case of a qualified long-term care insurance contract (as defined in section 7702B(b)), only eligible long-term care premiums (as defined in paragraph (10)) shall be taken into account under subparagraph (D).

* * * * * * *

(6) In the case of an insurance contract under which amounts are payable for other than medical care referred to in [subparagraphs (A) and (B)] *subparagraphs (A), (B), and (C)* of paragraph (1)—

(A) no amount shall be treated as paid for insurance to which [paragraph (1)(C)] *paragraph (1)(D)* applies unless the charge for such insurance is either separately stated in the contract, or furnished to the policyholder by the insurance company in a separate statement,

* * * * * * *

(7) Subject to the limitations of paragraph (6), premiums paid during the taxable year by a taxpayer before he attains the age of 65 for insurance covering medical care (within the meaning of [subparagraphs (A) and (B)] *subparagraphs (A), (B), and (C)* of paragraph (1)) for the taxpayer, his spouse, or a dependent after the taxpayer attains the age of 65 shall be treated as expenses paid during the taxable year for insurance which constitutes medical care if premiums for such insurance are payable (on a level payment basis) under the contract for a period of 10 years or more or until the year in which the taxpayer attains the age of 65 (but in no case for a period of less than 5 years).

* * * * * * *

(10) ELIGIBLE LONG-TERM CARE PREMIUMS.—

(A) IN GENERAL.—For purposes of this section, the term "eligible long-term care premiums" means the amount paid during a taxable year for any qualified long-term care insurance contract (as defined in section 7702B(b)) covering an individual, to the extent such amount does not exceed the limitation determined under the following table:

In the case of an individual with an attained age before the close of the taxable year of:	***The limitation is:***
40 or less	*$ 200*
More than 40 but not more than 50	*375*
More than 50 but not more than 60	*750*
More than 60 but not more than 70	*2,000*
More than 70	*2,500.*

(B) INDEXING.—

(i) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1997, each dollar amount contained in subparagraph (A) shall be increased by the medical care cost adjustment of such amount for such calendar year. If any increase determined under the preceding sentence is not a multiple

of $10, such increase shall be rounded to the nearest multiple of $10.

(ii) MEDICAL CARE COST ADJUSTMENT.—For purposes of clause (i), the medical care cost adjustment for any calendar year is the percentage (if any) by which—

(I) the medical care component of the Consumer Price Index (as defined in section 1(f)(5)) for August of the preceding calendar year, exceeds

(II) such component for August of 1996.

The Secretary shall, in consultation with the Secretary of Health and Human Services, prescribe an adjustment which the Secretary determines is more appropriate for purposes of this paragraph than the adjustment described in the preceding sentence, and the adjustment so prescribed shall apply in lieu of the adjustment described in the preceding sentence.

(11) CERTAIN PAYMENTS TO RELATIVES TREATED AS NOT PAID FOR MEDICAL CARE.—An amount paid for a qualified long-term care service (as defined in section 7702B(c)) provided to an individual shall be treated as not paid for medical care if such service is provided—

(A) by the spouse of the individual or by a relative (directly or through a partnership, corporation, or other entity) unless the service is provided by a licensed professional with respect to such service, or

(B) by a corporation or partnership which is related (within the meaning of section 267(b) or 707(b)) to the individual.

For purposes of this paragraph, the term "relative" means an individual bearing a relationship to the individual which is described in any of paragraphs (1) through (8) of section 152(a). This paragraph shall not apply for purposes of section 105(b) with respect to reimbursements through insurance.

* * * * * * *

SEC. 220. MEDICAL SAVINGS ACCOUNTS.

(a) DEDUCTION ALLOWED.—In the case of an individual who is an eligible individual for any month during the taxable year, there shall be allowed as a deduction for the taxable year an amount equal to the aggregate amount paid in cash during such taxable year by such individual to a medical savings account of such individual.

(b) LIMITATIONS.—

(1) IN GENERAL.—Except as otherwise provided in this subsection, the amount allowable as a deduction under subsection (a) to an individual for the taxable year shall not exceed—

(A) except as provided in subparagraph (B), the lesser of—

(i) $2,000, or

(ii) the annual deductible limit for any individual covered under the high deductible health plan, or

(B) in the case of a high deductible health plan covering the taxpayer and any other eligible individual who is the

spouse or any dependent (as defined in section 152) of the taxpayer, the lesser of—

(i) $4,000, or

(ii) the annual limit under the plan on the aggregate amount of deductibles required to be paid by all individuals.

The preceding sentence shall not apply if the spouse of such individual is covered under any other high deductible health plan.

(2) SPECIAL RULE FOR MARRIED INDIVIDUALS.—

(A) IN GENERAL.—This subsection shall be applied separately for each married individual.

(B) SPECIAL RULE.—If individuals who are married to each other are covered under the same high deductible health plan, then the amounts applicable under paragraph (1)(B) shall be divided equally between them unless they agree on a different division.

(3) COORDINATION WITH EXCLUSION FOR EMPLOYER CONTRIBUTIONS.—No deduction shall be allowed under this section for any amount paid for any taxable year to a medical savings account of an individual if—

(A) any amount is paid to any medical savings account of such individual which is excludable from gross income under section 106(b) for such year, or

(B) in a case described in paragraph (2), any amount is paid to any medical savings account of either spouse which is so excludable for such year.

(4) PRORATION OF LIMITATION.—

(A) IN GENERAL.—The limitation under paragraph (1) shall be the sum of the monthly limitations for months during the taxable year that the individual is an eligible individual if—

(i) such individual is not an eligible individual for all months of the taxable year,

(ii) the deductible under the high deductible health plan covering such individual is not the same throughout such taxable year, or

(iii) such limitation is determined under paragraph (1)(B) for some but not all months during such taxable year.

(B) MONTHLY LIMITATION.—The monthly limitation for any month shall be an amount equal to 1/12 of the limitation which would (but for this paragraph and paragraph (3)) be determined under paragraph (1) if the facts and circumstances as of the first day of such month that such individual is covered under a high deductible health plan were true for the entire taxable year.

(5) DENIAL OF DEDUCTION TO DEPENDENTS.—No deduction shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

(c) DEFINITIONS.—For purposes of this section—

(1) ELIGIBLE INDIVIDUAL.—

(A) IN GENERAL.—The term "eligible individual" means, with respect to any month, any individual—

(i) who is covered under a high deductible health plan as of the 1st day of such month, and

(ii) who is not, while covered under a high deductible health plan, covered under any health plan—

(I) which is not a high deductible health plan, and

(II) which provides coverage for any benefit which is covered under the high deductible health plan.

(B) CERTAIN COVERAGE DISREGARDED.—Subparagraph (A)(ii) shall be applied without regard to—

(i) coverage for any benefit provided by permitted insurance, and

(ii) coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

(2) HIGH DEDUCTIBLE HEALTH PLAN.—The term "high deductible health plan" means a health plan which—

(A) has an annual deductible limit for each individual covered by the plan which is not less than $1,500, and

(B) has an annual limit on the aggregate amount of deductibles required to be paid with respect to all individuals covered by the plan which is not less than $3,000.

Such term does not include a health plan if substantially all of its coverage is coverage described in paragraph (1)(B). A plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for preventive care if the absence of a deductible for such care is required by State law.

(3) PERMITTED INSURANCE.—The term "permitted insurance" means—

(A) Medicare supplemental insurance,

(B) insurance if substantially all of the coverage provided under such insurance relates to—

(i) liabilities incurred under workers' compensation laws,

(ii) tort liabilities,

(iii) liabilities relating to ownership or use of property, or

(iv) such other similar liabilities as the Secretary may specify by regulations,

(C) insurance for a specified disease or illness, and

(D) insurance paying a fixed amount per day (or other period) of hospitalization.

(d) MEDICAL SAVINGS ACCOUNT.—For purposes of this section—

(1) MEDICAL SAVINGS ACCOUNT.—The term "medical savings account" means a trust created or organized in the United States exclusively for the purpose of paying the qualified medical expenses of the account holder, but only if the written governing instrument creating the trust meets the following requirements:

(A) Except in the case of a rollover contribution described in subsection (f)(5), no contribution will be accepted—

(i) unless it is in cash, or

(ii) to the extent such contribution, when added to previous contributions to the trust for the calendar year, exceeds $4,000.

(B) The trustee is a bank (as defined in section 408(n)), an insurance company (as defined in section 816), or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with the requirements of this section.

(C) No part of the trust assets will be invested in life insurance contracts.

(D) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

(E) The interest of an individual in the balance in his account is nonforfeitable.

(2) QUALIFIED MEDICAL EXPENSES.—

(A) IN GENERAL.—The term "qualified medical expenses" means, with respect to an account holder, amounts paid by such holder for medical care (as defined in section 213(d)) for such individual, the spouse of such individual, and any dependent (as defined in section 152) of such individual, but only to the extent such amounts are not compensated for by insurance or otherwise.

(B) HEALTH INSURANCE MAY NOT BE PURCHASED FROM ACCOUNT.—

(i) IN GENERAL.—Subparagraph (A) shall not apply to any payment for insurance.

(ii) EXCEPTIONS.—Clause (i) shall not apply to any expense for coverage under—

(I) a health plan during any period of continuation coverage required under any Federal law,

(II) a qualified long-term care insurance contract (as defined in section 7702B(b)), or

(III) a health plan during a period in which the individual is receiving unemployment compensation under any Federal or State law.

(3) ACCOUNT HOLDER.—The term "account holder" means the individual on whose behalf the medical savings account was established.

(4) CERTAIN RULES TO APPLY.—Rules similar to the following rules shall apply for purposes of this section:

(A) Section 219(d)(2) (relating to no deduction for rollovers).

(B) Section 219(f)(3) (relating to time when contributions deemed made).

(C) Except as provided in section 106(b), section 219(f)(5) (relating to employer payments).

(D) Section 408(g) (relating to community property laws).

(E) Section 408(h) (relating to custodial accounts).

(e) TAX TREATMENT OF ACCOUNTS.—

(1) IN GENERAL.—A medical savings account is exempt from taxation under this subtitle unless such account has ceased to

be a medical savings account by reason of paragraph (2) or (3). Notwithstanding the preceding sentence, any such account is subject to the taxes imposed by section 511 (relating to imposition of tax on unrelated business income of charitable, etc. organizations).

(2) ACCOUNT TERMINATIONS.—Rules similar to the rules of paragraphs (2) and (4) of section 408(e) shall apply to medical savings accounts, and any amount treated as distributed under such rules shall be treated as not used to pay qualified medical expenses.

(f) TAX TREATMENT OF DISTRIBUTIONS.—

(1) AMOUNTS USED FOR QUALIFIED MEDICAL EXPENSES.—

(A) IN GENERAL.—Any amount paid or distributed out of a medical savings account which is used exclusively to pay qualified medical expenses of any account holder (or any spouse or dependent of the holder) shall not be includible in gross income.

(B) TREATMENT AFTER DEATH OF ACCOUNT HOLDER.—

(i) TREATMENT IF HOLDER IS SPOUSE.—If, after the death of the account holder, the account holder's interest is payable to (or for the benefit of) the holder's spouse, the medical savings account shall be treated as if the spouse were the account holder.

(ii) TREATMENT IF DESIGNATED HOLDER IS NOT SPOUSE.—In the case of an account holder's interest in a medical savings account which is payable to (or for the benefit of) any person other than such holder's spouse upon the death of such holder—

(I) such account shall cease to be a medical savings account as of the date of death, and

(II) an amount equal to the fair market value of the assets in such account on such date shall be includible if such person is not the estate of such holder, in such person's gross income for the taxable year which includes such date, or if such person is the estate of such holder, in such holder's gross income for the last taxable year of such holder.

(2) INCLUSION OF AMOUNTS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

(A) IN GENERAL.—Any amount paid or distributed out of a medical savings account which is not used exclusively to pay the qualified medical expenses of the account holder or of the spouse or dependents of such holder shall be included in the gross income of such holder.

(B) SPECIAL RULES.—For purposes of subparagraph (A)—

(i) all medical savings accounts of the account holder shall be treated as 1 account,

(ii) all payments and distributions during any taxable year shall be treated as 1 distribution, and

(iii) any distribution of property shall be taken into account at its fair market value on the date of the distribution.

(3) EXCESS CONTRIBUTIONS RETURNED BEFORE DUE DATE OF RETURN.—If the aggregate contributions (other than rollover contributions) for a taxable year to the medical savings accounts of an individual exceed the amount allowable as a deduction under this section for such contributions, paragraph (2) shall not apply to distributions from such accounts (in an amount not greater than such excess) if—

(A) such distribution is received by the individual on or before the last day prescribed by law (including extensions of time) for filing such individual's return for such taxable year, and

(B) such distribution is accompanied by the amount of net income attributable to such excess contribution.

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

(4) PENALTY FOR DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

(A) IN GENERAL.—The tax imposed by this chapter on the account holder for any taxable year in which there is a payment or distribution from a medical savings account of such holder which is includible in gross income under paragraph (2) shall be increased by 10 percent of the amount which is so includible.

(B) EXCEPTION FOR DISABILITY OR DEATH.—Subparagraph (A) shall not apply if the payment or distribution is made after the account holder becomes disabled within the meaning of section 72(m)(7) or dies.

(C) EXCEPTION FOR DISTRIBUTIONS AFTER AGE 59½.—Subparagraph (A) shall not apply to any payment or distribution after the date on which the account holder attains age 59½.

(5) ROLLOVER CONTRIBUTION.—An amount is described in this paragraph as a rollover contribution if it meets the requirements of subparagraphs (A) and (B).

(A) IN GENERAL.—Paragraph (2) shall not apply to any amount paid or distributed from a medical savings account to the account holder to the extent the amount received is paid into a medical savings account for the benefit of such holder not later than the 60th day after the day on which the holder receives the payment or distribution.

(B) LIMITATION.—This paragraph shall not apply to any amount described in subparagraph (A) received by an individual from a medical savings account if, at any time during the 1-year period ending on the day of such receipt, such individual received any other amount described in subparagraph (A) from a medical savings account which was not includible in the individual's gross income because of the application of this paragraph.

(6) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—For purposes of determining the amount of the deduction under section 213, any payment or distribution out of a medical savings account for qualified medical expenses shall not be treated as an expense paid for medical care.

(7) TRANSFER OF ACCOUNT INCIDENT TO DIVORCE.—The transfer of an individual's interest in a medical savings account to an individual's spouse or former spouse under a divorce or separation instrument described in subparagraph (A) of section 71(b)(2) shall not be considered a taxable transfer made by such individual notwithstanding any other provision of this subtitle, and such interest shall, after such transfer, be treated as a medical savings account with respect to which the spouse is the account holder.

(g) COST-OF-LIVING ADJUSTMENT.—

(1) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1997, each dollar amount in subsection (b)(1), (c)(2), or (d)(1)(A) shall be increased by an amount equal to—

(A) such dollar amount, multiplied by

(B) the medical care cost adjustment for such calendar year.

If any increase under the preceding sentence is not a multiple of $50, such increase shall be rounded to the nearest multiple of $50.

(2) MEDICAL CARE COST ADJUSTMENT.—For purposes of paragraph (1), the medical care cost adjustment for any calendar year is the percentage (if any) by which—

(A) the medical care component of the Consumer Price Index (as defined in section 1(f)(5)) for August of the preceding calendar year, exceeds

(B) such component for August of 1996.

(h) REPORTS.—The Secretary may require the trustee of a medical savings account to make such reports regarding such account to the Secretary and to the account holder with respect to contributions, distributions, and such other matters as the Secretary determines appropriate. The reports required by this subsection shall be filed at such time and in such manner and furnished to such individuals at such time and in such manner as may be required by those regulations.

SEC. [220.] *221.* CROSS REFERENCE.

For deductions in respect of a decedent, see section 691.

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PART VIII—SPECIAL DEDUCTIONS FOR CORPORATIONS

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SEC. 246. RULES APPLYING TO DEDUCTIONS FOR DIVIDENDS RECEIVED.

(a) * * *

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[(f) CROSS REFERENCE.—

[For special rule relating to mutual savings banks, etc., to which section 593 applies, see section 596.]

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PART XI—SPECIAL RULES RELATING TO CORPORATE PREFERENCE ITEMS

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SEC. 291. SPECIAL RULES RELATING TO CORPORATE PREFERENCE ITEMS.

(a) * * *

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

(1) FINANCIAL INSTITUTION PREFERENCE ITEM.—The term ''financial institution preference item'' includes the following:

(A) * * *

(B) INTEREST ON DEBT TO CARRY TAX-EXEMPT OBLIGATIONS ACQUIRED AFTER DECEMBER 31, 1982, AND BEFORE AUGUST 8, 1986.—

(i) IN GENERAL.—In the case of a financial institution which is a bank (as defined in section 585(a)(2)) [or to which section 593 applies], the amount of interest on indebtedness incurred or continued to purchase or carry obligations acquired after December 31, 1982, and before August 8, 1986, the interest on which is exempt from taxes for the taxable year, to the extent that a deduction would (but for this paragraph or section 265(b)) be allowable with respect to such interest for such taxable year.

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Subchapter F—Exempt Organizations

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PART I—GENERAL RULE

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SEC. 501. EXEMPTION FROM TAX ON CORPORATIONS, CERTAIN TRUSTS, ETC.

(a) * * *

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(c) LIST OF EXEMPT ORGANIZATIONS.—The following organizations are referred to in subsection (a):

(1) * * *

* * * * * * *

(26) Any membership organization if—

(A) such organization is established by a State exclusively to provide coverage for medical care (as defined in section 213(d)) on a not-for-profit basis to individuals described in subparagraph (B) through—

(i) insurance issued by the organization, or

(ii) a health maintenance organization under an arrangement with the organization,

(B) the only individuals receiving such coverage through the organization are individuals—

(i) who are residents of such State, and

(ii) who, by reason of the existence or history of a medical condition, are unable to acquire medical care coverage for such condition through insurance or from a health maintenance organization or are able to ac-

quire such coverage only at a rate which is substantially in excess of the rate for such coverage through the membership organization,

(C) the composition of the membership in such organization is specified by such State, and

(D) no part of the net earnings of the organization inures to the benefit of any private shareholder or individual.

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Subchapter H—Banking Institutions

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PART I—DEDUCTIONS

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SEC. 585. RESERVES FOR LOSSES ON LOANS OF BANKS.

(a) RESERVE FOR BAD DEBTS.—

(1) * * *

(2) BANK.—For purposes of this section—

(A) IN GENERAL.—The term "bank" means any bank (as defined in section 581) **[**other than an organization to which section 593 applies**]**.

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PART II—MUTUAL SAVINGS BANKS, ETC.

Sec. 591. Deduction for dividends paid on deposits.

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[Sec. 595. Foreclosure on property securing loans.**]**
[Sec. 596. Limitation on dividends received deduction.**]**

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SEC. 593. RESERVES FOR LOSSES ON LOANS.

(a) * * *

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(e) DISTRIBUTIONS TO SHAREHOLDERS.—

(1) IN GENERAL.—For purposes of this chapter, any distribution of property (as defined in section 317(a)) **[**by a domestic building and loan association or an institution that is treated as a mutual savings bank under section 591(b)**]** *by a taxpayer having a balance described in subsection (g)(2)(A)(ii)* to a shareholder with respect to its stock, if such distribution is not allowable as a deduction under section 591, shall be treated as made—

(A) first out of its earnings and profits accumulated in taxable years beginning after December 31, 1951, to the extent thereof,

[(B) then out of the reserve for losses on qualifying real property loans, to the extent additions to such reserve exceed the additions which would have been allowed under subsection (b)(3),**]**

(B) then out of the balance taken into account under subsection (g)(2)(A)(ii) (properly adjusted for amounts charged

against such reserves for taxable years beginning after December 31, 1987),

* * * * * * *

This paragraph shall apply in the case of any distribution in redemption of stock or in partial or complete liquidation of the association, or an institution that is treated as a mutual savings bank under section 591(b), except that any such distribution shall be treated as made first out of the amount referred to in subparagraph (B), second out of the amount referred to in subparagraph (C), third out of the amount referred to in subparagraph (A), and then out of such other accounts as may be proper. This paragraph shall not apply to any transaction to which section 381 applies, or to any distribution to the Federal Savings and Loan Insurance Corporation (or any successor thereof) or the Federal Deposit Insurance Corporation in redemption of an interest in an association, if such interest was originally received by any such entity in exchange for assistance provided under a provision of law referred to in section 597(c). *This paragraph shall not apply to any distribution of all of the stock of a bank (as defined in section 581) to another corporation if, immediately after the distribution, such bank and such other corporation are members of the same affiliated group (as defined in section 1504) and the provisions of section 5(e) of the Federal Deposit Insurance Act (as in effect on December 31, 1995) or similar provisions are in effect.*

* * * * * * *

(f) TERMINATION OF RESERVE METHOD.—Subsections (a), (b), (c), and (d) shall not apply to any taxable year beginning after December 31, 1995.

(g) 6-YEAR SPREAD OF ADJUSTMENTS.—

(1) IN GENERAL.—In the case of any taxpayer who is required by reason of subsection (f) to change its method of computing reserves for bad debts—

(A) such change shall be treated as a change in a method of accounting,

(B) such change shall be treated as initiated by the taxpayer and as having been made with the consent of the Secretary, and

(C) the net amount of the adjustments required to be taken into account by the taxpayer under section 481(a)—

(i) shall be determined by taking into account only applicable excess reserves, and

(ii) as so determined, shall be taken into account ratably over the 6-taxable year period beginning with the first taxable year beginning after December 31, 1995.

(2) APPLICABLE EXCESS RESERVES.—

(A) IN GENERAL.—For purposes of paragraph (1), the term ''applicable excess reserves'' means the excess (if any) of—

(i) the balance of the reserves described in subsection (c)(1) (other than the supplemental reserve) as of the close of the taxpayer's last taxable year beginning before December 31, 1995, over

(ii) the lesser of—

(I) the balance of such reserves as of the close of the taxpayer's last taxable year beginning before January 1, 1988, or

(II) the balance of the reserves described in subclause (I), reduced in the same manner as under section 585(b)(2)(B)(ii) on the basis of the taxable years described in clause (i) and this clause.

(B) SPECIAL RULE FOR THRIFTS WHICH BECOME SMALL BANKS.—In the case of a bank (as defined in section 581) which was not a large bank (as defined in section 585(c)(2)) for its first taxable year beginning after December 31, 1995—

(i) the balance taken into account under subparagraph (A)(ii) shall not be less than the amount which would be the balance of such reserves as of the close of its last taxable year beginning before such date if the additions to such reserves for all taxable years had been determined under section 585(b)(2)(A), and

(ii) the opening balance of the reserve for bad debts as of the beginning of such first taxable year shall be the balance taken into account under subparagraph (A)(ii) (determined after the application of clause (i) of this subparagraph).

The preceding sentence shall not apply for purposes of paragraphs (5) and (6) or subsection (e)(1).

(3) RECAPTURE OF PRE-1988 RESERVES WHERE TAXPAYER CEASES TO BE BANK.—If, during any taxable year beginning after December 31, 1995, a taxpayer to which paragraph (1) applied is not a bank (as defined in section 581), paragraph (1) shall apply to the reserves described in paragraph (2)(A)(ii) and the supplemental reserve; except that such reserves shall be taken into account ratably over the 6-taxable year period beginning with such taxable year.

(4) SUSPENSION OF RECAPTURE IF RESIDENTIAL LOAN REQUIREMENT MET.—

(A) IN GENERAL.—In the case of a bank which meets the residential loan requirement of subparagraph (B) for the first taxable year beginning after December 31, 1995, or for the following taxable year—

(i) no adjustment shall be taken into account under paragraph (1) for such taxable year, and

(ii) such taxable year shall be disregarded in determining—

(I) whether any other taxable year is a taxable year for which an adjustment is required to be taken into account under paragraph (1), and

(II) the amount of such adjustment.

(B) RESIDENTIAL LOAN REQUIREMENT.—A taxpayer meets the residential loan requirement of this subparagraph for any taxable year if the principal amount of the residential loans made by the taxpayer during such year is not less than the base amount for such year.

(C) RESIDENTIAL LOAN.—For purposes of this paragraph, the term "residential loan" means any loan described in clause (v) of section 7701(a)(19)(C) but only if such loan is incurred in acquiring, constructing, or improving the property described in such clause.

(D) BASE AMOUNT.—For purposes of subparagraph (B), the base amount is the average of the principal amounts of the residential loans made by the taxpayer during the 6 most recent taxable years beginning on or before December 31, 1995. At the election of the taxpayer who made such loans during each of such 6 taxable years, the preceding sentence shall be applied without regard to the taxable year in which such principal amount was the highest and the taxable year in such principal amount was the lowest. Such an election may be made only for the first taxable year beginning after such date, and, if made for such taxable year, shall apply to the succeeding taxable year unless revoked with the consent of the Secretary.

(E) CONTROLLED GROUPS.—In the case of a taxpayer which is a member of any controlled group of corporations described in section 1563(a)(1), subparagraph (B) shall be applied with respect to such group.

(5) CONTINUED APPLICATION OF FRESH START UNDER SECTION 585 TRANSITIONAL RULES.—In the case of a taxpayer to which paragraph (1) applied and which was not a large bank (as defined in section 585(c)(2)) for its first taxable year beginning after December 31, 1995:

(A) IN GENERAL.—For purposes of determining the net amount of adjustments referred to in section 585(c)(3)(A)(iii), there shall be taken into account only the excess (if any) of the reserve for bad debts as of the close of the last taxable year before the disqualification year over the balance taken into account by such taxpayer under paragraph (2)(A)(ii) of this subsection.

(B) TREATMENT UNDER ELECTIVE CUT-OFF METHOD.—For purposes of applying section 585(c)(4)—

(i) the balance of the reserve taken into account under subparagraph (B) thereof shall be reduced by the balance taken into account by such taxpayer under paragraph (2)(A)(ii) of this subsection, and

(ii) no amount shall be includible in gross income by reason of such reduction.

(6) SUSPENDED RESERVE INCLUDED AS SECTION 381(c) ITEMS.—The balance taken into account by a taxpayer under paragraph (2)(A)(ii) of this subsection and the supplemental reserve shall be treated as items described in section 381(c).

(7) CONVERSIONS TO CREDIT UNIONS.—In the case of a taxpayer to which paragraph (1) applied which becomes a credit union described in section 501(c) and exempt from taxation under section 501(a)—

(A) any amount required to be included in the gross income of the credit union by reason of this subsection shall be treated as derived from an unrelated trade or business (as defined in section 513), and

(B) for purposes of paragraph (3), the credit union shall not be treated as if it were a bank.

(8) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out this subsection and subsection (e), including regulations providing for the application of such subsections in the case of acquisitions, mergers, spinoffs, and other reorganizations.

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[SEC. 595. FORECLOSURE ON PROPERTY SECURING LOANS.

[(a) NONRECOGNITION OF GAIN OR LOSS AS A RESULT OF FORECLOSURE.—In the case of a creditor which is an organization described in section 593(a), no gain or loss shall be recognized, and no debt shall be considered as becoming worthless or partially worthless, as the result of such organization having bid in at foreclosure, or having otherwise reduced to ownership or possession by agreement or process of law, any property which was security for the payment of any indebtedness.

[(b) CHARACTER OF PROPERTY.—For purposes of sections 166 and 1221, any property acquired in a transaction with respect to which gain or loss to an organization was not recognized by reason of subsection (a) shall be considered as property having the same characteristics as the indebtedness for which such property was security. Any amount realized by such organization with respect to such property shall be treated for purposes of this chapter as a payment on account of such indebtedness, and any loss with respect thereto shall be treated as a bad debt to which the provisions of section 166 (relating to allowance of a deduction for bad debts) apply.

[(c) BASIS.—The basis of any property to which subsection (a) applies shall be the basis of the indebtedness for which such property was security (determined as of the date of the acquisition of such property), properly increased for costs of acquisition.

[(d) REGULATORY AUTHORITY.—The Secretary shall prescribe such regulations as he may deem necessary to carry out the purposes of this section.

[SEC. 596. LIMITATION ON DIVIDENDS RECEIVED DEDUCTION.

[In the case of an organization to which section 593 applies and which computes additions to the reserve for losses on loans for the taxable year under section 593(b)(2), the total amount allowed under sections 243, 244, and 245 (determined without regard to this section) for the taxable year as a deduction with respect to dividends received shall be reduced by an amount equal to 8 percent of such total amount.]

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Subchapter L—Insurance Companies

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PART I—LIFE INSURANCE COMPANIES

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Subpart E—Definitions and Special Rules

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SEC. 818. OTHER DEFINITIONS AND SPECIAL RULES.

(a) * * *

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(g) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—For purposes of this part—

(1) IN GENERAL.—Any reference to a life insurance contract shall be treated as including a reference to a qualified accelerated death benefit rider on such contract.

(2) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.—For purposes of this subsection, the term "qualified accelerated death benefit rider" means any rider on a life insurance contract if the only payments under the rider are payments meeting the requirements of section 101(g).

(3) EXCEPTION FOR LONG-TERM CARE RIDERS.—Paragraph (1) shall not apply to any rider which is treated as a long-term care insurance contract under section 7702B.

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PART II—OTHER INSURANCE COMPANIES

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SEC. 833. TREATMENT OF BLUE CROSS AND BLUE SHIELD ORGANIZATIONS, ETC.

(a) * * *

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(c) ORGANIZATIONS TO WHICH SECTION APPLIES.—

(1) * * *

* * * * * * *

(4) TREATMENT AS EXISTING BLUE CROSS OR BLUE SHIELD ORGANIZATION.—

(A) IN GENERAL.—Paragraph (2) shall be applied to an organization described in subparagraph (B) as if it were a Blue Cross or Blue Shield organization.

(B) APPLICABLE ORGANIZATION.—An organization is described in this subparagraph if it—

(i) is organized under, and governed by, State laws which are specifically and exclusively applicable to not-for-profit health insurance or health service type organizations, and

(ii) is not a Blue Cross or Blue Shield organization or health maintenance organization.

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PART III—PROVISIONS OF GENERAL APPLICATION

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SEC. 848. CAPITALIZATION OF CERTAIN POLICY ACQUISITION EXPENSES.

(a) * * *

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(e) CLASSIFICATION OF CONTRACTS.—FOR PURPOSES OF THIS SECTION—

(1) SPECIFIED INSURANCE CONTRACT.—

(A) * * *

(B) EXCEPTIONS.—The term ''specified insurance contract'' shall not include—

(i) any pension plan contract (as defined in section 818(a)),

(ii) any flight insurance or similar contract, [and]

(iii) any qualified foreign contract (as defined in section 807(e)(4) without regard to paragraph (5) of this subsection)[.], *and*

(iv) any contract which is a medical savings account (as defined in section 220(d)).

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Subchapter M—Regulated Investment Companies and Real Estate Investment Trusts

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PART IV—REAL ESTATE MORTGAGE INVESTMENT CONDUITS

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SEC. 860E. TREATMENT OF INCOME IN EXCESS OF DAILY ACCRUALS ON RESIDUAL INTERESTS.

(a) EXCESS INCLUSIONS MAY NOT BE OFFSET BY NET OPERATING LOSSES.—

(1) IN GENERAL.—[Except as provided in paragraph (2), the] *The* taxable income of any holder of a residual interest in a REMIC for any taxable year shall in no event be less than the excess inclusion for such taxable year.

[(2) EXCEPTION FOR CERTAIN FINANCIAL INSTITUTIONS.—Paragraph (1) shall not apply to any organization to which section 593 applies. The Secretary may by regulations provide that the preceding sentence shall not apply where necessary or appropriate to prevent avoidance of tax imposed by this chapter.

[(3)] *(2)* SPECIAL RULE FOR AFFILIATED GROUPS.—All members of an affiliated group filing a consolidated return shall be treated as 1 taxpayer for purposes of this subsection[, except that paragraph (2) shall be applied separately with respect to each corporation which is a member of such group and to which section 593 applies].

[(4) TREATMENT OF CERTAIN SUBSIDIARIES.—

[(A) IN GENERAL.—For purposes of this subsection, a corporation to which section 593 applies and each qualified subsidiary of such corporation shall be treated as a single corporation to which section 593 applies.

[(B) QUALIFIED SUBSIDIARY.—For purposes of this subsection, the term "qualified subsidiary" means any corporation—

[(i) all the stock of which, and substantially all the indebtedness of which, is held directly by the corporation to which section 593 applies, and

[(ii) which is organized and operated exclusively in connection with the organization and operation of 1 or more REMIC's.

[(5)] *(3)* COORDINATION WITH SECTION 172.—Any excess inclusion for any taxable year shall not be taken into account—

(A) in determining under section 172 the amount of any net operating loss for such taxable year, and

(B) in determining taxable income for such taxable year for purposes of the 2nd sentence of section 172(b)(2).

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Subchapter N—Tax Based on Income From Sources Within or Without the United States

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PART II—NONRESIDENT ALIENS AND FOREIGN CORPORATIONS

Subpart A—Nonresident Alien Individuals

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SEC. 877. EXPATRIATION TO AVOID TAX.

[(a) IN GENERAL.—Every nonresident alien individual who at any time after March 8, 1965, and within the 10-year period immediately preceding the close of the taxable year lost United States citizenship, unless such loss did not have for one of its principal purposes the avoidance of taxes under this subtitle or subtitle B, shall be taxable for such taxable year in the manner provided in subsection (b) if the tax imposed pursuant to such subsection exceeds the tax which, without regard to this section, is imposed pursuant to section 871.]

(a) TREATMENT OF EXPATRIATES.—

(1) IN GENERAL.—Every nonresident alien individual who, within the 10-year period immediately preceding the close of the taxable year, lost United States citizenship, unless such loss did not have for 1 of its principal purposes the avoidance of taxes under this subtitle or subtitle B, shall be taxable for such taxable year in the manner provided in subsection (b) if the tax imposed pursuant to such subsection (after any reduction in such tax under the last sentence of such subsection) exceeds the tax which, without regard to this section, is imposed pursuant to section 871.

(2) CERTAIN INDIVIDUALS TREATED AS HAVING TAX AVOIDANCE PURPOSE.—For purposes of paragraph (1), an individual shall be treated as having a principal purpose to avoid such taxes if—

(A) the average annual net income tax (as defined in section 38(c)(1)) of such individual for the period of 5 taxable years ending before the date of the loss of United States citizenship is greater than $100,000, or

(B) the net worth of the individual as of such date is $500,000 or more.

In the case of the loss of United States citizenship in any calendar year after 1996, such $100,000 and $500,000 amounts shall be increased by an amount equal to such dollar amount multiplied by the cost-of-living adjustment determined under section 1(f)(3) for such calendar year by substituting "1994" for "1992" in subparagraph (B) thereof. Any increase under the preceding sentence shall be rounded to the nearest multiple of $1,000.

(b) ALTERNATIVE TAX.—A nonresident alien individual described in subsection (a) shall be taxable for the taxable year as provided in section 1, 55, or 402(d)(1), except that—

(1) the gross income shall include only the gross income described in section 872(a) (as modified by subsection [(c)] *(d)* of this section), and

(2) the deductions shall be allowed if and to the extent that they are connected with the gross income included under this section, except that the capital loss carryover provided by section 1212(b) shall not be allowed; and the proper allocation and apportionment of the deductions for this purpose shall be determined as provided under regulations prescribed by the Secretary.

For purposes of paragraph (2), the deductions allowed by section 873(b) shall be allowed; and the deduction (for losses not connected with the trade or business if incurred in transactions entered into for profit) allowed by section 165(c)(2) shall be allowed, but only if the profit, if such transaction had resulted in a profit, would be included in gross income under this section. *The tax imposed solely by reason of this section shall be reduced (but not below zero) by the amount of any income, war profits, and excess profits taxes (within the meaning of section 903) paid to any foreign country or possession of the United States on any income of the taxpayer on which tax is imposed solely by reason of this section.*

(c) TAX AVOIDANCE NOT PRESUMED IN CERTAIN CASES.—

(1) IN GENERAL.—Subsection (a)(2) shall not apply to an individual if—

(A) such individual is described in a subparagraph of paragraph (2) of this subsection, and

(B) within the 1-year period beginning on the date of the loss of United States citizenship, such individual submits a ruling request for the Secretary's determination as to whether such loss has for 1 of its principal purposes the avoidance of taxes under this subtitle or subtitle B.

(2) INDIVIDUALS DESCRIBED.—

(A) DUAL CITIZENSHIP, ETC.—An individual is described in this subparagraph if—

(i) the individual became at birth a citizen of the United States and a citizen of another country and continues to be a citizen of such other country, or

(ii) the individual becomes (not later than the close of a reasonable period after loss of United States citizenship) a citizen of the country in which—

(I) such individual was born,

(II) if such individual is married, such individual's spouse was born, or

(III) either of such individual's parents were born.

(B) LONG-TERM FOREIGN RESIDENTS.—An individual is described in this subparagraph if, for each year in the 10-year period ending on the date of loss of United States citizenship, the individual was present in the United States for 30 days or less. The rule of section 7701(b)(3)(D)(ii) shall apply for purposes of this subparagraph.

(C) RENUNCIATION UPON REACHING AGE OF MAJORITY.—An individual is described in this subparagraph if the individual's loss of United States citizenship occurs before such individual attains age 18½.

(D) INDIVIDUALS SPECIFIED IN REGULATIONS.—An individual is described in this subparagraph if the individual is described in a category of individuals prescribed by regulation by the Secretary.

[(c) SPECIAL RULES OF SOURCE.—For purposes of subsection (b), the following items of gross income shall be treated as income from sources within the United States:

[(1) SALE OF PROPERTY.—Gains on the sale or exchange of property (other than stock or debt obligations) located in the United States.

[(2) STOCK OR DEBT OBLIGATIONS.—Gains on the sale or exchange of stock issued by a domestic corporation or debt obligations of United States persons or of the United States, a State or political subdivision thereof, or the District of Columbia.

[For purposes of this section, gain on the sale or exchange of property which has a basis determined in whole or in part by reference to property described in paragraph (1) or (2) shall be treated as gain described in paragraph (1) or (2).]

(d) SPECIAL RULES FOR SOURCE, ETC.—For purposes of subsection (b)—

(1) SOURCE RULES.—The following items of gross income shall be treated as income from sources within the United States:

(A) SALE OF PROPERTY.—Gains on the sale or exchange of property (other than stock or debt obligations) located in the United States.

(B) STOCK OR DEBT OBLIGATIONS.—Gains on the sale or exchange of stock issued by a domestic corporation or debt obligations of United States persons or of the United States, a State or political subdivision thereof, or the District of Columbia.

(C) INCOME OR GAIN DERIVED FROM CONTROLLED FOREIGN CORPORATION.—Any income or gain derived from stock in a foreign corporation but only—

(i) if the individual losing United States citizenship owned (within the meaning of section 958(a)), or is con-

sidered as owning (by applying the ownership rules of section 958(b)), at any time during the 2-year period ending on the date of the loss of United States citizenship, more than 50 percent of—

(I) the total combined voting power of all classes of stock entitled to vote of such corporation, or

(II) the total value of the stock of such corporation, and

(ii) to the extent such income or gain does not exceed the earnings and profits attributable to such stock which were earned or accumulated before the loss of citizenship and during periods that the ownership requirements of clause (i) are met.

(2) GAIN RECOGNITION ON CERTAIN EXCHANGES.—

(A) IN GENERAL.—In the case of any exchange of property to which this paragraph applies, notwithstanding any other provision of this title, such property shall be treated as sold for its fair market value on the date of such exchange, and any gain shall be recognized for the taxable year which includes such date.

(B) EXCHANGES TO WHICH PARAGRAPH APPLIES.—This paragraph shall apply to any exchange during the 10-year period described in subsection (a) if—

(i) gain would not (but for this paragraph) be recognized on such exchange in whole or in part for purposes of this subtitle,

(ii) income derived from such property was from sources within the United States (or, if no income was so derived, would have been from such sources), and

(iii) income derived from the property acquired in the exchange would be from sources outside the United States.

(C) EXCEPTION.—Subparagraph (A) shall not apply if the individual enters into an agreement with the Secretary which specifies that any income or gain derived from the property acquired in the exchange (or any other property which has a basis determined in whole or part by reference to such property) during such 10-year period shall be treated as from sources within the United States. If the property transferred in the exchange is disposed of by the person acquiring such property, such agreement shall terminate and any gain which was not recognized by reason of such agreement shall be recognized as of the date of such disposition.

(D) SECRETARY MAY EXTEND PERIOD.—To the extent provided in regulations prescribed by the Secretary, subparagraph (B) shall be applied by substituting the 15-year period beginning 5 years before the loss of United States citizenship for the 10-year period referred to therein.

(E) SECRETARY MAY REQUIRE RECOGNITION OF GAIN IN CERTAIN CASES.—To the extent provided in regulations prescribed by the Secretary—

(i) the removal of appreciated tangible personal property from the United States, and

(ii) any other occurrence which (without recognition of gain) results in a change in the source of the income or gain from property from sources within the United States to sources outside the United States,

shall be treated as an exchange to which this paragraph applies.

(3) SUBSTANTIAL DIMINISHING OF RISKS OF OWNERSHIP.—For purposes of determining whether this section applies to any gain on the sale or exchange of any property, the running of the 10-year period described in subsection (a) shall be suspended for any period during which the individual's risk of loss with respect to the property is substantially diminished by—

(A) the holding of a put with respect to such property (or similar property),

(B) the holding by another person of a right to acquire the property, or

(C) a short sale or any other transaction.

[(d) EXCEPTION FOR LOSS OF CITIZENSHIP FOR CERTAIN CAUSES.—Subsection (a) shall not apply to a nonresident alien individual whose loss of United States citizenship resulted from the application of section 301(b), 350, or 355 of the Immigration and Nationality Act, as amended (8 U.S.C. 1401(b), 1482, or 1487).]

(e) COMPARABLE TREATMENT OF LAWFUL PERMANENT RESIDENTS WHO CEASE TO BE TAXED AS RESIDENTS.—

(1) IN GENERAL.—Any long-term resident of the United States who—

(A) ceases to be a lawful permanent resident of the United States (within the meaning of section 7701(b)(6)), or

(B) commences to be treated as a resident of a foreign country under the provisions of a tax treaty between the United States and the foreign country and who does not waive the benefits of such treaty applicable to residents of the foreign country,

shall be treated for purposes of this section and sections 2107, 2501, and 6039F in the same manner as if such resident were a citizen of the United States who lost United States citizenship on the date of such cessation or commencement.

(2) LONG-TERM RESIDENT.—For purposes of this subsection, the term "long-term resident" means any individual (other than a citizen of the United States) who is a lawful permanent resident of the United States in at least 8 taxable years during the period of 15 taxable years ending with the taxable year during which the event described in subparagraph (A) or (B) of paragraph (1) occurs. For purposes of the preceding sentence, an individual shall not be treated as a lawful permanent resident for any taxable year if such individual is treated as a resident of a foreign country for the taxable year under the provisions of a tax treaty between the United States and the foreign country and does not waive the benefits of such treaty applicable to residents of the foreign country.

(3) SPECIAL RULES.—

(A) EXCEPTIONS NOT TO APPLY.—Subsection (c) shall not apply to an individual who is treated as provided in paragraph (1).

(B) STEP-UP IN BASIS.—Solely for purposes of determining any tax imposed by reason of this subsection, property which was held by the long-term resident on the date the individual first became a resident of the United States shall be treated as having a basis on such date of not less than the fair market value of such property on such date. The preceding sentence shall not apply if the individual elects not to have such sentence apply. Such an election, once made, shall be irrevocable.

(4) AUTHORITY TO EXEMPT INDIVIDUALS.—This subsection shall not apply to an individual who is described in a category of individuals prescribed by regulation by the Secretary.

(5) REGULATIONS.—The Secretary shall prescribe such regulations as may be appropriate to carry out this subsection, including regulations providing for the application of this subsection in cases where an alien individual becomes a resident of the United States during the 10-year period after being treated as provided in paragraph (1).

[(e)] *(f)* BURDEN OF PROOF.—If the Secretary establishes that it is reasonable to believe that an individual's loss of United States citizenship would, but for this section, result in a substantial reduction for the taxable year in the taxes on his probable income for such year, the burden of proving for such taxable year that such loss of citizenship did not have for one of its principal purposes the avoidance of taxes under this subtitle or subtitle B shall be on such individual.

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PART IV—DOMESTIC INTERNATIONAL SALES CORPORATION

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Subpart A—Treatment of Qualifying Corporations

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SEC. 992. REQUIREMENTS OF A DOMESTIC INTERNATIONAL SALES CORPORATION.

(a) * * *

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(d) INELIGIBLE CORPORATIONS.—The following corporations shall not be eligible to be treated as a DISC—

(1) * * *

* * * * * * *

(3) a financial institution to which section 581 [or 593] applies,

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Subchapter O—Gain or Loss on Disposition of Property

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PART III—COMMON NONTAXABLE EXCHANGES

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SEC. 1038. CERTAIN REACQUISITIONS OF REAL PROPERTY.

(a) * * *

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[(f) REACQUISITIONS BY DOMESTIC BUILDING AND LOAN ASSOCIATIONS.—This section shall not apply to a reacquisition of real property by an organization described in section 593(a) (relating to domestic building and loan associations, etc.).]

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SEC. 1042. SALES OF STOCK TO EMPLOYEE STOCK OWNERSHIP PLANS OR CERTAIN COOPERATIVES.

(a) * * *

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(c) DEFINITIONS; SPECIAL RULES.—For purposes of this section—

(1) * * *

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(4) QUALIFIED REPLACEMENT PROPERTY.—

(A) * * *

(B) OPERATING CORPORATION.—For purposes of this paragraph—

(i) * * *

(ii) FINANCIAL INSTITUTIONS AND INSURANCE COMPANIES.—The term "operating corporation" shall include—

(I) any financial institution described in section 581 [or 593], and

(II) an insurance company subject to tax under subchapter L.

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Subchapter P—Capital Gains and Losses

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PART V—SPECIAL RULES FOR BONDS AND OTHER DEBIT INSTRUMENTS

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Subpart B—Market Discount on Bonds

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SEC. 1277. DEFERRAL OF INTEREST DEDUCTION ALLOCABLE TO ACCRUED MARKET DISCOUNT.

(a) * * *

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(c) NET DIRECT INTEREST EXPENSE.—For purposes of this section, the term "net direct interest expense" means, with respect to any market discount bond, the excess (if any) of—

(1) the amount of interest paid or accrued during the taxable year on indebtedness which is incurred or continued to purchase or carry such bond, over

(2) the aggregate amount of interest (including original issue discount) includible in gross income for the taxable year with respect to such bond.

In the case of any financial institution which is a bank (as defined in section 585(a)(2)) [or to which section 593 applies], the determination of whether interest is described in paragraph (1) shall be made under principles similar to the principles of section 291(e)(1)(B)(ii). Under rules similar to the rules of section 265(a)(5), short sale expenses shall be treated as interest for purposes of determining net direct interest expense.

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Subchapter S—Tax Treatment of S Corporations and Their Shareholders

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PART I—IN GENERAL

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SEC. 1361. S CORPORATION DEFINED.

(a) * * *

(b) SMALL BUSINESS CORPORATION.—

(1) * * *

(2) INELIGIBLE CORPORATION DEFINED.—For purposes of paragraph (1), the term "ineligible corporation" means any corporation which is—

(A) a member of an affiliated group (determined under section 1504 without regard to the exceptions contained in subsection (b) thereof),

(B) a financial institution to which section 585 applies (or would apply but for subsection (c) thereof) [or to which section 593 applies],

(C) an insurance company subject to tax under subchapter L,

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Subtitle B—Estate and Gift Taxes

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CHAPTER 11—ESTATE TAX

Subchapter A—Estates of Citizens or Residents

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PART IV—TAXABLE ESTATE

SEC. 2057. MEDICAL SAVINGS ACCOUNTS.

For purposes of the tax imposed by section 2001, the value of the taxable estate shall be determined by deducting from the value of the gross estate an amount equal to the value of any medical savings account (as defined in section 220(d)) included in the gross estate.

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Subchapter B—Estates of Nonresidents Not Citizens

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SEC. 2107. EXPATRIATION TO AVOID TAX.

[(a) RATE OF TAX.— A tax computed in accordance with the table contained in section 2001 is hereby imposed on the transfer of the taxable estate, determined as provided in section 2106, of every decedent nonresident not a citizen of the United States dying after November 13, 1966, if after March 8, 1965, and within the 10-year period ending with the date of death such decedent lost United States citizenship, unless such loss did not have for one of its principal purposes the avoidance of taxes under this subtitle or subtitle A.]

(a) TREATMENT OF EXPATRIATES.—

(1) RATE OF TAX.—A tax computed in accordance with the table contained in section 2001 is hereby imposed on the transfer of the taxable estate, determined as provided in section 2106, of every decedent nonresident not a citizen of the United States if, within the 10-year period ending with the date of death, such decedent lost United States citizenship, unless such loss did not have for 1 of its principal purposes the avoidance of taxes under this subtitle or subtitle A.

(2) CERTAIN INDIVIDUALS TREATED AS HAVING TAX AVOIDANCE PURPOSE.—

(A) IN GENERAL.—For purposes of paragraph (1), an individual shall be treated as having a principal purpose to avoid such taxes if such individual is so treated under section 877(a)(2).

(B) EXCEPTION.—Subparagraph (A) shall not apply to a decedent meeting the requirements of section 877(c)(1).

(b) GROSS ESTATE.—For purposes of the tax imposed by subsection (a), the value of the gross estate of every decedent to whom subsection (a) applies shall be determined as provided in section 2103, except that—

(1) if such decedent owned (within the meaning of section 958(a)) at the time of his death 10 percent or more of the total combined voting power of all classes of stock entitled to vote of a foreign corporation, and

(2) if such decedent owned (within the meaning of section 958(a)), or is considered to have owned (by applying the ownership rules of section 958(b)), at the time of his death, [more than 50 percent of the total combined voting power of all classes of stock entitled to vote of such foreign corporation,] *more than 50 percent of—*

(A) the total combined voting power of all classes of stock entitled to vote of such corporation, or

(B) the total value of the stock of such corporation,

then that proportion of the fair market value of the stock of such foreign corporation owned (within the meaning of section 958(a)) by such decedent at the time of his death, which the fair market value of any assets owned by such foreign corporation and situated in the United States, at the time of his death, bears to the total fair market value of all assets owned by such foreign corporation at the time of his death, shall be included in the gross estate of such decedent. For purposes of the preceding sentence, a decedent shall be treated as owning stock of a foreign corporation at the time of his death if, at the time of a transfer, by trust or otherwise, within the meaning of sections 2035 to 2038, inclusive, he owned such stock.

(c) CREDITS.—

(1) * * *

(2) CREDIT FOR FOREIGN DEATH TAXES.—

(A) IN GENERAL.—The tax imposed by subsection (a) shall be credited with the amount of any estate, inheritance, legacy, or succession taxes actually paid to any foreign country in respect of any property which is included in the gross estate solely by reason of subsection (b).

(B) LIMITATION ON CREDIT.—The credit allowed by subparagraph (A) for such taxes paid to a foreign country shall not exceed the lesser of—

(i) the amount which bears the same ratio to the amount of such taxes actually paid to such foreign country in respect of property included in the gross estate as the value of the property included in the gross estate solely by reason of subsection (b) bears to the value of all property subjected to such taxes by such foreign country, or

(ii) such property's proportionate share of the excess of—

(I) the tax imposed by subsection (a), over

(II) the tax which would be imposed by section 2101 but for this section.

(C) PROPORTIONATE SHARE.—For purposes of subparagraph (B), a property's proportionate share is the percentage of the value of the property which is included in the gross estate solely by reason of subsection (b) bears to the total value of the gross estate.

[(2)] *(3)* OTHER CREDITS.—The tax imposed by subsection (a) shall be credited with the amounts determined in accordance with subsections (a) and (b) of section 2102. For purposes of subsection (a) of section 2102, sections 2011 to 2013, inclusive,

shall be applied as if the credit allowed under paragraph (1) were allowed under section 2010.

[(d) EXCEPTION FOR LOSS OF CITIZENSHIP FOR CERTAIN CAUSES.—Subsection (a) shall not apply to the transfer of the estate of a decedent whose loss of United States citizenship resulted from the application of section 301(b), 350, or 355 of the Immigration and Nationality Act, as amended (8 U.S.C. 1401(b), 1482, or 1487).]

[(e)] *(d)* BURDEN OF PROOF.—If the Secretary establishes that it is reasonable to believe that an individual's loss of United States citizenship would, but for this section, result in a substantial reduction in the estate, inheritance, legacy, and succession taxes in respect of the transfer of his estate, the burden of proving that such loss of citizenship did not have for one of its principal purposes the avoidance of taxes under this subtitle or subtitle A shall be on the executor of such individual's estate.

(e) CROSS REFERENCE.—

For comparable treatment of long-term lawful permanent residents who ceased to be taxed as residents, see section 877(e).

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CHAPTER 12—GIFT TAX

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Subchapter A—Determination of Tax Liability

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SEC. 2501. IMPOSITION OF TAX.

(a) TAXABLE TRANSFERS.—

(1) * * *

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[(3) EXCEPTIONS.—Paragraph (2) shall not apply in the case of a donor who at any time after March 8, 1965, and within the 10-year period ending with the date of transfer lost United States citizenship unless—

[(A) such donor's loss of United States citizenship resulted from the application of section 301(b), 350, or 355 of the Immigration and Nationality Act, as amended (8 U.S.C. 1401(b), 1482, or 1487), or

[(B) such loss did not have for one of its principal purposes the avoidance of taxes under this subtitle or subtitle A.]

(3) EXCEPTION.—

(A) CERTAIN INDIVIDUALS.—Paragraph (2) shall not apply in the case of a donor who, within the 10-year period ending with the date of transfer, lost United States citizenship, unless such loss did not have for 1 of its principal purposes the avoidance of taxes under this subtitle or subtitle A.

(B) CERTAIN INDIVIDUALS TREATED AS HAVING TAX AVOIDANCE PURPOSE.—For purposes of subparagraph (A), an individual shall be treated as having a principal purpose to

avoid such taxes if such individual is so treated under section 877(a)(2).

(C) EXCEPTION FOR CERTAIN INDIVIDUALS.—Subparagraph (B) shall not apply to a decedent meeting the requirements of section 877(c)(1).

(D) CREDIT FOR FOREIGN GIFT TAXES.—The tax imposed by this section solely by reason of this paragraph shall be credited with the amount of any gift tax actually paid to any foreign country in respect of any gift which is taxable under this section solely by reason of this paragraph.

(E) CROSS REFERENCE.—

For comparable treatment of long-term lawful permanent residents who ceased to be taxed as residents, see section 877(e).

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Subtitle C—Employment Taxes

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CHAPTER 21—FEDERAL INSURANCE CONTRIBUTIONS ACT

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Subchapter C—General Provisions

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SEC. 3121. DEFINITIONS.

(a) WAGES.—For purposes of this chapter, the term "wages" means all remuneration for employment, including the cash value of all remuneration (including benefits) paid in any medium other than cash; except that such term shall not include—

(1) * * *

* * * * * * *

(20) any benefit provided to or on behalf of an employee if at the time such benefit is provided it is reasonable to believe that the employee will be able to exclude such benefit from income under section 74(c), 117, or 132; **[**or**]**

(21) in the case of a member of an Indian tribe, any remuneration on which no tax is imposed by this chapter by reason of section 7873 (relating to income derived by Indians from exercise of fishing rights)**[**.**]***; or*

(22) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b).

Nothing in the regulations prescribed for purposes of chapter 24 (relating to income tax withholding) which provides an exclusion from "wages" as used in such chapter shall be construed to require a similar exclusion from "wages" in the regulations prescribed for purposes of this chapter. Except as otherwise provided in regulations prescribed by the Secretary, any third party which makes a payment included in wages solely by reason of the parenthetical matter contained in subparagraph (A) of paragraph (2) shall be

treated for purposes of this chapter and chapter 22 as the employer with respect to such wages.

CHAPTER 22—RAILROAD RETIREMENT ACT

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Subchapter C—Tax on Employees

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SEC. 3231. DEFINITIONS.

(a) * * *

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(e) COMPENSATION.—For purposes of this chapter—

(1) * * *

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(10) MEDICAL SAVINGS ACCOUNT CONTRIBUTIONS.—The term "compensation" shall not include any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b).

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CHAPTER 23—FEDERAL UNEMPLOYMENT TAX ACT

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SEC. 3306. DEFINITIONS.

(a) * * *

(b) WAGES.—For purposes of this chapter, the term "wages" means all remuneration for employment, including the cash value of all remuneration (including benefits) paid in any medium other than cash; except that such term shall not include—

(1) * * *

* * * * * * *

(15) any payment made by an employer to a survivor or the estate of a former employee after the calendar year in which such employee died; **[**or**]**

(16) any benefit provided to or on behalf of an employee if at the time such benefit is provided it is reasonable to believe that the employee will be able to exclude such benefit from income under section 74(c), 117, or 132**[**.**]***; or*

(17) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b).

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CHAPTER 24—COLLECTION ON INCOME TAX AT SOURCE ON WAGES

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Subchapter A—Withholding From Wages

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SEC. 3401. DEFINITIONS.

(a) WAGES. For purposes of this chapter, the term "wages" means all remuneration (other than fees paid to a public official) for services performed by an employee for his employer, including the cash value of all remuneration (including benefits) paid in any medium other than cash; except that such term shall not include remuneration paid—

(1) * * *

* * * * * * *

(19) any benefit provided to or on behalf of an employee if at the time such benefit is provided it is reasonable to believe that the employee will be able to exclude such benefit from income under section 74(c), 117, or 132; **[**or**]**

(20) for any medical care reimbursement made to or for the benefit of an employee under a self-insured medical reimbursement plan (within the meaning of section 105(h)(6))**[**.**]***; or*

(21) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b).

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Subtitle D—Miscellaneous Excise Taxes

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CHAPTER 43—QUALIFIED PENSION, ETC., PLANS

SEC. 4973. TAX ON EXCESS CONTRIBUTIONS TO INDIVIDUAL RETIREMENT ACCOUNTS, *MEDICAL SAVINGS ACCOUNTS,* CERTAIN SECTION 403(b) CONTRACTS, AND CERTAIN INDIVIDUAL RETIREMENT ANNUITIES.

(a) TAX IMPOSED.—In the case of—

(1) an individual retirement account (within the meaning of section 408(a)), **[**or**]**

(2) a medical savings account (within the meaning of section 220(d)), or

[(2)**]** *(3)* an individual retirement annuity (within the meaning of section 408(b)), a custodial account treated as an annuity contract under section 403(b)(7)(A) (relating to custodial accounts for regulated investment company stock),

there is imposed for each taxable year a tax in an amount equal to 6 percent of the amount of the excess contributions to such individual's accounts or annuities (determined as of the close of the taxable year). The amount of such tax for any taxable year shall not exceed 6 percent of the value of the account or annuity (determined as of the close of the taxable year). In the case of an endowment contract described in section 408(b), the tax imposed by this

section does not apply to any amount allocable to life, health, accident, or other insurance under such contract. The tax imposed by this subsection shall be paid by such individual.

* * * * * * *

(d) EXCESS CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—For purposes of this section, in the case of a medical savings accounts (within the meaning of section 220(d)), the term 'excess contributions' means the sum of—

"(1) the amount by which the amount contributed for the taxable year to the accounts (other than rollover contributions described in section 220(f)(5)) exceeds the amount allowable as a deduction under section 220 for such contributions, and

(2) the amount determined under this subsection for the preceding taxable year, reduced by the sum of distributions out of the account included in gross income under section 220(f) (2) or (3) and the excess (if any) of the maximum amount allowable as a deduction under section 220 for the taxable year over the amount contributed.

For purposes of this subsection, any contribution which is distributed out of the medical savings account in a distribution to which section 220(f)(3) applies shall be treated as an amount not contributed.

* * * * * * *

SEC. 4975. TAX ON PROHIBITED TRANSACTIONS.

(a) * * *

* * * * * * *

(c) PROHIBITED TRANSACTION.—

(1) GENERAL RULE.—For purposes of this section, the term "prohibited transaction" means any direct or indirect—

(A) * * *

* * * * * * *

(4) SPECIAL RULE FOR MEDICAL SAVINGS ACCOUNTS.—An individual for whose benefit a medical savings account (within the meaning of section 220(d)) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a medical savings account by reason of the application of section 220(e)(2) to such account.

* * * * * * *

(e) DEFINITIONS.—

[(1) PLAN.—For purposes of this section, the term "plan" means a trust described in section 401(a) which forms a part of a plan, or a plan described in section 403(a), which trust or plan is exempt from tax under section 501(a), an individual retirement account described in section 408(a) or an individual retirement annuity described in section 408(b) (or a trust, plan, account, or annuity which, at any time, has been determined by the Secretary to be such a trust, plan, or account).]

(1) PLAN.—For purposes of this section, the term "plan" means—

(A) a trust described in section 401(a) which forms a part of a plan, or a plan described in section 403(a), which trust or plan is exempt from tax under section 501(a),

(B) an individual retirement account described in section 408(a),

(C) an individual retirement annuity described in section 408(b),

(D) a medical savings account described in section 220(d), or

(E) a trust, plan, account, or annuity which, at any time, has been determined by the Secretary to be described in any preceding subparagraph of this paragraph.

* * * * * * *

SEC. 4980B. FAILURE TO SATISFY CONTINUATION COVERAGE REQUIREMENTS OF GROUP HEALTH PLANS.

(a) GENERAL RULE.—There is hereby imposed a tax on the failure of a group health plan to meet [the requirements of subsection (f) with respect to any qualified beneficiary.] *the requirements of—*

(1) subsection (f) with respect to any qualified beneficiary, or

(2) subject to subsection (h)—

(A) section 101 or 102 of the Health Coverage Availability and Affordability Act of 1996 with respect to any individual covered under the group health plan, or

(B) section 103 of such Act with respect to any individual.

* * * * * * *

(f) CONTINUATION COVERAGE REQUIREMENTS OF GROUP HEALTH PLANS.—

(1) * * *

* * * * * * *

(6) NOTICE REQUIREMENT.—In accordance with regulations prescribed by the secretary—

(A) The group health plan shall provide, at the time of commencement of coverage under the plan, written notice to each covered employee and spouse of the employee (if any) of the rights provided under this subsection *and subtitle A of title I of the Health Coverage Availability and Affordability Act of 1996.*

* * * * * * *

(9) CONTINUATION OF LONG-TERM CARE COVERAGE NOT REQUIRED.—A group health plan shall not be treated as failing to meet the requirements of this subsection solely by reason of failing to provide coverage under any qualified long-term care insurance contract (as defined in section 7702B(b)).

* * * * * * *

(h) SPECIAL RULES.—For purposes of applying this section in the case of requirements described in subsection (a)(2) relating to section 101, section 102, or section 103 of the Health Coverage Availability and Affordability Act of 1996—

(1) IN GENERAL.—

(A) DEFINITION OF GROUP HEALTH PLAN.—The term "group health plan" has the meaning given such term in section 191(a) of the Health Coverage Availability and Affordability Act of 1996.

(B) QUALIFIED BENEFICIARY.—Subsections (b), (c), and (e) shall be applied by substituting the term "individual" for the term "qualified beneficiary" each place it appears.

(C) NONCOMPLIANCE PERIOD.—Clause (ii) of subsection (b)(2)(B) and the second sentence of subsection (b)(2) shall not apply.

(D) LIMITATION ON TAX.—Subparagraph (B) of subsection (c)(3) shall not apply.

(E) LIABILITY FOR TAX.—Paragraph (2) of subsection (e) shall not apply.

(2) DEFERRAL TO STATE REGULATION.—No tax shall be imposed by this section on any failure to meet the requirements of such section by any entity which offers health insurance coverage and which is an insurer or health maintenance organization (as defined in section 191(c) of the Health Coverage Availability and Affordability Act of 1996) regulated by a State unless the Secretary of Health and Human Services has made the determination described in section 104(c)(2) of such Act with respect to such State, section, and entity.

(3) LIMITATION FOR INSURED PLANS.—In the case of a group health plan of a small employer (as defined in section 191 of the Health Coverage Availability and Affordability Act of 1996) that provides health care benefits solely through a contract with an insurer or health maintenance organization (as defined in such section), no tax shall be imposed by this section upon the employer on a failure to meet such requirements if the failure is solely because of the product offered by the insurer or organization under such contract.

(4) LIMITATION ON IMPOSITION OF TAX.—In no case shall a tax be imposed by this section for a failure to meet such a requirement if—

(A) a civil money penalty has been imposed by the Secretary of Labor under part 5 of subtitle A of title I of the Employee Retirement Income Security Act of 1974 with respect to such failure, or

(B) a civil money penalty has been imposed by the Secretary of Health and Human Services under section 104(c) of the Health Coverage Availability and Affordability Act of 1996 with respect to such failure.

* * * * * * *

SEC. 4980C. REQUIREMENTS FOR ISSUERS OF LONG-TERM CARE INSURANCE POLICIES.

(a) GENERAL RULE.—There is hereby imposed on any person failing to meet the requirements of subsection (c) or (d) a tax in the amount determined under subsection (b).

(b) AMOUNT.—

(1) IN GENERAL.—The amount of the tax imposed by subsection (a) shall be $100 per policy for each day any require-

ments of subsection (c) or (d) are not met with respect to each long-term care insurance policy.

(2) WAIVER.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that payment of the tax would be excessive relative to the failure involved.

(c) RESPONSIBILITIES.—The requirements of this subsection are as follows:

(1) REQUIREMENTS OF MODEL PROVISIONS.—

(A) MODEL REGULATION.—The following requirements of the model regulation must be met:

(i) Section 13 (relating to application forms and replacement coverage).

(ii) Section 14 (relating to reporting requirements), except that the issuer shall also report at least annually the number of claims denied during the reporting period for each class of business (expressed as a percentage of claims denied), other than claims denied for failure to meet the waiting period or because of any applicable preexisting condition.

(iii) Section 20 (relating to filing requirements for marketing).

(iv) Section 21 (relating to standards for marketing), including inaccurate completion of medical histories, other than sections 21C(1) and 21C(6) thereof, except that—

(I) in addition to such requirements, no person shall, in selling or offering to sell a long-term care insurance policy, misrepresent a material fact; and

(II) no such requirements shall include a requirement to inquire or identify whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance.

(v) Section 22 (relating to appropriateness of recommended purchase).

(vi) Section 24 (relating to standard format outline of coverage).

(vii) Section 25 (relating to requirement to deliver shopper's guide).

(B) MODEL ACT.—The following requirements of the model Act must be met:

(i) Section 6F (relating to right to return), except that such section shall also apply to denials of applications and any refund shall be made within 30 days of the return or denial.

(ii) Section 6G (relating to outline of coverage).

(iii) Section 6H (relating to requirements for certificates under group plans).

(iv) Section 6I (relating to policy summary).

(v) Section 6J (relating to monthly reports on accelerated death benefits).

(vi) Section 7 (relating to incontestability period).

(C) DEFINITIONS.—For purposes of this paragraph, the terms "model regulation" and "model Act" have the meanings given such terms by section 7702B(f)(2)(B).

(2) DELIVERY OF POLICY.—If an application for a long-term care insurance policy (or for a certificate under a group long-term care insurance policy) is approved, the issuer shall deliver to the applicant (or policyholder or certificateholder) the policy (or certificate) of insurance not later than 30 days after the date of the approval.

(3) INFORMATION ON DENIALS OF CLAIMS.—If a claim under a long-term care insurance policy is denied, the issuer shall, within 60 days of the date of a written request by the policyholder or certificateholder (or representative)—

(A) provide a written explanation of the reasons for the denial, and

(B) make available all information directly relating to such denial.

(d) DISCLOSURE.—The requirements of this subsection are met if the issuer of a long-term care insurance policy discloses in such policy and in the outline of coverage required under subsection (c)(1)(B)(ii) that the policy is intended to be a qualified long-term care insurance contract under section 7702B(b).

(e) LONG-TERM CARE INSURANCE POLICY DEFINED.—For purposes of this section, the term "long-term care insurance policy" means any product which is advertised, marketed, or offered as long-term care insurance.

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Subtitle F—Procedure and Administration

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CHAPTER 61—INFORMATION AND RETURNS

Subchapter A—Returns and Records

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PART III—INFORMATION RETURNS

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Subpart A—Information Concerning Persons Subject to Special Provisions

Sec. 6031. Return of partnership income.

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Sec. 6039F. Information on individuals losing United States citizenship.

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SEC. 6039F. INFORMATION ON INDIVIDUALS LOSING UNITED STATES CITIZENSHIP.

(a) IN GENERAL.—Notwithstanding any other provision of law, any individual who loses United States citizenship (within the meaning of section 877(a)) shall provide a statement which includes

the information described in subsection (b). Such statement shall be—

(1) provided not later than the earliest date of any act referred to in subsection (c), and

(2) provided to the person or court referred to in subsection (c) with respect to such act.

(b) INFORMATION TO BE PROVIDED.—Information required under subsection (a) shall include—

(1) the taxpayer's TIN,

(2) the mailing address of such individual's principal foreign residence,

(3) the foreign country in which such individual is residing,

(4) the foreign country of which such individual is a citizen,

(5) in the case of an individual having a net worth of at least the dollar amount applicable under section 877(a)(2)(B), information detailing the assets and liabilities of such individual, and

(6) such other information as the Secretary may prescribe.

(c) ACTS DESCRIBED.—For purposes of this section, the acts referred to in this subsection are—

(1) the individual's renunciation of his United States nationality before a diplomatic or consular officer of the United States pursuant to paragraph (5) of section 349(a) of the Immigration and Nationality Act (8 U.S.C. 1481(a)(5)),

(2) the individual's furnishing to the United States Department of State a signed statement of voluntary relinquishment of United States nationality confirming the performance of an act of expatriation specified in paragraph (1), (2), (3), or (4) of section 349(a) of the Immigration and Nationality Act (8 U.S.C. 1481(a)(1)–(4)),

(3) the issuance by the United States Department of State of a certificate of loss of nationality to the individual, or

(4) the cancellation by a court of the United States of a naturalized citizen's certificate of naturalization.

(d) PENALTY.—Any individual failing to provide a statement required under subsection (a) shall be subject to a penalty for each year (of the 10-year period beginning on the date of loss of United States citizenship) during any portion of which such failure continues in an amount equal to the greater of—

(1) 5 percent of the tax required to be paid under section 877 for the taxable year ending during such year, or

(2) $1,000,

unless it is shown that such failure is due to reasonable cause and not to willful neglect.

(e) INFORMATION TO BE PROVIDED TO SECRETARY.—Notwithstanding any other provision of law—

(1) any Federal agency or court which collects (or is required to collect) the statement under subsection (a) shall provide to the Secretary—

(A) a copy of any such statement, and

(B) the name (and any other identifying information) of any individual refusing to comply with the provisions of subsection (a),

(2) the Secretary of State shall provide to the Secretary a copy of each certificate as to the loss of American nationality under section 358 of the Immigration and Nationality Act which is approved by the Secretary of State, and

(3) the Federal agency primarily responsible for administering the immigration laws shall provide to the Secretary the name of each lawful permanent resident of the United States (within the meaning of section 7701(b)(6)) whose status as such has been revoked or has been administratively or judicially determined to have been abandoned.

Notwithstanding any other provision of law, not later than 30 days after the close of each calendar quarter, the Secretary shall publish in the Federal Register the name of each individual losing United States citizenship (within the meaning of section 877(a)) with respect to whom the Secretary receives information under the preceding sentence during such quarter.

(f) REPORTING BY LONG-TERM LAWFUL PERMANENT RESIDENTS WHO CEASE TO BE TAXED AS RESIDENTS.—In lieu of applying the last sentence of subsection (a), any individual who is required to provide a statement under this section by reason of section 877(e)(1) shall provide such statement with the return of tax imposed by chapter 1 for the taxable year during which the event described in such section occurs.

(g) EXEMPTION.—The Secretary may by regulations exempt any class of individuals from the requirements of this section if he determines that applying this section to such individuals is not necessary to carry out the purposes of this section.

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Subpart B—Information Concerning Transactions With Other Persons

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Sec. 6041. Information at source.

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Sec. 6050Q. Certain long-term care benefits.

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SEC. 6050Q. CERTAIN LONG-TERM CARE BENEFITS.

(a) REQUIREMENT OF REPORTING.—Any person who pays long-term care benefits shall make a return, according to the forms or regulations prescribed by the Secretary, setting forth—

(1) the aggregate amount of such benefits paid by such person to any individual during any calendar year, and

(2) the name, address, and TIN of such individual.

(b) STATEMENTS TO BE FURNISHED TO PERSONS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required to be set forth in such return a written statement showing—

(1) the name of the person making the payments, and

(2) the aggregate amount of long-term care benefits paid to the individual which are required to be shown on such return.

The written statement required under the preceding sentence shall be furnished to the individual on or before January 31 of the year following the calendar year for which the return under subsection (a) was required to be made.

(c) LONG-TERM CARE BENEFITS.—For purposes of this section, the term "long-term care benefit" means any amount paid under a long-term care insurance policy (within the meaning of section 4980C(e)).

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CHAPTER 63—ASSESSMENT

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Subchapter B—Deficiency Procedures in the Case of Income, Estate, Gift, and Certain Excise Taxes

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SEC. 6213. RESTRICTIONS APPLICABLE TO DEFICIENCIES; PETITION TO TAX COURT.

(a) * * *

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

(1) RETURN.—The term "return" includes any return, statement, schedule, or list, and any amendment or supplement thereto, filed with respect to any tax imposed by subtitle A or B, or chapter 41, 42, 43, or 44.

(2) MATHEMATICAL OR CLERICAL ERROR.—The term "mathematical or clerical error" means—

(A) an error in addition, subtraction, multiplication, or division shown on any return,

(B) an incorrect use of any table provided by the Internal Revenue Service with respect to any return if such incorrect use is apparent from the existence of other information on the return,

(C) an entry on a return of an item which is inconsistent with another entry of the same or another item on such return,

(D) an omission of information which is required to be supplied on the return to substantiate an entry on the return, **[**and**]**

(E) an entry on a return of a deduction or credit in an amount which exceeds a statutory limit imposed by subtitle A or B, or chapter 41, 42, 43, or 44, if such limit is expressed—

(i) as a specified monetary amount, or

(ii) as a percentage, ratio, or fraction,

and if the items entering into the application of such limit appear on such return**[**.**]**,

(F) an omission of a correct taxpayer identification number required under section 32 (relating to the earned income credit) to be included on a return, and

(G) an entry on a return claiming the credit under section 32 with respect to net earnings from self-employment described in section 32(c)(2)(A) to the extent the tax imposed

by section 1401 (relating to self-employment tax) on such net earnings has not been paid.

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CHAPTER 68—ADDITIONS TO THE TAX, ADDITIONAL AMOUNTS, AND ASSESSABLE PENALTIES

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Subchapter B—Assessable Penalties

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PART I—GENERAL PROVISIONS

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SEC. 6693. FAILURE TO PROVIDE REPORTS ON INDIVIDUAL RETIREMENT ACCOUNTS OR ANNUITIES; PENALTIES RELATING TO DESIGNATED NONDEDUCTIBLE CONTRIBUTIONS.

[(a) The person required by subsection (i) or (l) of section 408 to file a report regarding an individual retirement account or individual retirement annuity at the time and in the manner required by such subsection shall pay a penalty of $50 for each failure unless it is shown that such failure is due to reasonable cause.]

(a) REPORTS.—

(1) IN GENERAL.—If a person required to file a report under a provision referred to in paragraph (2) fails to file such report at the time and in the manner required by such provision, such person shall pay a penalty of $50 for each failure unless it is shown that such failure is due to reasonable cause.

(2) PROVISIONS.—The provisions referred to in this paragraph are—

(A) subsections (i) and (l) of section 408 (relating to individual retirement plans), and

(B) section 220(h) (relating to medical savings accounts).

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PART II—FAILURE TO COMPLY WITH CERTAIN INFORMATION REPORTING REQUIREMENTS

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SEC. 6724. WAIVER; DEFINITIONS AND SPECIAL RULES.

(a) * * *

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(d) DEFINITIONS.—For purposes of this part—

(1) INFORMATION RETURN.—The term 'information return' means—

(A) * * *

(B) any return required by—

(i) * * *

* * * * * * *

(ix) section 6050Q (relating to certain long-term care benefits),

[(ix)] *(x)* section 6052(a) (relating to reporting payment of wages in the form of group-life insurance),

[(x)] *(xi)* section 6053(c)(1) (relating to reporting with respect to certain tips),

[(xi)] *(xii)* subsection (b) or (e) of section 1060(b) (relating to reporting requirements of transferors and transferees in certain asset acquisitions),

[(xii)] *(xiii)* subparagraph (A) or (C) of subsection (c)(4), or section 4093 (relating to information reporting with respect to tax on diesel and aviation fuels), or

[(xiii)] *(xiv)* section 4101(d) (relating to information reporting with respect to fuels taxes)

[(xiv)] *(xv)* subparagraph (C) of section 338(h)(10)(relating to information required to be furnished to the Secretary in case of elective recognition of gain or loss).

Such term also includes any form, statement, or schedule required to be filed with the Secretary with respect to any amount from which tax was required to be deducted and withheld under chapter 3 (or from which tax would be required to be so deducted and withheld but for an exemption under this title or any treaty obligation of the United States).

(2) PAYEE STATEMENT.—The term 'payee statement' means any statement required to be furnished under—

(A) * * *

* * * * * * *

(Q) section 6050Q(b) (relating to certain long-term care benefits),

[(Q)] *(R)* section 6051 (relating to receipts for employees),

[(R)] *(S)* section 6052(b) (relating to returns regarding payment of wages in the form of group-term life insurance),

[(S)] *(T)* section 6053(b) or (c) (relating to reports of tips), or

[(T)] *(U)* section 4093(c)(4)(B) (relating to certain purchasers of diesel and aviation fuels).

Such term also includes any form, statement, or schedule required to be furnished to the recipient of any amount from which tax was required to be deducted and withheld under chapter 3 (or from which tax would be required to be so deducted and withheld but for an exemption under this title or any treaty obligation of the United States).

* * * * * * *

CHAPTER 79—DEFINITIONS

SEC. 7702B. TREATMENT OF QUALIFIED LONG-TERM CARE INSURANCE.

(a) IN GENERAL.—For purposes of this title—

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

(2) amounts (other than policyholder dividends, as defined in section 808, or premium refunds) received under a qualified long-term care insurance contract shall be treated as amounts received for personal injuries and sickness and shall be treated as reimbursement for expenses actually incurred for medical care (as defined in section 213(d)),

(3) any plan of an employer providing coverage under a qualified long-term care insurance contract shall be treated as an accident and health plan with respect to such coverage,

(4) except as provided in subsection (e)(3), amounts paid for a qualified long-term care insurance contract providing the benefits described in subsection (b)(2)(A) shall be treated as payments made for insurance for purposes of section 213(d)(1)(D), and

(5) a qualified long-term care insurance contract shall be treated as a guaranteed renewable contract subject to the rules of section 816(e).

(b) QUALIFIED LONG-TERM CARE INSURANCE CONTRACT.—For purposes of this title—

(1) IN GENERAL.—The term "qualified long-term care insurance contract" means any insurance contract if—

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

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

(C) such contract is guaranteed renewable,

(D) such contract does not provide for a cash surrender value or other money that can be—

(i) paid, assigned, or pledged as collateral for a loan, or

(ii) borrowed,

other than as provided in subparagraph (E) or paragraph (2)(C),

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

(F) such contract meets the requirements of subsection (f).

(2) SPECIAL RULES.—

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

(B) SPECIAL RULES RELATING TO MEDICARE.—

(i) Paragraph (1)(B) shall not apply to expenses which are reimbursable under title XVIII of the Social Security Act only as a secondary payor.

(ii) No provision of law shall be construed or applied so as to prohibit the offering of a qualified long-term care insurance contract on the basis that the contract coordinates its benefits with those provided under such title.

(C) REFUNDS OF PREMIUMS.—Paragraph (1)(E) shall not apply to any refund on the death of the insured, or on a complete surrender or cancellation of the contract, which cannot exceed the aggregate premiums paid under the contract. Any refund on a complete surrender or cancellation of the contract shall be includible in gross income to the extent that any deduction or exclusion was allowable with respect to the premiums.

(c) QUALIFIED LONG-TERM CARE SERVICES.—For purposes of this section—

(1) IN GENERAL.—The term "qualified long-term care services" means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, which—

(A) are required by a chronically ill individual, and

(B) are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(2) CHRONICALLY ILL INDIVIDUAL.—

(A) IN GENERAL.—The term "chronically ill individual" means any individual who has been certified by a licensed health care practitioner as—

(i) being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living for a period of at least 90 days due to a loss of functional capacity,

(ii) having a level of disability similar (as determined by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in clause (i), or

(iii) requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment.

Such term shall not include any individual otherwise meeting the requirements of the preceding sentence unless within the preceding 12-month period a licensed health care practitioner has certified that such individual meets such requirements.

(B) ACTIVITIES OF DAILY LIVING.—For purposes of subparagraph (A), each of the following is an activity of daily living:

(i) Eating.
(ii) Toileting.
(iii) Transferring.
(iv) Bathing.
(v) Dressing.
(vi) Continence.

Nothing in this section shall be construed to require a contract to take into account all of the preceding activities of daily living.

(3) MAINTENANCE OR PERSONAL CARE SERVICES.—The term "maintenance or personal care services" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

(4) LICENSED HEALTH CARE PRACTITIONER.—The term "licensed health care practitioner" means any physician (as defined in section 1861(r)(1) of the Social Security Act) and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary.

(d) AGGREGATE PAYMENTS IN EXCESS OF LIMITS.—

(1) IN GENERAL.—If the aggregate amount of periodic payments under all qualified long-term care insurance contracts with respect to an insured for any period exceeds the dollar amount in effect for such period under paragraph (3), such excess payments shall be treated as made for qualified long-term care services only to the extent of the costs incurred by the payee (not otherwise compensated for by insurance or otherwise) for qualified long-term care services provided during such period for such insured.

(2) PERIODIC PAYMENTS.—For purposes of paragraph (1), the term "periodic payment" means any payment (whether on a periodic basis or otherwise) made without regard to the extent of the costs incurred by the payee for qualified long-term care services.

(3) DOLLAR AMOUNT.—The dollar amount in effect under this subsection shall be $175 per day (or the equivalent amount in the case of payments on another periodic basis).

(4) INFLATION ADJUSTMENT.—In the case of a calendar year after 1997, the dollar amount contained in paragraph (3) shall be increased at the same time and in the same manner as amounts are increased pursuant to section 213(d)(10).

(e) TREATMENT OF COVERAGE PROVIDED AS PART OF A LIFE INSURANCE CONTRACT.—Except as otherwise provided in regulations prescribed by the Secretary, in the case of any long-term care insurance coverage (whether or not qualified) provided by a rider on or as part of a life insurance contract—

(1) IN GENERAL.—This section shall apply as if the portion of the contract providing such coverage is a separate contract.

(2) APPLICATION OF 7702.—Section 7702(c)(2) (relating to the guideline premium limitation) shall be applied by increasing the guideline premium limitation with respect to a life insurance contract, as of any date—

(A) by the sum of any charges (but not premium payments) against the life insurance contract's cash surrender value (within the meaning of section 7702(f)(2)(A)) for such coverage made to that date under the contract, less

(B) any such charges the imposition of which reduces the premiums paid for the contract (within the meaning of section 7702(f)(1)).

(3) APPLICATION OF SECTION 213.—No deduction shall be allowed under section 213(a) for charges against the life insurance contract's cash surrender value described in paragraph (2), unless such charges are includible in income as a result of the application of section 72(e)(10) and the rider is a qualified long-term care insurance contract under subsection (b).

(4) PORTION DEFINED.—For purposes of this subsection, the term "portion" means only the terms and benefits under a life insurance contract that are in addition to the terms and benefits under the contract without regard to the coverage under a qualified long-term care insurance contract.

(f) CONSUMER PROTECTION PROVISIONS.—

(1) IN GENERAL.—The requirements of this subsection are met with respect to any contract if any long-term care insurance policy issued under the contract meets—

(A) the requirements of the model regulation and model Act described in paragraph (2),

(B) the disclosure requirement of paragraph (3), and

(C) the requirements relating to nonforfeitability under paragraph (4).

(2) REQUIREMENTS OF MODEL REGULATION AND ACT.—

(A) IN GENERAL.—The requirements of this paragraph are met with respect to any policy if such policy meets—

(i) MODEL REGULATION.—The following requirements of the model regulation:

(I) Section 7A (relating to guaranteed renewal or noncancellability), and the requirements of section 6B of the model Act relating to such section 7A.

(II) Section 7B (relating to prohibitions on limitations and exclusions).

(III) Section 7C (relating to extension of benefits).

(IV) Section 7D (relating to continuation or conversion of coverage).

(V) Section 7E (relating to discontinuance and replacement of policies).

(VI) Section 8 (relating to unintentional lapse).

(VII) Section 9 (relating to disclosure), other than section 9F thereof.

(VIII) Section 10 (relating to prohibitions against post-claims underwriting).

(IX) Section 11 (relating to minimum standards).

(X) Section 12 (relating to requirement to offer inflation protection), except that any requirement for a signature on a rejection of inflation protection shall permit the signature to be on an application or on a separate form.

(XI) Section 23 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

(ii) MODEL ACT.—The following requirements of the model Act:

(I) Section 6C (relating to preexisting conditions).

(II) Section 6D (relating to prior hospitalization).

(B) DEFINITIONS.—For purposes of this paragraph—

(i) MODEL PROVISIONS.—The terms "model regulation" and "model Act" mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of January 1993).

(ii) COORDINATION.—Any provision of the model regulation or model Act listed under clause (i) or (ii) of subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision.

(iii) DETERMINATION.—For purposes of this section and section 4980C, the determination of whether any requirement of a model regulation or the model Act has been met shall be made by the Secretary.

(3) DISCLOSURE REQUIREMENT.—The requirement of this paragraph is met with respect to any policy if such policy meets the requirements of section 4980C(d)(1).

(4) NONFORFEITURE REQUIREMENTS.—

(A) IN GENERAL.—The requirements of this paragraph are met with respect to any level premium long-term care insurance policy, if the issuer of such policy offers to the policyholder, including any group policyholder, a nonforfeiture provision meeting the requirements of subparagraph (B).

(B) REQUIREMENTS OF PROVISION.—The nonforfeiture provision required under subparagraph (A) shall meet the following requirements:

(i) The nonforfeiture provision shall be appropriately captioned.

(ii) The nonforfeiture provision shall provide for a benefit available in the event of a default in the payment of any premiums and the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying policies approved by the Secretary for the same policy form.

(iii) The nonforfeiture provision shall provide at least one of the following:

(I) Reduced paid-up insurance.

(II) Extended term insurance.

(III) Shortened benefit period.

(IV) Other similar offerings approved by the Secretary.

(5) LONG-TERM CARE INSURANCE POLICY DEFINED.—For purposes of this subsection, the term "long-term care insurance policy" has the meaning given such term by section 4980C(e).

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SOCIAL SECURITY ACT

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DEFINITION OF WAGES

SEC. 209. (a) For the purposes of this title, the term "wages" means remuneration paid prior to 1951 which was wages for the purposes of this title under the law applicable to the payment of such remuneration, and remuneration paid after 1950 for employment, including the cash value of all remuneration (including benefits) paid in any medium other than cash; except that, in the case of remuneration paid after 1950, such term shall not include—

(1) * * *

* * * * * * *

(17) Any benefit provided to or on behalf of an employee if at the time such benefit is provided it is reasonable to believe that the employee will be able to exclude such benefit from income under section 74(c), 117, or 132 of the Internal Revenue Code of 1986; **[**or**]**

(18) Remuneration consisting of income excluded from taxation under section 7873 of the Internal Revenue Code of 1986 (relating to income derived by Indians from exercise of fishing rights)**[**.**]**; or

(19) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b) of the Internal Revenue Code of 1986.

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[TITLE XI—GENERAL PROVISIONS AND PEER REVIEW**]** *TITLE XI—GENERAL PROVISIONS, PEER REVIEW, AND ADMINISTRATIVE SIMPLIFICATION*

PART A—GENERAL PROVISIONS

EXCLUSION OF CERTAIN INDIVIDUALS AND ENTITIES FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS

SEC. 1128. (a) MANDATORY EXCLUSION.—The Secretary shall exclude the following individuals and entities from participation in any program under title XVIII and shall direct that the following individuals and entities be excluded from participation in any State health care program (as defined in subsection (h)):

(1) * * *

* * * * * * *

(3) FELONY CONVICTION RELATING TO HEALTH CARE FRAUD.—Any individual or entity that has been convicted after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program (other than those specifically described in paragraph (1)) operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.

(4) FELONY CONVICTION RELATING TO CONTROLLED SUBSTANCE.—Any individual or entity that has been convicted after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

(b) PERMISSIVE EXCLUSION.—The Secretary may exclude the following individuals and entities from participation in any program under title XVIII and may direct that the following individuals and entities be excluded from participation in any State health care program:

[(1) CONVICTION RELATING TO FRAUD.—Any individual or entity that has been convicted, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a program operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.**]**

(1) CONVICTION RELATING TO FRAUD.—Any individual or entity that has been convicted after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, under Federal or State law—

(A) of a criminal offense consisting of a misdemeanor relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct—

(i) in connection with the delivery of a health care item or service, or

(ii) with respect to any act or omission in a health care program (other than those specifically described in subsection (a)(1)) operated by or financed in whole or in part by any Federal, State, or local government agency; or

(B) of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct with respect to any act or omission in a program (other than a health care program) operated by or financed in whole or in part by any Federal, State, or local government agency.

* * * * * * *

(3) **[**CONVICTION**]** *MISDEMEANOR CONVICTION RELATING TO CONTROLLED SUBSTANCE*.—Any individual or entity that has

been convicted, under Federal or State law, of a [criminal offense] *criminal offense consisting of a misdemeanor* relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

* * * * * * *

(15) INDIVIDUALS CONTROLLING A SANCTIONED ENTITY.—(A) Any individual—

(i) who has a direct or indirect ownership or control interest in a sanctioned entity and who knows or should know (as defined in section 1128A(i)(6)) of the action constituting the basis for the conviction or exclusion described in subparagraph (B); or

(ii) who is an officer or managing employee (as defined in section 1126(b)) of such an entity.

(B) For purposes of subparagraph (A), the term "sanctioned entity" means an entity—

(i) that has been convicted of any offense described in subsection (a) or in paragraph (1), (2), or (3) of this subsection; or

(ii) that has been excluded from participation under a program under title XVIII or under a State health care program.

(c) NOTICE, EFFECTIVE DATE, AND PERIOD OF EXCLUSION.—(1) * * *

* * * * * * *

(3)(A) * * *

* * * * * * *

(D) In the case of an exclusion of an individual or entity under paragraph (1), (2), or (3) of subsection (b), the period of the exclusion shall be 3 years, unless the Secretary determines in accordance with published regulations that a shorter period is appropriate because of mitigating circumstances or that a longer period is appropriate because of aggravating circumstances.

(E) In the case of an exclusion of an individual or entity under subsection (b)(4) or (b)(5), the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended, or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B), the period of the exclusion shall be not less than 1 year.

* * * * * * *

CIVIL MONETARY PENALTIES

SEC. 1128A. (a) Any person (including an organization, agency, or other entity, but excluding a beneficiary, as defined in subsection (i)(5)) that—

(1) *knowingly* presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency (as defined in subsection (i)(1)), a claim (as defined in subsection (i)(2)) that the Secretary determines—

(A) is for a medical or other item or service that the person knows or should know was not provided as [claimed], *claimed, including any person who engages in a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a code that the person knows or should know will result in a greater payment to the person than the code the person knows or should know is applicable to the item or service actually provided,*

(C) is presented for a physician's service (or an item or service incident to a physician's service) by a person who knows or should know that the individual who furnished (or supervised the furnishing of) the service—

(i) was not licensed as a physician,

(ii) was licensed as a physician, but such license had been obtained through a misrepresentation of material fact (including cheating on an examination required for licensing), or

(iii) represented to the patient at the time the service was furnished that the physician was certified in a medical specialty by a medical specialty board when the individual was not so certified, [or]

(D) is for a medical or other item or service furnished during a period in which the person was excluded from the program under which the claim was made pursuant to a determination by the Secretary under this section or under section 1128, 1156, 1160(b) (as in effect on September 2, 1982), 1862(d) (as in effect on the date of the enactment of the Medicare and Medicaid Patient and Program Protection Act of 1987), or 1866(b) or as a result of the application of the provisions of section 1842(j)(2); [or],*or*

(E) is for a medical or other item or service that a person knows or should know is not medically necessary; or

(2) *knowlingly* presents or causes to be presented to any person a request for payment which is in violation of the terms of (A) an assignment under section 1842(b)(3)(B)(ii), or (B) an agreement with a State agency (or other requirement of a State plan under title XIX) not to charge a person for an item or service in excess of the amount permitted to be charged, or (c) an agreement to be a participating physician or supplier under section 1842(h)(1), or (D) an agreement pursuant to section 1866(a)(1)(G), [or];

(3) [gives] *knowingly gives or causes to be given* to any person, with respect to coverage under title XVIII of inpatient hospital services subject to the provisions of section 1886, information that he knows or should know is false or misleading, and that could reasonably be expected to influence the decision when to discharge such person or another individual from the hospital[;];

(4) in the case of a person who is not an organization, agency, or other entity, is excluded from participating in a program under title XVIII or a State health care program in accordance with this subsection or under section 1128 and who, at the time of a violation of this subsection—

(A) retains a direct or indirect ownership or control interest in an entity that is participating in a program under title XVIII or a State health care program, and who knows or should know of the action constituting the basis for the exclusion; or

(B) is an officer or managing employee (as defined in section 1126(b) of such an entity; or

(5) offers to or transfers remuneration to any individual eligible for benefits under title XVIII of this Act, or under a State health care program (as defined in section 1128(h)) that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under title XVIII, or a State health care program (as so defined);

shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than [$2,000] *$10,000* for each item or service (or, in cases under paragraph (3) $15,000 for each individual with respect to whom false or misleading information was given*; in cases under paragraph (4), $10,000 for each day the prohibited relationship occurs*). In addition, such a person shall be subject to an assessment of not more than [twice the amount] *3 times the amount* claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim. In addition the Secretary may make a determination in the same proceeding to exclude the person from participation in the [programs under title XVIII] *Federal health care programs (as defined in section 1128B(f)(1))* and to direct the appropriate State agency to exclude the person from participation in any State health care program.

(b)(1) * * *

* * * * * * *

(3)(A) Any physician who executes a document described in subparagraph (B) with respect to an individual knowing that all of the requirements referred to in such subparagraph are not met with respect to the individual shall be subject to a civil monetary penalty of not more than the greater of—

(i) $5,000, or

(ii) three times the amount of the payments under title XVIII for home health services which are made pursuant to such certification.

(B) A document described in this subparagraph is any document that certifies, for purposes of title XVIII, that an individual meets the requirements of section 1814(a)(2)(C) or 1835(a)(2)(A) in the case of home health services furnished to the individual.

(f) Civil money penalties and assessments imposed under this section may be compromised by the Secretary and may be recovered in a civil action in the name of the United States brought in United States district court for the district where the claim was presented, or where the claimant resides, as determined by the Secretary. Amounts recovered under this section shall be paid to the Secretary and disposed of as follows:

(1) * * *

* * * * * * *

(3) With respect to amounts recovered arising out of a claim under a Federal health care program (as defined in section 1128B(f)), the portion of such amounts as is determined to have been paid by the program shall be repaid to the program, and the portion of such amounts attributable to the amounts recovered under this section by reason of the amendments made by the Health Coverage Availability and Affordability Act of 1996 (as estimated by the Secretary) shall be deposited into the Federal Hospital Insurance Trust Fund pursuant to section 1817(k)(2)(C).

[(3)**]** *(4)* The remainder of the amounts recovered shall be deposited as miscellaneous receipts of the Treasury of the United States.

The amount of such penalty or assessment, when finally determined, or the amount agreed upon in compromise, may be deducted from any sum then or later owing by the United States or a State agency to the person against whom the penalty or assessment has been assessed.

* * * * * * *

(i) For the purposes of this section:

(1) The term "State agency" means the agency established or designated to administer or supervise the administration of the State plan under title XIX of this Act or designed to administer the State's program under title V or XX of this Act.

(2) The term "claim" means an application for payments for items and services under **[**title V, XVIII, XIX, or XX of this Act**]** *a Federal health care program (as defined in section 1128B(f)).*

* * * * * * *

(4) The term "agency of the United States" includes any contractor acting as a fiscal intermediary, carrier, or fiscal agent or any other claims processing agent for **[**a health insurance or medical services program under title XVIII or XIX of this Act**]** *a Federal health care program (as so defined).*

(5) The term "beneficiary" means an individual who is eligible to receive items or services for which payment may be made under **[**title V, XVIII, XIX, or XX**]** but does not include a provider, supplier, or practitioner.

(6) The term "remuneration" includes the waiver of coinsurance and deductible amounts (or any part thereof), and transfers of items or services for free or for other than fair market value. The term "remuneration" does not include—

(A) the waiver of coinsurance and deductible amounts by a person, if—

(i) the waiver is not offered as part of any advertisement or solicitation;

(ii) the person does not routinely waive coinsurance or deductible amounts; and

(iii) the person—

(I) waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need;

(II) fails to collect coinsurance or deductible amounts after making reasonable collection efforts; or

(III) provides for any permissible waiver as specified in section 1128B(b)(3) or in regulations issued by the Secretary;

(B) differentials in coinsurance and deductible amounts as part of a benefit plan design as long as the differentials have been disclosed in writing to all beneficiaries, third party payers, and providers, to whom claims are presented and as long as the differentials meet the standards as defined in regulations promulgated by the Secretary not later than 180 days after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996; or

(C) incentives given to individuals to promote the delivery of preventive care as determined by the Secretary in regulations so promulgated.

(7) The term "should know" means that a person, with respect to information—

(A) acts in deliberate ignorance of the truth or falsity of the information; or

(B) acts in reckless disregard of the truth or falsity of the information,

and no proof of specific intent to defraud is required.

* * * * * * *

(m)(1) For purposes of this section, with respect to a Federal health care program not contained in this Act, references to the Secretary in this section shall be deemed to be references to the Secretary or Administrator of the department or agency with jurisdiction over such program and references to the Inspector General of the Department of Health and Human Services in this section shall be deemed to be references to the Inspector General of the applicable department or agency.

(2)(A) The Secretary and Administrator of the departments and agencies referred to in paragraph (1) may include in any action pursuant to this section, claims within the jurisdiction of other Federal departments or agencies as long as the following conditions are satisfied:

(i) The case involves primarily claims submitted to the Federal health care programs of the department or agency initiating the action.

(ii) The Secretary or Administrator of the department or agency initiating the action gives notice and an opportunity to participate in the investigation to the Inspector General of the department or agency with primary jurisdiction over the Federal health care programs to which the claims were submitted.

(B) If the conditions specified in subparagraph (A) are fulfilled, the Inspector General of the department or agency initiating the action is authorized to exercise all powers granted under the Inspector General Act of 1978 with respect to the claims submitted to the other departments or agencies to the same manner and extent as

provided in that Act with respect to claims submitted to such departments or agencies.

CRIMINAL PENALTIES FOR ACTS INVOLVING [MEDICARE OR STATE HEALTH CARE PROGRAMS] FEDERAL HEALTH CARE PROGRAMS

SEC. 1128B. (a) Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under [a program under title XVIII or a State health care program (as defined in section 1128(h))] *a Federal health care program*,

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person, [or]

(5) presents or causes to be presented a claim for a physician's service for which payment may be made under [a program under title XVIII or a State health care program] and knows that the individual who furnished the service was not licensed as a physician, or *a Federal health care program,*]

(6) knowingly and willfully disposes of assets (including by any transfer in trust) in order for an individual to become eligible for medical assistance under a State plan under title XIX, if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1917(c),

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under the program, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under [a State plan approved under title XIX] *a Federal health care program* is convicted of an offense under the preceding provisions of this subsection, [the State may at its option (notwithstanding any other provision of that title or of such plan)] *the administrator of such program may at its option (notwithstanding any other provision of such program)* limit, restrict or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or serv-

ice for which payment may be made in whole or in part under title XVIII or a State health care program, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under [title XVIII or a State health care program] *a Federal health care program*,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under [title XVIII or a State health care program] *a Federal health care program*, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under [title XVIII or a State health care program] *a Federal health care program*,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to—

(A) a discount or other reduction in price obtained by a provider of services or other entity under [title XVIII or a State health care program] *a Federal health care program* if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under [title XVIII or a State health care program] *a Federal health care program*;

* * * * * * *

(C) any amount paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of individuals or entities who are furnishing services reimbursed under [title XVIII or a State health care program] *a Federal health care program* if—

(i) * * *

* * * * * * *

(D) a waiver of any coinsurance under part B of title XVIII by a Federally qualified health care center with respect to an individual who qualifies for subsidized services under a provision of the Public Health Service Act; [and]

(E) any payment practice specified by the Secretary in regulations promulgated pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987[.]*; and*

(F) any remuneration between an organization and an individual or entity providing items or services, or a combination

thereof, pursuant to a written agreement between the organization and the individual or entity if the organization is an eligible organization under section 1876 or if the written agreement places the individual or entity at substantial financial risk for the cost or utilization of the items or services, or a combination thereof, which the individual or entity is obligated to provide, whether through a withhold, capitation, incentive pool, per diem payment, or any other similar risk arrangement which places the individual or entity at substantial financial risk.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution, facility, or entity in order that such institution, facility, or entity may qualify (either upon initial certification or upon recertification) as a hospital, rural primary care hospital, skilled nursing facility, nursing facility, intermediate care facility for the mentally retarded, or other entity (including an eligible organization under section 1876(b)) for which certification is required under title XVIII or a State health care program (*as defined in section 1128(h))*, or with respect to information required to be provided under section 1124A, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

* * * * * * *

(f) For purposes of this section, the term "Federal health care program" means—

(1) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the health insurance program under chapter 89 of title 5, United States Code); or

(2) any State health care program, as defined in section 1128(h).

FRAUD AND ABUSE CONTROL PROGRAM

SEC. 1128C. (a) ESTABLISHMENT OF PROGRAM.—

(1) IN GENERAL.—Not later than January 1, 1997, the Secretary, acting through the Office of the Inspector General of the Department of Health and Human Services, and the Attorney General shall establish a program—

(A) to coordinate Federal, State, and local law enforcement programs to control fraud and abuse with respect to health plans,

(B) to conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care in the United States,

(C) to facilitate the enforcement of the provisions of sections 1128, 1128A, and 1128B and other statutes applicable to health care fraud and abuse,

(D) to provide for the modification and establishment of safe harbors and to issue advisory opinions and special fraud alerts pursuant to section 1128D, and

(E) to provide for the reporting and disclosure of certain final adverse actions against health care providers, suppliers, or practitioners pursuant to the data collection system established under section 1128E.

(2) COORDINATION WITH HEALTH PLANS.—In carrying out the program established under paragraph (1), the Secretary and the Attorney General shall consult with, and arrange for the sharing of data with representatives of health plans.

(3) GUIDELINES.—

(A) IN GENERAL.—The Secretary and the Attorney General shall issue guidelines to carry out the program under paragraph (1). The provisions of sections 553, 556, and 557 of title 5, United States Code, shall not apply in the issuance of such guidelines.

(B) INFORMATION GUIDELINES.—

(i) IN GENERAL.—Such guidelines shall include guidelines relating to the furnishing of information by health plans, providers, and others to enable the Secretary and the Attorney General to carry out the program (including coordination with health plans under paragraph (2)).

(ii) CONFIDENTIALITY.—Such guidelines shall include procedures to assure that such information is provided and utilized in a manner that appropriately protects the confidentiality of the information and the privacy of individuals receiving health care services and items.

(iii) QUALIFIED IMMUNITY FOR PROVIDING INFORMATION.—The provisions of section 1157(a) (relating to limitation on liability) shall apply to a person providing information to the Secretary or the Attorney General in conjunction with their performance of duties under this section.

(4) ENSURING ACCESS TO DOCUMENTATION.—The Inspector General of the Department of Health and Human Services is authorized to exercise such authority described in paragraphs (3) through (9) of section 6 of the Inspector General Act of 1978 (5 U.S.C. App.) as necessary with respect to the activities under the fraud and abuse control program established under this subsection.

(5) AUTHORITY OF INSPECTOR GENERAL.—Nothing in this Act shall be construed to diminish the authority of any Inspector General, including such authority as provided in the Inspector General Act of 1978 (5 U.S.C. App.).

(b) ADDITIONAL USE OF FUNDS BY INSPECTOR GENERAL.—

(1) REIMBURSEMENTS FOR INVESTIGATIONS.—The Inspector General of the Department of Health and Human Services is authorized to receive and retain for current use reimbursement for the costs of conducting investigations and audits and for monitoring compliance plans when such costs are ordered by a court, voluntarily agreed to by the payor, or otherwise.

(2) CREDITING.—Funds received by the Inspector General under paragraph (1) as reimbursement for costs of conducting investigations shall be deposited to the credit of the appropriation from which initially paid, or to appropriations for similar

purposes currently available at the time of deposit, and shall remain available for obligation for 1 year from the date of the deposit of such funds.

(c) HEALTH PLAN DEFINED.—For purposes of this section, the term "health plan" means a plan or program that provides health benefits, whether directly, through insurance, or otherwise, and includes—

(1) a policy of health insurance;

(2) a contract of a service benefit organization; and

(3) a membership agreement with a health maintenance organization or other prepaid health plan.

GUIDANCE REGARDING APPLICATION OF HEALTH CARE FRAUD AND ABUSE SANCTIONS

SEC. 1128D. (a) SOLICITATION AND PUBLICATION OF MODIFICATIONS TO EXISTING SAFE HARBORS AND NEW SAFE HARBORS.—

(1) IN GENERAL.—

(A) SOLICITATION OF PROPOSALS FOR SAFE HARBORS.—Not later than January 1, 1997, and not less than annually thereafter, the Secretary shall publish a notice in the Federal Register soliciting proposals, which will be accepted during a 60-day period, for—

(i) modifications to existing safe harbors issued pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987 (42 U.S.C. 1320a–7b note);

(ii) additional safe harbors specifying payment practices that shall not be treated as a criminal offense under section 1128B(b) and shall not serve as the basis for an exclusion under section 1128(b)(7);

(iii) advisory opinions to be issued pursuant to subsection (b); and

(iv) special fraud alerts to be issued pursuant to subsection (c).

(B) PUBLICATION OF PROPOSED MODIFICATIONS AND PROPOSED ADDITIONAL SAFE HARBORS.—After considering the proposals described in clauses (i) and (ii) of subparagraph (A), the Secretary, in consultation with the Attorney General, shall publish in the Federal Register proposed modifications to existing safe harbors and proposed additional safe harbors, if appropriate, with a 60-day comment period. After considering any public comments received during this period, the Secretary shall issue final rules modifying the existing safe harbors and establishing new safe harbors, as appropriate.

(C) REPORT.—The Inspector General of the Department of Health and Human Services (in this section referred to as the "Inspector General") shall, in an annual report to Congress or as part of the year-end semiannual report required by section 5 of the Inspector General Act of 1978 (5 U.S.C. App.), describe the proposals received under clauses (i) and (ii) of subparagraph (A) and explain which proposals were included in the publication described in subparagraph (B), which proposals were not included in that publication, and

the reasons for the rejection of the proposals that were not included.

(2) CRITERIA FOR MODIFYING AND ESTABLISHING SAFE HARBORS.—In modifying and establishing safe harbors under paragraph (1)(B), the Secretary may consider the extent to which providing a safe harbor for the specified payment practice may result in any of the following:

(A) An increase or decrease in access to health care services.

(B) An increase or decrease in the quality of health care services.

(C) An increase or decrease in patient freedom of choice among health care providers.

(D) An increase or decrease in competition among health care providers.

(E) An increase or decrease in the ability of health care facilities to provide services in medically underserved areas or to medically underserved populations.

(F) An increase or decrease in the cost to Federal health care programs (as defined in section 1128B(f)).

(G) An increase or decrease in the potential overutilization of health care services.

(H) The existence or nonexistence of any potential financial benefit to a health care professional or provider which may vary based on their decisions of—

(i) whether to order a health care item or service; or

(ii) whether to arrange for a referral of health care items or services to a particular practitioner or provider.

(I) Any other factors the Secretary deems appropriate in the interest of preventing fraud and abuse in Federal health care programs (as so defined).

(b) ADVISORY OPINIONS.—

(1) ISSUANCE OF ADVISORY OPINIONS.—The Secretary shall issue written advisory opinions as provided in this subsection.

(2) MATTERS SUBJECT TO ADVISORY OPINIONS.—The Secretary shall issue advisory opinions as to the following matters:

(A) What constitutes prohibited remuneration within the meaning of section 1128B(b).

(B) Whether an arrangement or proposed arrangement satisfies the criteria set forth in section 1128B(b)(3) for activities which do not result in prohibited remuneration.

(C) Whether an arrangement or proposed arrangement satisfies the criteria which the Secretary has established, or shall establish by regulation for activities which do not result in prohibited remuneration.

(D) What constitutes an inducement to reduce or limit services to individuals entitled to benefits under title XVIII or title XIX or title XXI within the meaning of section 1128B(b).

(E) Whether any activity or proposed activity constitutes grounds for the imposition of a sanction under section 1128, 1128A, or 1128B.

(3) MATTERS NOT SUBJECT TO ADVISORY OPINIONS.—Such advisory opinions shall not address the following matters:

(A) Whether the fair market value shall be, or was paid or received for any goods, services or property.

(B) Whether an individual is a bona fide employee within the requirements of section 3121(d)(2) of the Internal Revenue Code of 1986.

(4) EFFECT OF ADVISORY OPINIONS.—

(A) BINDING AS TO SECRETARY AND PARTIES INVOLVED.—Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion.

(B) FAILURE TO SEEK OPINION.—The failure of a party to seek an advisory opinion may not be introduced into evidence to prove that the party intended to violate the provisions of sections 1128, 1128A, or 1128B.

(5) REGULATIONS.—

(A) IN GENERAL.—Not later than 180 days after the date of the enactment of this section, the Secretary shall issue regulations to carry out this section. Such regulations shall provide for—

(i) the procedure to be followed by a party applying for an advisory opinion;

(ii) the procedure to be followed by the Secretary in responding to a request for an advisory opinion;

(iii) the interval in which the Secretary shall respond;

(iv) the reasonable fee to be charged to the party requesting an advisory opinion; and

(v) the manner in which advisory opinions will be made available to the public.

(B) SPECIFIC CONTENTS.—Under the regulations promulgated pursuant to subparagraph (A)—

(i) the Secretary shall be required to respond to a party requesting an advisory opinion by not later than 30 days after the request is received; and

(ii) the fee charged to the party requesting an advisory opinion shall be equal to the costs incurred by the Secretary in responding to the request.

(c) SPECIAL FRAUD ALERTS.—

(1) IN GENERAL.—

(A) REQUEST FOR SPECIAL FRAUD ALERTS.—Any person may present, at any time, a request to the Inspector General for a notice which informs the public of practices which the Inspector General considers to be suspect or of particular concern under the medicare program or a State health care program, as defined in section 1128(h) (in this subsection referred to as a "special fraud alert").

(B) ISSUANCE AND PUBLICATION OF SPECIAL FRAUD ALERTS.—Upon receipt of a request described in subparagraph (A), the Inspector General shall investigate the subject matter of the request to determine whether a special fraud alert should be issued. If appropriate, the Inspector General shall issue a special fraud alert in response to the

request. All special fraud alerts issued pursuant to this subparagraph shall be published in the Federal Register.

(2) CRITERIA FOR SPECIAL FRAUD ALERTS.—In determining whether to issue a special fraud alert upon a request described in paragraph (1), the Inspector General may consider—

(A) whether and to what extent the practices that would be identified in the special fraud alert may result in any of the consequences described in subsection (a)(2); and

(B) the volume and frequency of the conduct that would be identified in the special fraud alert.

HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM

SEC. 1128E. (a) GENERAL PURPOSE.—Not later than January 1, 1997, the Secretary shall establish a national health care fraud and abuse data collection program for the reporting of final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners as required by subsection (b), with access as set forth in subsection (c).

(b) REPORTING OF INFORMATION.—

(1) IN GENERAL.—Each Government agency and health plan shall report any final adverse action (not including settlements in which no findings of liability have been made) taken against a health care provider, supplier, or practitioner.

(2) INFORMATION TO BE REPORTED.—The information to be reported under paragraph (1) includes:

(A) The name and TIN (as defined in section 7701(a)(41) of the Internal Revenue Code of 1986) of any health care provider, supplier, or practitioner who is the subject of a final adverse action.

(B) The name (if known) of any health care entity with which a health care provider, supplier, or practitioner is affiliated or associated.

(C) The nature of the final adverse action and whether such action is on appeal.

(D) A description of the acts or omissions and injuries upon which the final adverse action was based, and such other information as the Secretary determines by regulation is required for appropriate interpretation of information reported under this section.

(3) CONFIDENTIALITY.—In determining what information is required, the Secretary shall include procedures to assure that the privacy of individuals receiving health care services is appropriately protected.

(4) TIMING AND FORM OF REPORTING.—The information required to be reported under this subsection shall be reported regularly (but not less often than monthly) and in such form and manner as the Secretary prescribes. Such information shall first be required to be reported on a date specified by the Secretary.

(5) TO WHOM REPORTED.—The information required to be reported under this subsection shall be reported to the Secretary.

(c) DISCLOSURE AND CORRECTION OF INFORMATION.—

(1) DISCLOSURE.—With respect to the information about final adverse actions (not including settlements in which no findings of liability have been made) reported to the Secretary under this section respecting a health care provider, supplier, or practitioner, the Secretary shall, by regulation, provide for—

(A) disclosure of the information, upon request, to the health care provider, supplier, or licensed practitioner, and

(B) procedures in the case of disputed accuracy of the information.

(2) CORRECTIONS.—Each Government agency and health plan shall report corrections of information already reported about any final adverse action taken against a health care provider, supplier, or practitioner, in such form and manner that the Secretary prescribes by regulation.

(d) ACCESS TO REPORTED INFORMATION.—

(1) AVAILABILITY.—The information in this database shall be available to Federal and State government agencies and health plans pursuant to procedures that the Secretary shall provide by regulation.

(2) FEES FOR DISCLOSURE.—The Secretary may establish or approve reasonable fees for the disclosure of information in this database (other than with respect to requests by Federal agencies). The amount of such a fee shall be sufficient to recover the full costs of operating the database. Such fees shall be available to the Secretary or, in the Secretary's discretion to the agency designated under this section to cover such costs.

(e) PROTECTION FROM LIABILITY FOR REPORTING.—No person or entity, including the agency designated by the Secretary in subsection (b)(5) shall be held liable in any civil action with respect to any report made as required by this section, without knowledge of the falsity of the information contained in the report.

(f) DEFINITIONS AND SPECIAL RULES.—For purposes of this section:

(1) FINAL ADVERSE ACTION.—

(A) IN GENERAL.—The term "final adverse action" includes:

(i) Civil judgments against a health care provider, supplier, or practitioner in Federal or State court related to the delivery of a health care item or service.

(ii) Federal or State criminal convictions related to the delivery of a health care item or service.

(iii) Actions by Federal or State agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners, including—

(I) formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, censure or probation,

(II) any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise, or

(III) any other negative action or finding by such Federal or State agency that is publicly available information.

(iv) Exclusion from participation in Federal or State health care programs.

(v) Any other adjudicated actions or decisions that the Secretary shall establish by regulation.

(B) EXCEPTION.—The term does not include any action with respect to a malpractice claim.

(2) PRACTITIONER.—The terms "licensed health care practitioner", "licensed practitioner", and "practitioner" mean, with respect to a State, an individual who is licensed or otherwise authorized by the State to provide health care services (or any individual who, without authority holds himself or herself out to be so licensed or authorized).

(3) GOVERNMENT AGENCY.—The term "Government agency" shall include:

(A) The Department of Justice.

(B) The Department of Health and Human Services.

(C) Any other Federal agency that either administers or provides payment for the delivery of health care services, including, but not limited to the Department of Defense and the Veterans' Administration.

(D) State law enforcement agencies.

(E) State medicaid fraud control units.

(F) Federal or State agencies responsible for the licensing and certification of health care providers and licensed health care practitioners.

(4) HEALTH PLAN.—The term "health plan" has the meaning given such term by section 1128C(c).

(5) DETERMINATION OF CONVICTION.—For purposes of paragraph (1), the existence of a conviction shall be determined under paragraph (4) of section 1128(i).".

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PART B—PEER REVIEW OF THE UTILIZATION AND QUALITY OF HEALTH CARE SERVICES

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OBLIGATIONS OF HEALTH CARE PRACTITIONERS AND PROVIDERS OF HEALTH CARE SERVICES; SANCTIONS AND PENALTIES; HEARINGS AND REVIEW

SEC. 1156. (a) * * *

(b)(1) If after reasonable notice and opportunity for discussion with the practitioner or person concerned, and, if appropriate, after the practitioner or person has been given a reasonable opportunity to enter into and complete a corrective action plan (which may include remedial education) agreed to by the organization, and has failed successfully to complete such plan, any organization having a contract with the Secretary under this part determines that such practitioner or person has—

(A) failed in a substantial number of cases substantially to comply with any obligation imposed on him under subsection (a), or

(B) grossly and flagrantly violated any such obligation in one or more instances,

such organization shall submit a report and recommendations to the Secretary. If the Secretary agrees with such determination, [and determines that such practitioner or person, in providing health care services over which such organization has review responsibility and for which payment (in whole or in part) may be made under this Act, has demonstrated an unwillingness or a lack of ability substantially to comply with such obligations,] the Secretary (in addition to any other sanction provided under law) may exclude (permanently or for such period as the Secretary [may prescribe)] *may prescribe, except that such period may not be less than 1 year)* such practitioner or person from eligibility to provide services under this Act on a reimbursable basis. [In determining whether a practitioner or person has demonstrated an unwillingness or lack of ability substantially to comply with such obligations, the Secretary shall consider the practitioner's or person's willingness or lack of ability, during the period before the organization submits its report and recommendations, to enter into and successfully complete a corrective action plan.] If the Secretary fails to act upon the recommendations submitted to him by such organization within 120 days after such submission, such practitioner or person shall be excluded from eligibility to provide services on a reimbursable basis until such time as the Secretary determines otherwise.

(2) A determination made by the Secretary under this subsection to exclude a practitioner or person shall be effective on the same date and in the same manner as an exclusion from participation under the programs under this Act becomes effective under section 1128(c), and [shall remain] *shall (subject to the minimum period specified in the second sentence of paragraph (1)) remain* in effect until the Secretary finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

(3) In lieu of the sanction authorized by paragraph (1), the Secretary may require that (as a condition to the continued eligibility of such practitioner or person to provide such health care services on a reimbursable basis) such practitioner or person pays to the United States, in case such acts or conduct involved the provision or ordering by such practitioner or person of health care services which were medically improper or unnecessary, an amount not in excess of [the actual or estimated cost] *up to $10,000 for each instance* of the medically improper or unnecessary services so provided. Such amount may be deducted from any sums owing by the United States (or any instrumentality thereof) to the practitioner or person from whom such amount is claimed.

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PART C—ADMINISTRATIVE SIMPLIFICATION

"SEC. 1171. DEFINITIONS.

For purposes of this part:

"(1) CLEARINGHOUSE.—The term "clearinghouse" means a public or private entity that—

(A) processes or facilitates the processing of nonstandard data elements of health information into standard data elements; or

(B) provides the means by which persons may meet the requirements of this part.

(2) CODE SET.—The term "code set" means any set of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes.

(3) HEALTH CARE PROVIDER.—The term "health care provider" includes a provider of services (as defined in section 1861(u)), a provider of medical or other health services (as defined in section 1861(s)), and any other person furnishing health care services or supplies.

(4) HEALTH INFORMATION.—The term "health information" means any information, whether oral or recorded in any form or medium that—

(A) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or clearinghouse; and

(B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

(5) HEALTH PLAN.—The term "health plan" means a plan which provides, or pays the cost of, health benefits. Such term includes the following, or any combination thereof:

(A) Part A or part B of the medicare program under title XVIII.

(B) The medicaid program under title XIX.

(C) A medicare supplemental policy (as defined in section 1882(g)(1)).

(D) Coverage issued as a supplement to liability insurance.

(E) General liability insurance.

(F) Worker's compensation or similar insurance.

(G) Automobile or automobile medical-payment insurance.

(H) A long-term care policy, including a nursing home fixed indemnity policy (unless the Secretary determines that such a policy does not provide sufficiently comprehensive coverage of a benefit so that the policy should be treated as a health plan).

(I) A hospital or fixed indemnity income-protection policy.

(J) An employee welfare benefit plan, as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(1)), but only to the extent the plan is established or maintained for the purpose of providing

health benefits and has 50 or more participants (as defined in section 3(7) of such Act).

(K) An employee welfare benefit plan or any other arrangement which is established or maintained for the purpose of offering or providing health benefits to the employees of 2 or more employers.

(L) The health care program for active military personnel under title 10, United States Code.

(M) The veterans health care program under chapter 17 of title 38, United States Code.

(N) The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), as defined in section 1073(4) of title 10, United States Code.

(O) The Indian health service program under the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

(P) The Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code.

(Q) Such other plan or arrangement as the Secretary determines is a health plan.

(6) INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.—The term "individually identifiable health information" means any information, including demographic information collected from an individual, that—

(A) is created or received by a health care provider, health plan, employer, or clearinghouse; and

(B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and—

(i) identifies the individual; or

(ii) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

(7) STANDARD.—The term "standard", when used with reference to a data element of health information or a transaction referred to in section 1173(a)(1), means any such data element or transaction that meets each of the standards and implementation specifications adopted or established by the Secretary with respect to the data element or transaction under sections 1172 and 1173.

(8) STANDARD SETTING ORGANIZATION.—The term "standard setting organization" means a standard setting organization accredited by the American National Standards Institute, including the National Council for Prescription Drug Programs, that develops standards for information transactions, data elements, or any other standard that is necessary to, or will facilitate, the implementation of this part.

SEC. 1172. GENERAL REQUIREMENTS FOR ADOPTION OF STANDARDS.

(a) APPLICABILITY.—Any standard or modification of a standard adopted under this part shall apply to the following persons:

(1) A health plan.

(2) A clearinghouse.

(3) A health care provider who transmits any health information in electronic form in connection with a transaction referred to in section 1173(a)(1).

(b) REDUCTION OF COSTS.—Any standard or modification of a standard adopted under this part shall be consistent with the objective of reducing the administrative costs of providing and paying for health care.

(c) ROLE OF STANDARD SETTING ORGANIZATIONS.—

(1) IN GENERAL.—Except as provided in paragraph (2), any standard or modification of a standard adopted under this part shall be developed or modified by a standard setting organization.

(2) SPECIAL RULES.—

(A) DIFFERENT STANDARDS.—The Secretary may adopt a standard or modification of a standard that is different from any standard developed or modified by a standard setting organization, if—

(i) the different standard or modification will substantially reduce administrative costs to health care providers and health plans compared to the alternatives; and

(ii) the standard or modification is promulgated in accordance with the rulemaking procedures of subchapter III of chapter 5 of title 5, United States Code.

(B) NO STANDARD BY STANDARD SETTING ORGANIZATION.—If no standard setting organization has adopted or modified any standard relating to a standard, or a modification of a standard, that the Secretary is authorized or required to adopt under this part—

(i) paragraph (1) shall not apply; and

(ii) subsection (f) shall apply.

(d) IMPLEMENTATION SPECIFICATIONS.—The Secretary shall establish specifications for implementing each of the standards and modifications adopted under this part.

(e) PROTECTION OF TRADE SECRETS.—Except as otherwise required by law, a standard or modification of a standard adopted under this part shall not require disclosure of trade secrets or confidential commercial information by a person required to comply with this part.

(f) ASSISTANCE TO THE SECRETARY.—In complying with the requirements of this part, the Secretary shall rely on the recommendations of the Health Information Advisory Committee established under section 1179 and shall consult with appropriate Federal and State agencies and private organizations. The Secretary shall publish in the Federal Register the recommendations of the Health Information Advisory Committee regarding the adoption of a standard or modification of a standard under this part.

SEC. 1173. STANDARDS FOR INFORMATION TRANSACTIONS AND DATA ELEMENTS.

(a) STANDARDS TO ENABLE ELECTRONIC EXCHANGE.—

(1) IN GENERAL.—The Secretary shall adopt standards for transactions, and data elements for such transactions, to enable health information to be exchanged electronically, that are—

(A) appropriate for the financial and administrative transactions described in paragraph (2); and

(B) related to other financial and administrative transactions determined appropriate by the Secretary consistent with the goals of improving the operation of the health care system and reducing administrative costs.

(2) TRANSACTIONS.—The transactions referred to in paragraph (1)(A) are the following:

(A) Claims (including coordination of benefits) or equivalent encounter information.

(B) Claims attachments.

(C) Enrollment and disenrollment.

(D) Eligibility.

(E) Health care payment and remittance advice.

(F) Premium payments.

(G) First report of injury.

(H) Claims status.

(I) Referral certification and authorization.

(3) ACCOMMODATION OF SPECIFIC PROVIDERS.—The standards adopted by the Secretary under paragraph (1) shall accommodate the needs of different types of health care providers.

(b) UNIQUE HEALTH IDENTIFIERS.—

(1) IN GENERAL.—The Secretary shall adopt standards providing for a standard unique health identifier for each individual, employer, health plan, and health care provider for use in the health care system. In carrying out the preceding sentence for each health plan and health care provider, the Secretary shall take into account multiple uses for identifiers and multiple locations and specialty classifications for health care providers.

(2) USE OF IDENTIFIERS.—The standards adopted under paragraphs (1) shall specify the purposes for which a unique health identifier may be used.

(c) CODE SETS.—

(1) IN GENERAL.—The Secretary shall adopt standards that—

(A) select code sets for appropriate data elements for the transactions referred to in subsection (a)(1) from among the code sets that have been developed by private and public entities; or

(B) establish code sets for such data elements if no code sets for the data elements have been developed.

(2) DISTRIBUTION.—The Secretary shall establish efficient and low-cost procedures for distribution (including electronic distribution) of code sets and modifications made to such code sets under section 1174(b).

(d) SECURITY STANDARDS FOR HEALTH INFORMATION.—

(1) SECURITY STANDARDS.—The Secretary shall adopt security standards that—

(A) take into account—

(i) the technical capabilities of record systems used to maintain health information;

(ii) the costs of security measures;

(iii) the need for training persons who have access to health information;

(iv) the value of audit trails in computerized record systems; and

(v) the needs and capabilities of small health care providers and rural health care providers (as such providers are defined by the Secretary); and

(B) ensure that a clearinghouse, if it is part of a larger organization, has policies and security procedures which isolate the activities of the clearinghouse with respect to processing information in a manner that prevents unauthorized access to such information by such larger organization.

(2) SAFEGUARDS.—Each person described in section 1172(a) who maintains or transmits health information shall maintain reasonable and appropriate administrative, technical, and physical safeguards—

(A) to ensure the integrity and confidentiality of the information;

(B) to protect against any reasonably anticipated—

(i) threats or hazards to the security or integrity of the information; and

(ii) unauthorized uses or disclosures of the information; and

(C) otherwise to ensure compliance with this part by the officers and employees of such person.

(e) PRIVACY STANDARDS FOR HEALTH INFORMATION.—The Secretary shall adopt standards with respect to the privacy of individually identifiable health information. Such standards shall include standards concerning at least the following:

(1) The rights of an individual who is a subject of such information.

(2) The procedures to be established for the exercise of such rights.

(3) The uses and disclosures of such information that are authorized or required.

(f) ELECTRONIC SIGNATURE.—

(1) IN GENERAL.—The Secretary, in coordination with the Secretary of Commerce, shall adopt standards specifying procedures for the electronic transmission and authentication of signatures, compliance with which shall be deemed to satisfy Federal and State statutory requirements for written signatures with respect to the transactions referred to in subsection (a)(1).

(2) PAYMENTS FOR SERVICES AND PREMIUMS.—Nothing in this part shall be construed to prohibit payment for health care services or health plan premiums by debit, credit, payment card or numbers, or other electronic means.

(g) TRANSFER OF INFORMATION BETWEEN HEALTH PLANS.—The Secretary shall adopt standards for transferring among health plans appropriate standard data elements needed for the coordination of benefits, the sequential processing of claims, and other data elements for individuals who have more than one health plan.

SEC. 1174. TIMETABLES FOR ADOPTION OF STANDARDS.

(a) INITIAL STANDARDS.—The Secretary shall carry out section 1173 not later than 18 months after the date of the enactment of

this part, except that standards relating to claims attachments shall be adopted not later than 30 months after such date.

(b) ADDITIONS AND MODIFICATIONS TO STANDARDS.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary shall review the standards adopted under section 1173, and shall adopt additional or modified standards, as determined appropriate, but not more frequently than once every 6 months. Any addition or modification to a standard shall be completed in a manner which minimizes the disruption and cost of compliance.

(2) SPECIAL RULES.—

(A) FIRST 12-MONTH PERIOD.—Except with respect to additions and modifications to code sets under subparagraph (B), the Secretary may not adopt any modification to a standard adopted under this part during the 12-month period beginning on the date the standard is initially adopted, unless the Secretary determines that the modification is necessary in order to permit compliance with the standard.

(B) ADDITIONS AND MODIFICATIONS TO CODE SETS.—

(i) IN GENERAL.—The Secretary shall ensure that procedures exist for the routine maintenance, testing, enhancement, and expansion of code sets.

(ii) ADDITIONAL RULES.—If a code set is modified under this subsection, the modified code set shall include instructions on how data elements of health information that were encoded prior to the modification may be converted or translated so as to preserve the informational value of the data elements that existed before the modification. Any modification to a code set under this subsection shall be implemented in a manner that minimizes the disruption and cost of complying with such modification.

SEC. 1175. REQUIREMENTS.

(a) CONDUCT OF TRANSACTIONS BY PLANS.—

(1) IN GENERAL.—If a person desires to conduct a transaction referred to in section 1173(a)(1) with a health plan as a standard transaction—

(A) the health plan may not refuse to conduct such transaction as a standard transaction;

(B) the health plan may not delay such transaction, or otherwise adversely affect, or attempt to adversely affect, the person or the transaction on the ground that the transaction is a standard transaction; and

(C) the information transmitted and received in connection with the transaction shall be in the form of standard data elements of health information.

(2) SATISFACTION OF REQUIREMENTS.—A health plan may satisfy the requirements under paragraph (1) by—

(A) directly transmitting and receiving standard data elements of health information; or

(B) submitting nonstandard data elements to a clearinghouse for processing into standard data elements and transmission by the clearinghouse, and receiving standard data elements through the clearinghouse.

(3) TIMETABLE FOR COMPLIANCE.—Paragraph (1) shall not be construed to require a health plan to comply with any standard, implementation specification, or modification to a standard or specification adopted or established by the Secretary under sections 1172 and 1173 at any time prior to the date on which the plan is required to comply with the standard or specification under subsection (b).

(b) COMPLIANCE WITH STANDARDS.—

(1) INITIAL COMPLIANCE.—

(A) IN GENERAL.—Not later than 24 months after the date on which an initial standard or implementation specification is adopted or established under sections 1172 and 1173, each person to whom the standard or implementation specification applies shall comply with the standard or specification.

(B) SPECIAL RULE FOR SMALL HEALTH PLANS.—In the case of a small health plan, paragraph (1) shall be applied by substituting "36 months" for "24 months". For purposes of this subsection, the Secretary shall determine the plans that qualify as small health plans.

(2) COMPLIANCE WITH MODIFIED STANDARDS.—If the Secretary adopts a modification to a standard or implementation specification under this part, each person to whom the standard or implementation specification applies shall comply with the modified standard or implementation specification at such time as the Secretary determines appropriate, taking into account the time needed to comply due to the nature and extent of the modification. The time determined appropriate under the preceding sentence may not be earlier than the last day of the 180-day period beginning on the date such modification is adopted. The Secretary may extend the time for compliance for small health plans, if the Secretary determines that such extension is appropriate.

SEC. 1176. GENERAL PENALTY FOR FAILURE TO COMPLY WITH REQUIREMENTS AND STANDARDS.

(a) GENERAL PENALTY.—

(1) IN GENERAL.—Except as provided in subsection (b), the Secretary shall impose on any person who violates a provision of this part a penalty of not more than $100 for each such violation, except that the total amount imposed on the person for all violations of an identical requirement or prohibition during a calendar year may not exceed $25,000.

(2) PROCEDURES.—The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to the imposition of a civil money penalty under this subsection in the same manner as such provisions apply to the imposition of a penalty under such section 1128A.

(b) LIMITATIONS.—

(1) OFFENSES OTHERWISE PUNISHABLE.—A penalty may not be imposed under subsection (a) with respect to an act if the act constitutes an offense punishable under section 1177.

(2) NONCOMPLIANCE NOT DISCOVERED.—A penalty may not be imposed under subsection (a) with respect to a provision of this part if it is established to the satisfaction of the Secretary that

the person liable for the penalty did not know, and by exercising reasonable diligence would not have known, that such person violated the provision.

(3) FAILURES DUE TO REASONABLE CAUSE.—

(A) IN GENERAL.—Except as provided in subparagraph (B), a penalty may not be imposed under subsection (a) if—

(i) the failure to comply was due to reasonable cause and not to willful neglect; and

(ii) the failure to comply is corrected during the 30-day period beginning on the first date the person liable for the penalty knew, or by exercising reasonable diligence would have known, that the failure to comply occurred.

(B) EXTENSION OF PERIOD.—

(i) NO PENALTY.—The period referred to in subparagraph (A)(ii) may be extended as determined appropriate by the Secretary based on the nature and extent of the failure to comply.

(ii) ASSISTANCE.—If the Secretary determines that a person failed to comply because the person was unable to comply, the Secretary may provide technical assistance to the person during the period described in subparagraph (A)(ii). Such assistance shall be provided in any manner determined appropriate by the Secretary.

(4) REDUCTION.—In the case of a failure to comply which is due to reasonable cause and not to willful neglect, any penalty under subsection (a) that is not entirely waived under paragraph (3) may be waived to the extent that the payment of such penalty would be excessive relative to the compliance failure involved.

SEC. 1177. WRONGFUL DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

(a) OFFENSE.—A person who knowingly and in violation of this part—

(1) uses or causes to be used a unique health identifier;

(2) obtains individually identifiable health information relating to an individual; or

(3) discloses individually identifiable health information to another person,

shall be punished as provided in subsection (b).

(b) PENALTIES.—A person described in subsection (a) shall—

(1) be fined not more than $50,000, imprisoned not more than 1 year, or both;

(2) if the offense is committed under false pretenses, be fined not more than $100,000, imprisoned not more than 5 years, or both; and

(3) if the offense is committed with intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm, fined not more than $250,000, imprisoned not more than 10 years, or both.

SEC. 1178. EFFECT ON STATE LAW.

(a) GENERAL EFFECT.—

(1) GENERAL RULE.—Except as provided in paragraph (2), a provision or requirement under this part, or a standard or implementation specification adopted or established under sections 1172 and 1173, shall supersede any contrary provision of State law, including a provision of State law that requires medical or health plan records (including billing information) to be maintained or transmitted in written rather than electronic form.

(2) EXCEPTIONS.—A provision or requirement under this part, or a standard or implementation specification adopted or established under sections 1172 and 1173, shall not supersede a contrary provision of State law, if the provision of State law—

(A) imposes requirements, standards, or implementation specifications that are more stringent than the requirements, standards, or implementation specifications under this part with respect to the privacy of individually identifiable health information; or

(B) is a provision the Secretary determines—

(i) is necessary to prevent fraud and abuse, or for other purposes; or

(ii) addresses controlled substances.

(b) PUBLIC HEALTH REPORTING.—Nothing in this part shall be construed to invalidate or limit the authority, power, or procedures established under any law providing for the reporting of disease or injury, child abuse, birth, or death, public health surveillance, or public health investigation or intervention.

SEC. 1179. HEALTH INFORMATION ADVISORY COMMITTEE.

(a) ESTABLISHMENT.—There is established a committee to be known as the Health Information Advisory Committee (in this section referred to as the "committee").

(b) DUTIES.—The committee shall—

(1) provide assistance to the Secretary in complying with the requirements imposed on the Secretary under this part;

(2) study the issues related to the adoption of uniform data standards for patient medical record information and the electronic exchange of such information;

(3) report to the Secretary not later than 4 years after the date of the enactment of this part recommendations and legislative proposals for such standards and electronic exchange; and

(4) generally be responsible for advising the Secretary and the Congress on the status of the implementation of this part.

(c) MEMBERSHIP.—

(1) IN GENERAL.—The committee shall consist of 15 members of whom—

(A) 3 shall be appointed by the President;

(B) 6 shall be appointed by the Speaker of the House of Representatives after consultation with the minority leader of the House of Representatives; and

(C) 6 shall be appointed by the President pro tempore of the Senate after consultation with the minority leader of the Senate.

The appointments of the members shall be made not later than 60 days after the date of the enactment of this part. The President shall designate 1 member as the Chair.

(2) EXPERTISE.—The membership of the committee shall consist of individuals who are of recognized standing and distinction in the areas of information systems, information networking and integration, consumer health, health care financial management, or privacy, and who possess the demonstrated capacity to discharge the duties imposed on the committee.

(3) TERMS.—Each member of the committee shall be appointed for a term of 5 years, except that the members first appointed shall serve staggered terms such that the terms of not more than 3 members expire at one time.

(4) INITIAL MEETING.—Not later than 30 days after the date on which a majority of the members have been appointed, the committee shall hold its first meeting.

(d) REPORTS.—Not later than 1 year after the date of the enactment of this part, and annually thereafter, the committee shall submit to the Congress, and make public, a report regarding—

(1) the extent to which persons required to comply with this part are cooperating in implementing the standards adopted under this part;

(2) the extent to which such entities are meeting the privacy and security standards adopted under this part and the types of penalties assessed for noncompliance with such standards;

(3) whether the Federal and State Governments are receiving information of sufficient quality to meet their responsibilities under this part;

(4) any problems that exist with respect to implementation of this part; and

(5) the extent to which timetables under this part are being met.

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TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

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PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

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USE OF PUBLIC AGENCIES OR PRIVATE ORGANIZATIONS TO FACILITATE PAYMENT TO PROVIDERS OF SERVICES

SEC. 1816. (a) * * *

* * * * * * *

(l) No agency or organization may carry out (or receive payment for carrying out) any activity pursuant to an agreement under this section to the extent that the activity is carried out pursuant to a contract under the Medicare Integrity Program under section 1893.

FEDERAL HOSPITAL INSURANCE TRUST FUND

SEC. 1817. (a) * * *

* * * * * * *

(k) HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.—

(1) ESTABLISHMENT.—There is hereby established in the Trust Fund an expenditure account to be known as the "Health Care Fraud and Abuse Control Account" (in this subsection referred to as the "Account").

(2) APPROPRIATED AMOUNTS TO TRUST FUND.—

(A) IN GENERAL.—There are hereby appropriated to the Trust Fund—

(i) such gifts and bequests as may be made as provided in subparagraph (B);

(ii) such amounts as may be deposited in the Trust Fund as provided in sections 242(b) and 249(c) of the Health Coverage Availability and Affordability Act of 1996, and title XI; and

(iii) such amounts as are transferred to the Trust Fund under subparagraph (C).

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

(C) TRANSFER OF AMOUNTS.—The Managing Trustee shall transfer to the Trust Fund, under rules similar to the rules in section 9601 of the Internal Revenue Code of 1986, an amount equal to the sum of the following:

(i) Criminal fines recovered in cases involving a Federal health care offense (as defined in section 982(a)(6)(B) of title 18, United States Code).

(ii) Civil monetary penalties and assessments imposed in health care cases, including amounts recovered under titles XI, XVIII, and XIX, and chapter 38 of title 31, United States Code (except as otherwise provided by law).

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

(iv) Penalties and damages obtained and otherwise creditable to miscellaneous receipts of the general fund of the Treasury obtained under sections 3729 through 3733 of title 31, United States Code (known as the False Claims Act), in cases involving claims related to the provision of health care items and services (other than funds awarded to a relator, for restitution or otherwise authorized by law).

(3) APPROPRIATED AMOUNTS TO ACCOUNT FOR FRAUD AND ABUSE CONTROL PROGRAM, ETC.—

(A) DEPARTMENTS OF HEALTH AND HUMAN SERVICES AND JUSTICE.—

(i) IN GENERAL.—There are hereby appropriated to the Account from the Trust Fund such sums as the Secretary and the Attorney General certify are necessary to

carry out the purposes described in subparagraph (C), to be available without further appropriation, in an amount not to exceed—

(I) for fiscal year 1997, $104,000,000,

(II) for each of the fiscal years 1998 through 2003, the limit for the preceding fiscal year, increased by 15 percent; and

(III) for each fiscal year after fiscal year 2003, the limit for fiscal year 2003.

(ii) MEDICARE AND MEDICAID ACTIVITIES.—For each fiscal year, of the amount appropriated in clause (i), the following amounts shall be available only for the purposes of the activities of the Office of the Inspector General of the Department of Health and Human Services with respect to the medicare and medicaid programs—

(I) for fiscal year 1997, not less than $60,000,000 and not more than $70,000,000;

(II) for fiscal year 1998, not less than $80,000,000 and not more than $90,000,000;

(III) for fiscal year 1999, not less than $90,000,000 and not more than $100,000,000;

(IV) for fiscal year 2000, not less than $110,000,000 and not more than $120,000,000;

(V) for fiscal year 2001, not less than $120,000,000 and not more than $130,000,000;

(VI) for fiscal year 2002, not less than $140,000,000 and not more than $150,000,000; and

(VII) for each fiscal year after fiscal year 2002, not less than $150,000,000 and not more than $160,000,000.

(B) FEDERAL BUREAU OF INVESTIGATION.—There are hereby appropriated from the general fund of the United States Treasury and hereby appropriated to the Account for transfer to the Federal Bureau of Investigation to carry out the purposes described in subparagraph (C), to be available without further appropriation—

(i) for fiscal year 1997, $47,000,000;

(ii) for fiscal year 1998, $56,000,000;

(iii) for fiscal year 1999, $66,000,000;

(iv) for fiscal year 2000, $76,000,000;

(v) for fiscal year 2001, $88,000,000;

(vi) for fiscal year 2002, $101,000,000; and

(vii) for each fiscal year after fiscal year 2002, $114,000,000.

(C) USE OF FUNDS.—The purposes described in this subparagraph are to cover the costs (including equipment, salaries and benefits, and travel and training) of the administration and operation of the health care fraud and abuse control program established under section 1128C(a), including the costs of—

(i) prosecuting health care matters (through criminal, civil, and administrative proceedings);

(ii) investigations;

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

(iv) inspections and other evaluations; and

(v) provider and consumer education regarding compliance with the provisions of title XI.

(4) APPROPRIATED AMOUNTS TO ACCOUNT FOR MEDICARE INTEGRITY PROGRAM.—

(A) IN GENERAL.—There are hereby appropriated to the Account from the Trust Fund for each fiscal year such amounts as are necessary to carry out the Medicare Integrity Program under section 1893, subject to subparagraph (B) and to be available without further appropriation.

(B) AMOUNTS SPECIFIED.—The amount appropriated under subparagraph (A) for a fiscal year is as follows:

(i) For fiscal year 1997, such amount shall be not less than $430,000,000 and not more than $440,000,000.

(ii) For fiscal year 1998, such amount shall be not less than $490,000,000 and not more than $500,000,000.

(iii) For fiscal year 1999, such amount shall be not less than $550,000,000 and not more than $560,000,000.

(iv) For fiscal year 2000, such amount shall be not less than $620,000,000 and not more than $630,000,000.

(v) For fiscal year 2001, such amount shall be not less than $670,000,000 and not more than $680,000,000.

(vi) For fiscal year 2002, such amount shall be not less than $690,000,000 and not more than $700,000,000.

(vii) For each fiscal year after fiscal year 2002, such amount shall be not less than $710,000,000 and not more than $720,000,000.

(5) ANNUAL REPORT.—The Secretary and the Attorney General shall submit jointly an annual report to Congress on the amount of revenue which is generated and disbursed, and the justification for such disbursements, by the Account in each fiscal year.

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PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

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USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

SEC. 1842. (a) * * *

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(c)(1) * * *

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(6) No carrier may carry out (or receive payment for carrying out) any activity pursuant to a contract under this subsection to the extent that the activity is carried out pursuant to a contract under the Medicare Integrity Program under section 1893. The previous sentence shall not apply with respect to the activity described in section 1893(b)(5) (relating to prior authorization of certain items of durable medical equipment under section 1834(a)(15)).

* * * * * * *

(r) The Secretary shall establish a system which provides for a unique identifier for each physician who furnishes services for which payment may be made under this title. *Under such system, the Secretary may impose appropriate fees on such physicians to cover the costs of investigation and recertification activities with respect to the issuance of the identifiers.*

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PART C—MISCELLANEOUS PROVISIONS

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AGREEMENTS WITH PROVIDERS OF SERVICES

SEC. 1866. (a)(1) Any provider of services (except a fund designated for purposes of section 1814(g) and section 1835(e)) shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

(A) * * *

* * * * * * *

(P) in the case of home health agencies which provide home health services to individuals entitled to benefits under this title who require catheters, catheter supplies, ostomy bags, and supplies related to ostomy car (described in section 1861(m)(5)), to offer to furnish such supplies to such an individual as part of their furnishing of home health services, **[**and**]**

(Q) in the case of hospitals, skilled nursing facilities, home health agencies, and hospice programs, to comply with the requirement of subsection (f) (relating to maintaining written policies and procedures respecting advance directives)**[**.**]***; and*

(R) to contract only with a clearinghouse (as defined in section 1171) that meets each standard and implementation specification adopted or established under sections 1172 and 1173 on or after the date on which the clearinghouse is required to comply with the standard or specification.

In the case of a hospital which has an agreement in effect with an organization described in subparagraph (F), which organization's contract with the Secretary under part B of title XI is terminated on or after October 1, 1984, the hospital shall not be determined to be out of compliance with the requirement of such subparagraph during the six month period beginning on the date of the termination of that contract.

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PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS

SEC. 1876. (a) * * *

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(i)(1) Each contract under this section shall be for a term of at least one year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that [the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the eligible organization involved as he may provide in regulations), if he finds that the organization—

[(A) has failed substantially to carry out the contract,

[(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this section, or

[(C) no longer substantially meets the applicable conditions of subsections (b), (c), (e), and (f).] *in accordance with procedures established under paragraph (9), the Secretary may at any time terminate any such contract or may impose the intermediate sanctions described in paragraph (6)(B) or (6)(C) (whichever is applicable) on the eligible organization if the Secretary determines that the organization—*

(A) has failed substantially to carry out the contract;

(B) is carrying out the contract in a manner substantially inconsistent with the efficient and effective administration of this section; or

(C) no longer substantially meets the applicable conditions of subsections (b), (c), (e), and (f).

* * * * * * *

(6)(A) * * *

(B) The remedies described in this subparagraph are—

(i) civil money penalties of not more than $25,000 for each determination under subparagraph (A) or, with respect to a determination under clause (iv) or (v)(I) of such subparagraph, of not more than $100,000 for each such determination, plus, with respect to a determination under subparagraph (A)(ii), double the excess amount charged in violation of such subparagraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under subparagraph (A)(iv), $15,000 for each individual not enrolled as a result of the practice involved,

(ii) suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under subparagraph (A) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur, or

(iii) suspension of payment to the organization under this section for individuals enrolled after the date the Secretary notifies the organization of a determination under subparagraph

(A) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

[The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).]

(C) In the case of an eligible organization for which the Secretary makes a determination under paragraph (1) the basis of which is not described in subparagraph (A), the Secretary may apply the following intermediate sanctions:

(i) Civil money penalties of not more than $25,000 for each determination under paragraph (1) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract.

(ii) Civil money penalties of not more than $10,000 for each week beginning after the initiation of procedures by the Secretary under paragraph (9) during which the deficiency that is the basis of a determination under paragraph (1) exists.

(iii) Suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.

(D) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under subparagraph (B)(i) or (C)(i) in the same manner as such provisions apply to a civil money penalty or proceeding under section 1128A(a).

(7)(A) Each risk-sharing contract with an eligible organization under this section shall provide that the organization will maintain [an agreement] *a written agreement* with a utilization and quality control peer review organization (which has a contract with the Secretary under part B of title XI for the area in which the eligible organization is located) or with an entity selected by the Secretary under section 1154(a)(4)(C) under which the review organization will perform functions under section 1154(a)(4)(B) and section 1154(a)(14) (other than those performed under contracts described in section 1866(a)(1)(F)) with respect to services, furnished by the eligible organization, for which payment may be made under this title.

* * * * * * *

(9) The Secretary may terminate a contract with an eligible organization under this section or may impose the intermediate sanctions described in paragraph (6) on the organization in accordance with formal investigation and compliance procedures established by the Secretary under which—

(A) the Secretary first provides the organization with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under paragraph (1) and the organization fails to develop or implement such a plan;

(B) in deciding whether to impose sanctions, the Secretary considers aggravating factors such as whether an organization has a history of deficiencies or has not taken action to correct

deficiencies the Secretary has brought to the organization's attention;

(C) there are no unreasonable or unnecessary delays between the finding of a deficiency and the imposition of sanctions; and

(D) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before imposing any sanction or terminating the contract.

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CERTIFICATION OF MEDICARE SUPPLEMENTAL HEALTH INSURANCE POLICIES

SEC. 1882. (a) * * *

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(d)(1) * * *

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(3)(A)[(i) It is unlawful for a person to sell or issue to an individual entitled to benefits under part A or enrolled under part B of this title—

[(I) a health insurance policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under this title or title XIX,

[(II) a medicare supplemental policy with knowledge that the individual is entitled to benefits under another medicare supplemental policy, or

[(III) a health insurance policy (other than a medicare supplemental policy) with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled, other than benefits to which the individual is entitled under a requirement of State or Federal law.] *(i) It is unlawful for a person to sell or issue to an individual entitled to benefits under part A or enrolled under part B of this title—*

(I) a health insurance policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under this title or title XIX,

(II) a medicare supplemental policy with knowledge that the individual is entitled to benefits under another medicare supplemental policy, or

(III) a health insurance policy (other than a medicare supplemental policy) with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled, other than benefits to which the individual is entitled under a requirement of State or Federal law.

Subclause (I) or (III) shall not apply with respect to the sale or issuance of a health insurance policy or plan under which all the benefits are fully payable directly to or on behalf of the individual without regard to other health benefit coverage of the individual.

(ii) Whoever violates clause (i) shall be fined under title 18, United States Code, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $25,000 (or $15,000 in the case

of a person other than the issuer of the policy) for each such prohibited act.

(iii) A seller (who is not the issuer of a health insurance policy) shall not be considered to violate clause (i)*(II)* with respect to the sale of a medicare supplemental policy if the policy is sold in compliance with subparagraph (B).

(iv) For purposes of this subparagraph, a health insurance policy shall be considered to "duplicate" benefits only when, under its terms, the policy provides specific reimbursement for identical items and services to the extent paid for under other coverage of such individual, and a health insurance policy providing for benefits which are payable to or on behalf of an individual without regard to other health benefit coverage of such individual is not considered to "duplicate" any health benefits.

(v) For purposes of this subparagraph, a health insurance policy (or a rider to an insurance contract which is not a health insurance policy), providing benefits for long-term care, nursing home care, home health care, or community-based care, or a contract with a health maintenance organization that provides comprehensive health benefits, and that coordinates against or excludes items and services available or paid for under this title and (for policies other than contracts with health maintenance organizations sold or issued on or after 90 days after the date of enactment of this provision) that discloses such coordination or exclusion in the policy's outline of coverage, is not considered to "duplicate" health benefits under this title. For purposes of this clause, the terms "coordinates" and "coordination" mean, with respect to a policy in relation to health benefits under this title, that the policy under its terms is secondary to, or excludes from payment, items and services to the extent available or paid for under this title.

(vi) Notwithstanding any other provision of law, no criminal or civil penalty may be imposed at any time under this subparagraph and no legal action may be brought or continued at any time in any Federal or State court if the penalty or action is based on an act or omission that occurred after November 5, 1991, and before the date of the enactment of this clause, and relates to the sale, issuance, or renewal of any health insurance policy or rider during such period, if such policy or rider meets the nonduplication requirements of clause (iv) or (v).

(vii) A State may not impose, in the case of the sale, issuance, or renewal of a health insurance policy (other than a medicare supplemental policy) or rider to an insurance contract which is not a health insurance policy, that meets the nonduplication requirements of this section pursuant to clause (iv) or (v) to an individual entitled to benefits under part A or enrolled under part B, any requirement with respect to the duplication or nonduplication of health benefits to which the individual is otherwise entitled to under this title.

* * * * * * *

(C) Subparagraph (A) shall not apply **[**with respect to (i)**]** *with respect to* the sale or issuance of a group policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or for members or former members (or combina-

tion thereof) of the labor organizations[, (ii) the sale or issuance of a policy or plan described in subparagraph (A)(i)(I) (other than a medicare supplemental policy to an individual entitled to any medical assistance under title XIX) under which all the benefits are fully payable directly to or on behalf of the individual without regard to other health benefit coverage of the individual but only if (for policies sold or issued more than 60 days after the date the statements are published or promulgated under subparagraph (D)) there is disclosed in a prominent manner as part of (or together with) the application the applicable statement (specified under subparagraph (D)) of the extent to which benefits payable under the policy or plan duplicate benefits under this title, or (iii) the sale or issuance of a policy or plan described in subparagraph (A)(i)(III) under which all the benefits are fully payable directly to or on behalf of the individual without regard to other health benefit coverage of the individual].

[(D)(i) If—

[(I) within the 90-day period beginning on the date of the enactment of this subparagraph, the National Association of Insurance Commissioners develops (after consultation with consumer and insurance industry representatives) and submits to the Secretary a statement for each of the types of health insurance policies (other than medicare supplemental policies and including, but not limited to, as separate types of policies, policies paying directly to the beneficiary fixed, cash benefits, and policies that limit benefit payments to specific diseases) which are sold or issued to persons entitled to health benefits under this title, of the extent to which benefits payable under the policy or plan duplicate benefits under this title, and

[(II) the Secretary approves all the statements submitted as meeting the requirements of subclause (I),

each such statement shall be (for purposes of subparagraph (C)) the statement specified under this subparagraph for the type of policy involved. The Secretary shall review and approve (or disapprove) all the statements submitted under subclause (I) within 30 days after the date of their submittal. Upon approval of such statements, the Secretary shall publish such statements.

[(ii) If the Secretary does not approve the statements under clause (i) or the statements are not submitted within the 90-day period specified in such clause, the Secretary shall promulgate (after consultation with consumer and insurance industry representatives and not later than 90 days after the date of disapproval or the end of such 90-day period (as the case may be)) a statement for each of the types of health insurance policies (other than medicare supplemental policies and including, but not limited to, as separate types of policies, policies paying directly to the beneficiary fixed, cash benefits, and policies that limit benefit payments to specific diseases) which are sold or issued to persons entitled to health benefits under this title, of the extent to which benefits payable under the policy or plan duplicate benefits under this title, and each such statement shall be (for purposes of subparagraph (C)) the statement specified under this subparagraph for the type of policy involved.]

* * * * * * *

MEDICARE INTEGRITY PROGRAM

SEC. 1893. (a) ESTABLISHMENT OF PROGRAM.—There is hereby established the Medicare Integrity Program (in this section referred to as the "Program") under which the Secretary shall promote the integrity of the medicare program by entering into contracts in accordance with this section with eligible private entities to carry out the activities described in subsection (b).

(b) ACTIVITIES DESCRIBED.—The activities described in this subsection are as follows:

(1) Review of activities of providers of services or other individuals and entities furnishing items and services for which payment may be made under this title (including skilled nursing facilities and home health agencies), including medical and utilization review and fraud review (employing similar standards, processes, and technologies used by private health plans, including equipment and software technologies which surpass the capability of the equipment and technologies used in the review of claims under this title as of the date of the enactment of this section).

(2) Audit of cost reports.

(3) Determinations as to whether payment should not be, or should not have been, made under this title by reason of section 1862(b), and recovery of payments that should not have been made.

(4) Education of providers of services, beneficiaries, and other persons with respect to payment integrity and benefit quality assurance issues.

(5) Developing (and periodically updating) a list of items of durable medical equipment in accordance with section 1834(a)(15) which are subject to prior authorization under such section.

(c) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract under the Program to carry out any of the activities described in subsection (b) if—

(1) the entity has demonstrated capability to carry out such activities;

(2) in carrying out such activities, the entity agrees to cooperate with the Inspector General of the Department of Health and Human Services, the Attorney General of the United States, and other law enforcement agencies, as appropriate, in the investigation and deterrence of fraud and abuse in relation to this title and in other cases arising out of such activities;

(3) the entity demonstrates to the Secretary that the entity's financial holdings, interests, or relationships will not interfere with its ability to perform the functions to be required by the contract in an effective and impartial manner; and

(4) the entity meets such other requirements as the Secretary may impose.

In the case of the activity described in subsection (b)(5), an entity shall be deemed to be eligible to enter into a contract under the Program to carry out the activity if the entity is a carrier with a contract in effect under section 1842.

(d) PROCESS FOR ENTERING INTO CONTRACTS.—The Secretary shall enter into contracts under the Program in accordance with such procedures as the Secretary shall by regulation establish, except that such procedures shall include the following:

(1) The Secretary shall determine the appropriate number of separate contracts which are necessary to carry out the Program and the appropriate times at which the Secretary shall enter into such contracts.

(2)(A) Except as provided in subparagraph (B), the provisions of section 1153(e)(1) shall apply to contracts and contracting authority under this section.

(B) Competitive procedures must be used when entering into new contracts under this section, or at any other time considered appropriate by the Secretary, except that the Secretary may contract with entities that are carrying out the activities described in this section pursuant to agreements under section 1816 or contracts under section 1842 in effect on the date of the enactment of this section.

(3) A contract under this section may be renewed without regard to any provision of law requiring competition if the contractor has met or exceeded the performance requirements established in the current contract.

(e) LIMITATION ON CONTRACTOR LIABILITY.—The Secretary shall by regulation provide for the limitation of a contractor's liability for actions taken to carry out a contract under the Program, and such regulation shall, to the extent the Secretary finds appropriate, employ the same or comparable standards and other substantive and procedural provisions as are contained in section 1157.

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TITLE 18, UNITED STATES CODE

CHAPTER 1—GENERAL PROVISIONS

Sec.
1. Repealed.
2. Principals.

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24. Definition of Federal health care offense.

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§ 24. Definition of Federal health care offense

(a) As used in this title, the term "Federal health care offense" means a violation of, or a criminal conspiracy to violate—

(1) section 669, 1035, or 1347 of this title; or

(2) section 287, 371, 664, 666, 1001, 1027, 1341, 1343, or 1954 of this title, if the violation or conspiracy relates to a health care benefit program.

(b) As used in this title, the term "health care benefit program" has the meaning given such term in section 1347(b) of this title.

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CHAPTER 31—EMBEZZLEMENT AND THEFT

Sec.
641. Public money, property or records

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669. Theft or embezzlement in connection with health care.

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§ 669. Theft or embezzlement in connection with health care

(a) Whoever embezzles, steals, or otherwise without authority willfully and unlawfully converts to the use of any person other than the rightful owner, or intentionally misapplies any of the moneys, funds, securities, premiums, credits, property, or other assets of a health care benefit program, shall be fined under this title or imprisoned not more than 10 years, or both; but if the value of such property does not exceed the sum of $100 the defendant shall be fined under this title or imprisoned not more than one year, or both.

(b) As used in this section, the term "health care benefit program" has the meaning given such term in section 1347(b) of this title.

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CHAPTER 46—FORFEITURE

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§ 982. Criminal forfeiture

(a)(1) The court, in imposing sentence on a person convicted of an offense in violation of section 5313(a), 5316, or 5324 of title 31, or of section 1956, 1957, or 1960 of this title, shall order that the person forfeit to the United States any property, real or personal, involved in such offense, or any property traceable to such property. However, no property shall be seized or forfeited in the case of a violation of section 5313(a) of title 31 by a domestic financial institution examined by a Federal bank supervisory agency or a financial institution regulated by the Securities and Exchange Commission or a partner, director, or employee thereof.

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(6) The court, in imposing sentence on a person convicted of a Federal health car offense, shall order the person to forfeit property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense.

(b)(1) Property subject to forfeiture under this section, any seizure and disposition thereof, and any administrative or judicial proceeding in relation thereto, shall be governed—

(A) in the case of a forfeiture under subsection (a)(1) *or (a)(6)* of this section, by subsections (c) and (e) through (p) of section 413 of the Comprehensive Drug Abuse Prevention and Control Act of 1970 (21 U.S.C. 853); and

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CHAPTER 47—FRAUD AND FALSE STATEMENTS

Sec.

§ 1035. False statements relating to health care matters

(a) Whoever, in any matter involving a health care benefit program, knowingly—

(1) falsifies, conceals, or covers up by any trick, scheme, or device a material fact; or

(2) makes any false, fictitious, or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry,

in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 5 years, or both.

(b) As used in this section, the term "health care benefit program" has the meaning given such term in section 1347(b) of this title.

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CHAPTER 63—MAIL FRAUD

§ 1345. Injunctions against fraud

(a)(1) If a person is—

(A) violating or about to violate this chapter or section 287, 371 (insofar as such violation involves a conspiracy to defraud the United States or any agency thereof), or 1001 of this title; **[**or**]**

(B) committing or about to commit a banking law violation (as defined in section 3322(d) of this title), *or*

(C) committing or about to commit a Federal health care offense.

the Attorney General may commence a civil action in any Federal court to enjoin such violation.

(2) If a person is alienating or disposing of property, or intends to alienate or dispose of property, obtained as a result of a banking law violation (as defined in section 3322(d) of this title) *or a Federal health care offense* or property which is traceable to such violation, the Attorney General may commence a civil action in any Federal court—

(A) a enjoin such alienation or disposition of property; or

(B) for a restraining order to—

(i) prohibit any person from withdrawing, transferring, removing, dissipating, or disposing of any such property or property of equivalent value; and

(ii) appoint a temporary receiver to administer such restraining order.

* * * * * * *

§ 1347. Health care fraud

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

(1) to defraud any health care benefit program; or

(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program;

in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 10 years, or both. If the violation results in serious bodily injury (as defined in section 1365 of this title), such person shall be fined under this title or imprisoned not more than 20 years, or both; and if the violation results in death, such person shall be fined under this title, or imprisoned for any term of years or for life, or both.

(b) As used in this section, the term "health care benefit program" means any public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract.

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CHAPTER 73—OBSTRUCTION OF JUSTICE

Sec.

§ 1510. Obstruction of criminal investigations

(a) * * *

(b)(1) Whoever, being an officer of a financial institution, with the intent to obstruct a judicial proceeding, directly or indirectly notifies any other person about the existence or contents of a subpoena for records of that financial institution, or information that has been furnished to the grand jury in response to that subpoena, shall be fined under this title or imprisoned not more than 5 years, or both.

* * * * * * *

(3) As used in this subsection—

(A) the term "an officer of a financial institution" means an officer, director, partner, employee, agent, or attorney of or for a financial institution; and

(B) the term "subpoena for records" means a Federal grand jury subpoena or a Department of Justice subpoena (issued under section 3486 of title 18), for customer records that has

been served relating to a violation of, or a conspiracy to violate—

(i) section 215, 656, 657, 1005, 1006, 1007, 1014, 1344, 1956, 1957, or chapter 53 of title 31; or

(ii) section 1341 or 1343 affecting a financial institution.

* * * * * * *

§ 1518. Obstruction of criminal investigations of health care offenses

(a) Whoever willfully prevents, obstructs, misleads, delays or attempts to prevent, obstruct, mislead, or delay the communication of information or records relating to a violation of a Federal health care offense to a criminal investigator shall be fined under this title or imprisoned not more than 5 years, or both.

(b) As used in this section the term "criminal investigator" means any individual duly authorized by a department, agency, or armed force of the United States to conduct or engage in investigations for prosecutions for violations of health care offenses.

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CHAPTER 95—RACKETEERING

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§ 1956. Laundering of monetary instruments

(a) * * *

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(c) As used in this section—

(1) * * *

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(7) the term "specified unlawful activity" means—

(A) * * *

* * * * * * *

(F) Any act or activity constituting an offense involving a Federal health care offense.

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CHAPTER 223—WITNESSES AND EVIDENCE

Sec.

3481. Competency of accused.

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3486. Authorized investigative demand procedures.

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§ 3486. Authorized investigative demand procedures

(a) AUTHORIZATION.—In any investigation relating to any act or activity involving a Federal health care offense, the Attorney General or the Attorney General's designee may issue in writing and cause to be served a subpoena requiring the production of any records (including any books, papers, documents, electronic media, or other objects or tangible things), which may be relevant to an au-

thorized law enforcement inquiry, that a person or legal entity may possess or have care, custody, or control. A subpoena shall describe the objects required to be produced and prescribe a return date within a reasonable period of time within which the objects can be assembled and made available.

(b) SERVICE.—A subpoena issued under this section may be served by any person designated in the subpoena to serve it. Service upon a natural person may be made by personal delivery of the subpoena to him. Service may be made upon a domestic or foreign corporation or upon a partnership or other unincorporated association which is subject to suit under a common name, by delivering the subpoena to an officer, to a managing or general agent, or to any other agent authorized by appointment or by law to receive service of process. The affidavit of the person serving the subpoena entered on a true copy thereof by the person serving it shall be proof of service.

(c) ENFORCEMENT.—In the case of contumacy by or refusal to obey a subpoena issued to any person, the Attorney General may invoke the aid of any court of the United States within the jurisdiction of which the investigation is carried on or of which the subpoenaed person is an inhabitant, or in which he carries on business or may be found, to compel compliance with the subpoena. The court may issue an order requiring the subpoenaed person to appear before the Attorney General to produce records, if so ordered, or to give testimony touching the matter under investigation. Any failure to obey the order of the court may be punished by the court as a contempt thereof. All process in any such case may be served in any judicial district in which such person may be found.

(d) IMMUNITY FROM CIVIL LIABILITY.—Notwithstanding any Federal, State, or local law, any person, including officers, agents, and employees, receiving a summons under this section, who complies in good faith with the summons and thus produces the materials sought, shall not be liable in any court of any State or the United States to any customer or other person for such production or for nondisclosure of that production to the customer.

(e) LIMITATION ON USE.—(1) Health information about an individual that is disclosed under this section may not be used in, or disclosed to any person for use in, any administrative, civil, or criminal action or investigation directed against the individual who is the subject of the information unless the action or investigation arises out of and is directly related to receipt of health care or payment for health care or action involving a fraudulent claim related to health; or if authorized by an appropriate order of a court of competent jurisdiction, granted after application showing good cause therefor.

(2) In assessing good cause, the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services.

(3) Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

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VII. DISSENTING VIEWS

DISSENTING VIEWS OF 12 WAYS AND MEANS DEMOCRATS TO REPUBLICAN HEALTH INSURANCE BILL

This bill should be called "The Sink the Good Ship Kassebaum-Kennedy bill." It seems designed in every way to torpedo the passage of the modest, helpful provisions of Kassebaum-Kennedy-Roukema ("KKR").

The bill, as reported by the Committee on Ways and Means, is not health insurance reform. It includes only a weakened version of the group non-discrimination provisions of KKR. In the Republican bill, there is no protection for individuals in a group plan against extra charges because of their health status. There would be in KKR.

We have been told that this bill will be added to health insurance-related provisions from two other Committees, but the sum of the parts still will not equal KKR. The combined language still will not achieve the protections that Congress should enact—the protections in KKR. Unlike KKR, the Republican health bill that is being assembled fails to require insurance companies to make available insurance plans to groups of more than 50 (so-called guaranteed issue); guarantee an individual the right to purchase any individual policy offered for sale in a State. Instead individuals will only be guaranteed the chance to by a new type of policy (as yet undeveloped) equal to the average value policy sold in the State or by a company in the State.

The Ways and Means Democrats were unanimous in their support of clean, pure KKR substitute for the full text of the Republican bill. Unfortunately that effort failed on a party line vote.

The Republican sabotage lies in the extra, controversial provisions added to the basic bill.

The Republicans included many good Medicare anti-fraud provisions, but also three controversial provisions that law enforcement agencies say will weaken our fight against Medicare and health care fraud and corruption. As the Department of Health and Human Services Inspector General wrote us,

> there are three provisions which would significantly impede the efforts to control Medicare fraud: (a) making the civil monetary penalties law for false claims more lenient, (b) creating an easily-abused exception under the anti-kickback statute for certain managed care arrangements, and (c) creating an unprecedented advisory opinion mechanism for criminal and certain other intent-based statutes.

The Congressional Budget Office estimates that the cost of the advisory opinion provision alone will be $390 million over six years,

as precious crime-fighting resources are pulled away from the already understaffed Office of Inspector General.

In three separate votes, the Republicans rejected our efforts to strike these expensive, pro-fraud provisions. With most experts saying that waste, fraud and abuse equals about 10% of the health budget, it is unconscionable that the Republicans would include these provisions, which will only make the current situation worse.

The bill also includes $1.8 billion in spending between 1996 and 2002 for Medical Savings Accounts. Most independent experts agree that MSAs will be used mostly by the healthier and wealthier in our society, and that they will segment the insurance pool, causing insurance costs for most people to rise and in turn, causing the number of uninsured to rise. The attached Washington Post editorial of March 18, 1996, makes the argument against MSAs very well.

We are also disappointed that the Republicans on this Committee continue to be unwilling to adopt meaningful reforms to prevent tax avoidance by expatriation. We do not intend to again list the many reasons why the proposal include by the Committee in this bill is ineffectual. These reasons were set forth at some length in our dissenting views on H.R. 1812. At this time, however, we wish to emphasize that the Republicans on this Committee and their Republican colleagues in the House are the only ones opposing meaningful reforms in this area.

On an overwhelmingly bipartisan basis, the Senate adopted, as part of its reconciliation bill, a provision which would effectively eliminate the potential for tax avoidance through expatriation. We support that provision and the Administration also supports that provision. The House Republicans are the only ones that refuse to support the Senate provision. The puzzling questing is, why.

Finally, this bill signals, loud and clear, that the Republicans do not really support efforts to balance the budget or to save the Medicare Part A Trust Fund. Casually, in a four hour mark-up, the Committee Republicans decided to spend over $6.7 billion on new tax breaks. Some of these tax breaks are very popular and worth supporting, but what are our priorities? Should deficit reduction come first—as the Republicans keep talking about? Should extending the life of the Medicare Part A Trust Fund come first—as the Republicans have spent the last year claiming they want to do? Their votes on this bill show that they talk the talk, but don't walk the walk.

The Republicans paid for their potpourri of tax breaks by (1) taking $2.6 billion in Medicare anti-fraud savings and (2) $4.3 billion in most non-controversial tax changes left in the cupboard. They have taken the "easy money" and spent it on new and complicated tax changes, and prevented its use for deficit reduction and extending the life of Medicare.

This Congress should pass the useful insurance reforms of KKR. Those reforms will help millions of people, by ending job lock and discrimination against those most in need of insurance. We urge the House to reject efforts to encumber this reform effort with a laundry list of good, half-baked, and just plain bad add-ons.

[From the Washington Post, March 18, 1996]

BAD MOVE ON HEALTH CARE

Not too many weeks ago, it seemed as if Congress was about to pass, and the president to sign, a modest bill to help people keep their health insurance while between jobs. Not even the principal sponsors, Sens. Nancy Kassebaum and Edward Kennedy, describe the bill as more than a first step. It would not help people to afford the insurance, just require insurance companies to offer it to them. Still, it would be an advance.

Now, however, House Republicans are threatening to add to the bill some amendments from their health care wish list that could derial it. If some of these amendments are added, the bill ought to be derailed. The worst is a proposal to begin to subsidize through the tax code what are know as medical savings accounts. The underlying bill seeks to strengthen the health insurance system, if not by making it seamless, at least by moving it in that direction. The savings accounts would tend to fragment and weaken the system instead. The Republicans in 1994 accused the president of overreaching on health care reform, in part to satisfy assorted interest groups. He ended up with nothing to put before the voters on Election Day. They risk the same result.

Under current law, if an employer helps buy health insurance for his employees, he can deduct the premiums or other costs, and they don't have to count the money as taxable income. Medical savings accounts would work the same way, except that only part of the employers' contribution would go to buy insurance, of the so-called catastrophic variety, that would only kick in after several thousand dollars of expenses. The rest would be put in a medical savings account in the employee's name, to accumulate if not spent. The employee would become a better shopper, because he would save what he didn't use, and he would be free to shop for care as he chose; no more pressure to join an HMO unless he wanted to.

That's the theory, and it sounds pretty harmless, even sensible, except for one thing; It would split the insurance market. In conventional insurance you create a pool. The sums paid into the pool on behalf of the healthy in any given year are used to help support the sick, and when the healthy then get sick, they are supported in turn. If the healthy can opt out of the pool and build up their own savings accounts instead, you break up the system. The sick are left much more to fend for themselves—pay their own bills—which leaves them doubly afflicted.

Supporters of the plan include insurers who would like to sell the catastrophic coverage, some physicians who think that it might save them form the trend toward managed care and a lot of other people simply drawn to the idea of maximizing private choice. But this is the last thing the government ought to be spending scare dollars

on now. The long-run effect of creating separate systems for the healthy and sick would likely be to increase the number of people in the country who are finally forced to go without health insurance because they cannot afford it. If they put it on this bill, the president would be, not merely justified in vetoing it, but obliged to do so. They should leave it be.

SAM GIBBONS.
SANDER M. LEVIN.
RICHARD E. NEAL.
WILLIAN J. COYNE.
MIKE MCNULTY.
ROBERT T. MATSUI.
PETE STARK.
HAROLD FORD.
C.B. RANGEL.
BARBARA B. KENNELLY.
JIM MCDERMOTT.
JOHN LEWIS.

DISSENTING VIEWS OF HON. JIM MCDERMOTT AND HON. PETE STARK

Republican priorities are nowhere better revealed than in their proposal to increase the tax deduction for health insurance for the self-employed—and their opposition to making that same tax benefit available to the co-workers of the self-employed.

The Republicans propose to raise the deduction for the expense of buying health insurance from 30% to 50% over eight years for the doctor, the lawyer, the small businessman, and other professionals. Yet they refuse to provide the same benefit to the receptionist, the sale clerk, the nurse, and the other co-workers of the self-employed.

We fully recognize that most employees of small businessmen do not have the income to buy health insurance. But if they did, they should be afforded the same tax breaks as their bosses. Making the tax break available to workers would help make insurance affordable to some and thus help reduce the number of uninsured in our society.

Refusing to allow workers the same tax break as their bosses is Republican class warfare. It would cost the self-employed nothing—absolutely nothing—to allow their clerks and receptionists to go out on their own and try to buy health insurance. Yet the Republicans mindlessly oppose it. This kind of policy is driving a wedge in our society between the haves and the have nots. This amendment widens the gap between the rich and the rest of society. It is a needless insult to the working people of America.

Health care coverage is already unfair in corporate America. The New York Times of March 17, 1996 carried an article entitled, "A Double Standard in Health Coverage: Executives are Cradled while Medical Benefits are Cut for Rank and File."

> As companies herd their employees into managed care, limiting their choices to doctors and hospitals that have agreed to cut their charges, the chiefs of many of the nation's largest corporations—including Atlantic Richfield; Charles Schwab; RJR Nabisco; SBC Communications, the parent of Southwestern Bell, and Gannett—are leading more by precept than example.
>
> According to recent Securities and Exchange Commission filings and the companies themselves, the executives have medical coverage more bountiful than what their employees enjoyed even before their companies began economizing.

The Republican refusal to consider tax help for workers equal to what is provided their self-employed bosses just reinforces the creation of two-tier health care in America. This division is not good for our society, and we oppose it.

JIM MCDERMOTT.
PETE STARK.

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