

103^D CONGRESS
1ST SESSION

H. R. 2610

To amend the Social Security Act and the Internal Revenue Code of 1986 to provide for a Mediplan that assures the provision of health insurance coverage to all residents, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JULY 1, 1993

Mr. STARK introduced the following bill; which was referred jointly to the Committees on Ways and Means and Energy and Commerce

SEPTEMBER 29, 1993

Additional sponsors: Mr. COYNE, Mr. SABO, and Mr. YATES

A BILL

To amend the Social Security Act and the Internal Revenue Code of 1986 to provide for a Mediplan that assures the provision of health insurance coverage to all residents, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as
5 “Mediplan Health Care Act of 1993”.

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

Sec. 1. Short title; table of contents.

TITLE I—HEALTH CARE ELIGIBILITY AND BENEFITS

Sec. 101. Eligibility and benefits.

“TITLE XXI—MEDIPLAN HEALTH BENEFITS

“PART A—ELIGIBILITY

“Sec. 2101. Eligibility.

“Sec. 2102. Enrollment and Mediplan cards.

“PART B—BENEFITS

“Sec. 2121. Scope of benefits.

“Sec. 2122. Exclusions.

“PART C—PAYMENT FOR BENEFITS AND FINANCING

“Sec. 2141. Payments for benefits.

“Sec. 2142. Mediplan Trust Fund.

“PART D—ADMINISTRATIVE SIMPLIFICATION

“Sec. 2151. Requirement for entitlement verification system.

“Sec. 2152. Requirements for uniform claims and electronic claims data set.

“Sec. 2153. Electronic medical records and reporting.

“Sec. 2154. Uniform hospital cost reporting.

“Sec. 2155. Health service provider defined.

“PART E—GENERAL PROVISIONS

“Sec. 2161. Definitions relating to beneficiaries and income.

“Sec. 2162. Incorporation of certain medicare provisions and other provisions.

“Sec. 2163. State maintenance of effort payments.

“Sec. 2164. Modification of medicaid and other programs to avoid duplication of benefits.

“Sec. 2165. Maintenance of additional benefits for current beneficiaries under group health plans.

“PART F—REGULATION OF MEDIPLAN SUPPLEMENTAL POLICIES

“Sec. 2171. Standards and requirements for Mediplan supplemental policies.

“Sec. 2172. Establishment of standards.

“Sec. 2173. Requirements applicable to all Mediplan supplemental policies.

“Sec. 2174. Standards applicable only to insured Mediplan supplemental policies.

“Sec. 2175. Prohibition of duplication.

“Sec. 2176. Additional prohibitions.

“Sec. 2177. Information disclosure.

“Sec. 2178. Limitations on sales commissions.

“Sec. 2179. Definitions.

“PART G—STATE OPT OUT

- “Sec. 2181. Election.
- “Sec. 2182. Requirements for State alternative health care programs.
- “Sec. 2183. Control of aggregate expenditures.
- “Sec. 2184. Termination of approval of State election.
- “Sec. 2185. Payments to States.
- “Sec. 2186. No impact on medicare benefits.

TITLE II—COST CONTAINMENT

- Sec. 201. National Mediplan expenditure budget.
- Sec. 202. Classes of health care services.
- Sec. 203. Allocation of health budget by class of service.
- Sec. 204. National health expenditures reporting system.
- Sec. 205. Conforming medicare payment rates to Mediplan health expenditure allocations; transition.
- Sec. 206. Adjustments to medicare payments for graduate medical education.
- Sec. 207. Definitions.

TITLE III—FINANCING PROVISIONS

- Sec. 301. Income taxes for Mediplan health care.

1 **TITLE I—HEALTH CARE** 2 **ELIGIBILITY AND BENEFITS**

3 **SEC. 101. ELIGIBILITY AND BENEFITS.**

4 (a) IN GENERAL.—The Social Security Act is amend-
 5 ed by adding at the end the following new title:

6 “TITLE XXI—MEDIPLAN HEALTH BENEFITS

7 “PART A—ELIGIBILITY

8 “**SEC. 2101. ELIGIBILITY.**

9 “(a) UNIVERSAL ELIGIBILITY FOR RESIDENTS.—Ex-
 10 cept as provided in section 2163(a), each individual who
 11 is a resident of the United States is entitled to health in-
 12 surance benefits under this title.

13 “(b) SPECIAL ELIGIBILITY GROUPS.—For purposes
 14 of this title, an individual described in subsection (a) may
 15 obtain special benefits under this title on the basis of one
 16 or more of the following special eligibility groups:

1 “(1) Children (as defined in section
2 2161(a)(1)).

3 “(2) Low-income individuals (as defined in sec-
4 tion 2161(a)(2)).

5 “(3) Pregnant women (as defined in section
6 2161(a)(3)).

7 “(c) RECIPROCAL COVERAGE OF NONRESIDENTS.—
8 An individual who—

9 “(1) is not a resident of the United States,

10 “(2) is in the United States, and

11 “(3) is a national of a foreign state which pro-
12 vides health benefits to nationals of the United
13 States who are nonresidents in that state,

14 is entitled to such health insurance benefits under this
15 title, but only to the extent the Secretary determines that
16 such benefits would be available to nationals of the United
17 States similarly situated as a nonresident in the foreign
18 state.

19 **“SEC. 2102. ENROLLMENT AND MEDIPLAN CARDS.**

20 “(a) ENROLLMENT.—The Secretary shall provide a
21 mechanism for the enrollment of individuals entitled to
22 benefits under this title and, in conjunction with such en-
23 rollment, the issuance of a Mediplan card which may be
24 used for purposes of identification and processing of
25 claims for benefits under this title. Mediplan cards shall

1 identify (as appropriate) if the individual is a child, a preg-
2 nant woman, or a low-income individual.

3 “(b) ENROLLMENT AT BIRTH.—The mechanism
4 under subsection (a) shall include a process for the auto-
5 matic enrollment of individuals at the time of birth in the
6 United States.

7 “PART B—BENEFITS

8 “**SEC. 2121. SCOPE OF BENEFITS.**

9 “(a) IN GENERAL.—Except as provided in the suc-
10 ceeding provisions of this part, the benefits provided to
11 an individual described in section 2101(a) by the program
12 established by this title shall consist of entitlement to the
13 same benefits as are provided under title XVIII to individ-
14 uals entitled to benefits under part A, and enrolled under
15 part B, of title XVIII.

16 “(b) CHANGE IN THE DEDUCTIBLE AND LIMIT ON
17 COST-SHARING.—

18 “(1) IN GENERAL.—Except as provided in the
19 succeeding provisions of this part, the amount of ex-
20 penses (other than expenses for benefits described in
21 subsection (c)) with respect to which an individual is
22 entitled to have payment made under this title for
23 any year shall first be reduced by a deductible of
24 \$350, except that in no case shall the amount of the
25 deductible for all the members of a family exceed

1 \$500. Such deductible shall be instead of the deduct-
2 ible for inpatient hospital services under the first
3 sentence of section 1813(a)(1) and the deductible
4 under section 1833(b).

5 “(2) LIMIT ON OUT-OF-POCKET EXPENSES.—
6 Whenever in a calendar year an individual’s ex-
7 penses for deductibles, coinsurance, and copayments
8 with respect to services covered under this title (in-
9 cluding expenses for benefits described in subsection
10 (c)) and furnished during the year equals \$2,500, or
11 \$3,000 for all the members of a family, payment of
12 benefits under this title for the individual (or for the
13 members of such family, respectively) for services
14 furnished during the remainder of the year shall be
15 paid without the application of any coinsurance or
16 copayments.

17 “(c) PRESCRIPTION DRUGS.—

18 “(1) IN GENERAL.—Subject to paragraph (2),
19 benefits shall also be made available under this title
20 for outpatient prescription drugs and biologicals
21 (based on a formulary developed by the Secretary).

22 “(2) SEPARATE DEDUCTIBLE.—With respect to
23 benefits under this subsection, instead of applying
24 the cost-sharing described in subsection (b), except
25 as provided in the succeeding provisions of this sec-

1 tion and subsection (b)(2), such benefits shall be
2 subject to an annual individual deductible of \$800
3 and coinsurance of 20 percent of the recognized pay-
4 ment amount under section 2141(g).

5 “(d) CHILDREN.—

6 “(1) NO DEDUCTIBLES OR COINSURANCE.—In
7 the case of children (as defined in section
8 2161(a)(1)), there shall be no coinsurance,
9 deductibles, or copayments applicable to covered
10 benefits (including benefits described in paragraphs
11 (2) and (3)).

12 “(2) ADDITIONAL PREVENTIVE BENEFITS.—

13 “(A) IN GENERAL.—Subject to the perio-
14 dicity schedule established with respect to the
15 services under subparagraph (B), for children
16 benefits shall be available under this title for
17 the following items and services:

18 “(i) Newborn and well-baby care, in-
19 cluding normal newborn care and pediatri-
20 cian services for high-risk deliveries.

21 “(ii) Well-child care, including routine
22 office visits, routine immunizations (includ-
23 ing the vaccine itself), routine laboratory
24 tests, and preventive dental care.

1 “(B) PERIODICITY SCHEDULE.—The Sec-
2 retary, in consultation with the American Acad-
3 emy of Pediatrics and the American Dental As-
4 sociation, shall establish a schedule of periodic-
5 ity which reflects the general, appropriate fre-
6 quency with which services listed in subpara-
7 graph (A) should be provided to healthy chil-
8 dren.

9 “(3) OTHER ADDITIONAL SERVICES FOR CHIL-
10 DREN.—For children, benefits also shall be available
11 under this title for the following:

12 “(A) Inpatient hospital services (without
13 regard to the restrictions described in sub-
14 sections (a)(1) and (b)(1) of section 1812 and
15 the coinsurance described in section
16 1813(a)(1)).

17 “(B) Eyeglasses and hearing aids, and ex-
18 aminations therefor.

19 “(e) PREGNANCY-RELATED SERVICES.—

20 “(1) IN GENERAL.—In the case of a pregnant
21 woman (as defined in section 2161(a)(3)), benefits
22 under this title shall include entitlement to have pay-
23 ment made for the following, without the application
24 of deductibles, coinsurance, or copayments, subject
25 to the periodicity schedule established with respect

1 to the services under paragraph (2) and prior au-
2 thorization of certain services under paragraph (3):

3 “(A) Prenatal care, including care for all
4 complications of pregnancy.

5 “(B) Inpatient labor and delivery services.

6 “(C) Postnatal care.

7 “(D) Postnatal family planning services.

8 “(2) PERIODICITY SCHEDULE.—The Secretary,
9 in consultation with the American College of Obstet-
10 rics and Gynecology, shall establish a schedule of pe-
11 riodicity which reflects the general, appropriate fre-
12 quency with which services listed in paragraph (1)
13 should be provided to pregnant women without com-
14 plications of pregnancy.

15 “(3) PRIOR AUTHORIZATION REQUIRED FOR
16 CERTAIN SERVICES.—

17 “(A) IN GENERAL.—Except in the case of
18 items and services specified under subpara-
19 graph (B), benefits are not available with re-
20 spect to an item or service under paragraph (1)
21 unless the provision of the item or service has
22 been approved by a utilization and quality con-
23 trol peer review organization before the provi-
24 sion of the item or service.

1 “(B) EXCEPTION FOR ROUTINE OR COM-
2 MON ITEMS AND SERVICES.—Subparagraph (A)
3 shall not apply to items and services which the
4 Secretary has specified on a list as being ei-
5 ther—

6 “(i) related to normal pregnancy, or
7 “(ii) related to a highly prevalent
8 complication of pregnancy,
9 or in the case of emergency services.

10 “(4) MULTIPLE BASES FOR ELIGIBILITY.—In
11 the case of a pregnant woman who is also a child
12 or a low-income individual, the benefits under this
13 subsection shall be in addition or supplementation to
14 the benefits otherwise available to the individual.

15 “(f) LOWER-INCOME INDIVIDUALS.—

16 “(1) LIMITATIONS ON DEDUCTIBLES AND COIN-
17 SURANCE.—

18 “(A) NONE FOR LOW-INCOME INDIVID-
19 UALS.—In the case of a low-income individual,
20 there shall be no coinsurance, deductibles, or
21 copayments under this title.

22 “(B) PHASE-IN FOR OTHER LOWER-IN-
23 COME INDIVIDUALS.—In the case of an individ-
24 ual whose applicable modified gross income (as
25 defined in section 2161(b)(1)) exceeds the pov-

1 erty level (as defined in section 2161(b)(2)) but
2 does not exceed twice the poverty level, the co-
3 insurance, deductibles, and copayments applica-
4 ble under this title shall bear the same ratio to
5 the coinsurance, deductibles, and copayments
6 otherwise applicable as—

7 “(i) the excess of the applicable modi-
8 fied gross income over the poverty level,
9 bears to

10 “(ii) the poverty level.

11 If the ratio determined under the preceding
12 sentence is not a multiple of 25 percentage
13 points, such ratio shall be rounded to the near-
14 est 25 percentage points.

15 “(2) ADDITIONAL BENEFITS FOR LOW-INCOME
16 INDIVIDUALS.—In the case of low-income individuals
17 (as defined in section 2161(a)(2)), benefits under
18 this title shall also include entitlement to have pay-
19 ment made for the following, without the application
20 of deductibles, coinsurance, or copayments:

21 “(A) Inpatient hospital services (without
22 regard to the restrictions described in sub-
23 sections (a)(1) and (b)(1) of section 1812 and
24 the coinsurance described in section
25 1813(a)(1)).

1 “(B) Eyeglasses and hearing aids and ex-
2 aminations therefor.

3 **“SEC. 2122. EXCLUSIONS.**

4 “(a) IN GENERAL.—Except as provided in this sec-
5 tion, section 1862 shall apply to expenses incurred for
6 items and services provided under this title the same man-
7 ner as such section applies to items and services provided
8 under title XVIII.

9 “(b) BENEFITS EXCEPTION.—

10 “(1) CHILDRENS’ SERVICES.—In applying sec-
11 tion 1862(a) with respect to services described in
12 section 2121(d)(2)(A) (relating to well-child serv-
13 ices), payment shall not be denied under paragraph
14 (1), (7), or (12) of such section 1862(a) if the serv-
15 ices are provided in accordance with the periodicity
16 schedule described in section 2121(d)(2)(B).

17 “(2) SERVICES FOR PREGNANT WOMEN.—In
18 applying section 1862(a) with respect to services de-
19 scribed in section 2121(e)(1) (other than subpara-
20 graph (A) thereof), payment shall not be denied
21 under paragraph (1) or (7) of such section 1862(a)
22 if the services are provided in accordance with the
23 periodicity schedule described in section 2121(e)(2).

24 “(3) TREATMENT OF EYEGLASSES AND HEAR-
25 ING AIDS FOR CHILDREN AND LOW-INCOME INDIVID-

1 UALS.—Payment shall not be denied under this title
2 under section 1862(a)(7) with respect to eyeglasses
3 and hearing aids and examinations therefor in the
4 case of children and low-income individuals.

5 “(c) COORDINATION OF PAYMENTS.—

6 “(1) PRIMARY TO GROUP HEALTH PLANS.—
7 Section 1862(b)(1) (relating to requirements of
8 group health plans) shall not apply under this title.

9 “(2) SECONDARY TO MEDICARE.—Payment
10 shall not be made under this title with respect to
11 benefits to the extent that payment for such benefits
12 may be made under title XVIII.

13 “PART C—PAYMENT FOR BENEFITS AND FINANCING

14 “**SEC. 2141. PAYMENTS FOR BENEFITS.**

15 “(a) IN GENERAL.—Except as otherwise provided in
16 this section and in section 2121—

17 “(1) payment of benefits under this title with
18 respect to benefits shall be made in an amount con-
19 sistent with subsection (h) and on the same basis as
20 payment is made with respect to such benefits under
21 title XVIII, and

22 “(2) the provisions of sections 1814, 1833,
23 1834, 1842, 1848, and 1886 shall apply to payment
24 of benefits under this title in the same manner as
25 they apply to benefits under title XVIII.

1 “(b) NO COST-SHARING FOR CERTAIN SERVICES.—
2 No deductibles, coinsurance, copayments, or other cost-
3 sharing shall be imposed with respect to—

4 “(1) well-child care services described in section
5 2121(d)(1),

6 “(2) items and services for which an individual
7 is entitled under this title as a pregnant woman, and

8 “(3) items and services for qualified low-income
9 individuals.

10 For provision limiting the deductibles, coinsurance, and
11 copayments under this title in any year, see section
12 2121(b)(2).

13 “(c) NO EXTRA BILLING PERMITTED.—Payment
14 under this title may only be made on an assignment-relat-
15 ed basis (as defined in section 1842(i)(1)). If an entity
16 knowingly and willfully presents or causes to be presented
17 a claim or bills an individual enrolled under this title for
18 charges for services other than on an assignment-related
19 basis, the Secretary may apply sanctions against such en-
20 tity in accordance with section 1842(j)(2).

21 “(d) ADJUSTMENT OF PAYMENTS.—

22 “(1) ESTABLISHMENT OF NEW DRGS AND
23 WEIGHTS.—In making payment under this title with
24 respect to inpatient hospital services, the Secretary
25 shall establish such additional diagnosis-related

1 groups (and weighting factors with respect to dis-
2 charges within such groups) and make such adjust-
3 ments in the diagnosis-related groups and weighting
4 factors with respect to discharges within such groups
5 otherwise established under section 1886(d)(4) as
6 may be necessary—

7 “(A) to reflect the types of discharges oc-
8 ccurring under this title which are not occurring
9 under title XVIII, and

10 “(B) to provide for a weighting factor, for
11 cesarean section deliveries, which is 95 percent
12 of the weighting factor that otherwise would be
13 established.

14 “(2) PAYMENT FOR OBSTETRICAL SERVICES.—

15 “(A) GLOBAL FEE.—In making payment
16 under this title with respect to the group of ob-
17 stetrical services typical of treatment through-
18 out a course of pregnancy, the Secretary shall
19 establish, as a schedule under section 1848, a
20 global fee with respect to such group of serv-
21 ices.

22 “(B) BONUS FOR EARLY PRESEN-
23 TATION.—The fee schedule amount with respect
24 to obstetrical services under this title shall be
25 increased by 5 percent in the case of services

1 furnished to women who have presented for pre-
2 natal care during the first trimester.

3 “(C) DISINCENTIVE FOR CESAREAN SEC-
4 TIONS.—The fee schedule amount otherwise es-
5 tablished with respect to a cesarean section
6 shall be 95 percent of the fee schedule amount
7 otherwise established.

8 “(e) CONDITIONS OF AND LIMITATIONS ON PAY-
9 MENTS.—The provisions of sections 1814 and 1835 shall
10 apply to payment for services under this title in the same
11 manner as they apply to payment for services under parts
12 A and B, respectively, of title XVIII.

13 “(f) USE OF TRUST FUND.—In carrying out this sec-
14 tion, any reference in title XVIII to a trust fund shall be
15 treated as a reference to the Mediplan Trust Fund estab-
16 lished under section 2142.

17 “(g) PAYMENT FOR OUTPATIENT PRESCRIPTION
18 DRUGS AND BIOLOGICALS.—The Secretary, taking into
19 account the payment methodology that was described in
20 the amendments made by section 202 of the Medicare Cat-
21 astrophic Coverage Act of 1988 (as in effect before its re-
22 peal), shall establish a prospective payment methodology
23 for the payment for outpatient prescription drugs and
24 biologicals under this title. Such methodology shall be es-
25 tablished in a manner so as to meet the assurance de-

1 scribed in subsection (h) with respect to the class of serv-
2 ices that includes outpatient prescription drugs and
3 biologicals.

4 “(h) COMPUTATION OF APPROPRIATE REFERENCE
5 RATES OR CONVERSION FACTORS TO STAY WITHIN
6 BUDGET.—In computing the amount of payment with re-
7 spect to services (within a class of services) for which a
8 standardized amount, conversion factor, or other rate
9 basis is established under title XVIII, such standardized
10 amount, conversion factor, or other rate basis shall be es-
11 tablished in such a manner as will assure that—

12 “(1) the aggregate Mediplan expenditures (as
13 defined in section 201(d) of the Mediplan Health
14 Care Act of 1993) for all the services within such
15 class which are not attributable to services furnished
16 to individuals who are enrolled in a staff or group
17 model health maintenance organization (as defined
18 in section 207(b)(2)(B) of such Act) with respect to
19 health care services covered under the subscriber
20 agreement, is equal to

21 “(2) the allocation to such class for the year
22 under section 202 of such Act with respect to the
23 national Mediplan expenditure budget, less the prod-
24 uct of such allocation and the proportion of such al-
25 location that the Secretary estimates is attributable

1 to services furnished to individuals who are enrolled
2 in such a staff or group model health maintenance
3 organization with respect to health care services cov-
4 ered under the subscriber agreement.

5 In computing the aggregate Mediplan expenditures under
6 paragraph (1), there shall be taken into account the ad-
7 justment in medicare payment rates under section 205 of
8 such Act.

9 **“SEC. 2142. MEDIPLAN TRUST FUND.**

10 “(a) ESTABLISHMENT.—(1) There is hereby created
11 on the books of the Treasury of the United States a trust
12 fund to be known as the ‘Mediplan Trust Fund’ (in this
13 section referred to as the ‘Trust Fund’). The Trust Fund
14 shall consist of such gifts and bequests as may be made
15 as provided in section 201(i)(1) and amounts appropriated
16 under paragraph (2).

17 “(2) There are hereby appropriated to the Trust
18 Fund amounts equivalent to 100 percent of the taxes im-
19 posed by sections 59B and 59C of the Internal Revenue
20 Code of 1986. The amounts appropriated by the preceding
21 sentence shall be transferred from time to time from the
22 general fund in the Treasury to the Trust Fund, such
23 amounts to be determined on the basis of estimates by
24 the Secretary of the Treasury of the taxes, paid to or de-
25 posited into the Treasury; and proper adjustments shall

1 be made in amounts subsequently transferred to the extent
2 prior estimates were in excess of or were less than the
3 taxes specified in such sentence.

4 “(b) INCORPORATION OF PROVISIONS.—

5 “(1) IN GENERAL.—Subject to paragraph (2),
6 the provisions of subsections (b) through (e) and (g)
7 through (i) of section 1817 shall apply to the Trust
8 Fund in the same manner as they apply to the
9 Federal Hospital Insurance Trust Fund.

10 “(2) EXCEPTIONS.—In applying paragraph
11 (1)—

12 “(A) the Board of Trustees and Managing
13 Trustee of the Trust Fund shall be composed of
14 the members of the Board of Trustees and the
15 Managing Trustee, respectively, of the Federal
16 Hospital Insurance Trust Fund; and

17 “(B) any reference in section 1817 to the
18 Federal Hospital Insurance Trust Fund or to
19 title XVIII (or part A thereof) is deemed a ref-
20 erence to the Trust Fund under this section
21 and this title, respectively.

22 “PART D—ADMINISTRATIVE SIMPLIFICATION

23 **“SEC. 2151. REQUIREMENT FOR ENTITLEMENT VERIFICA-**
24 **TION SYSTEM.**

25 “(a) IN GENERAL.—

1 “(1) REQUIREMENT.—Each Mediplan supple-
2 mental plan (as defined in section 2166(d)) and the
3 Secretary, with respect to the plan provided under
4 this title, shall provide for an electronic system, that
5 is certified by the Secretary as meeting the stand-
6 ards established under subsection (c), for the ver-
7 ification of an individual’s entitlement to benefits
8 under such plan.

9 “(2) DEADLINE FOR APPLICATION OF REQUIRE-
10 MENT.—The deadline specified under this paragraph
11 for the requirement under paragraph (1) is 6
12 months after the date the standards are established
13 under subsection (c).

14 “(b) ENFORCEMENT THROUGH CIVIL MONEY PEN-
15 ALTIES.—

16 “(1) IN GENERAL.—In the case of a Mediplan
17 supplemental plan that fails to provide for an elec-
18 tronic verification system that is certified by the
19 Secretary as meeting the standards established
20 under subsection (c), the plan is subject to a civil
21 money penalty of not to exceed \$100 for each day
22 in which such failure persists. The provisions of sec-
23 tion 1128A of the Social Security Act (other than
24 subsections (a) and (b)) shall apply to a civil money
25 penalty under this subsection in the same manner as

1 such provisions apply to a penalty or proceeding
2 under section 1128A(a) of such Act.

3 “(2) EFFECTIVE DATE.—No penalty may be
4 imposed under paragraph (1) for any failure occur-
5 ring before the deadline specified in subsection
6 (a)(2).

7 “(c) STANDARDS FOR ENTITLEMENT VERIFICATION
8 SYSTEMS.—

9 “(1) IN GENERAL.—The Secretary shall estab-
10 lish standards consistent with this subsection re-
11 specting the requirements for certification of entitle-
12 ment verification systems.

13 “(2) INFORMATION AVAILABLE.—Such stand-
14 ards shall require a system to provide information,
15 with respect to individuals, concerning the following:

16 “(A) The specific benefits to which the in-
17 dividual is entitled under the plan.

18 “(B) Current status of the individual with
19 respect to fulfillment of deductibles,
20 copayments, and out-of-pocket limits on cost-
21 sharing.

22 “(C) Restrictions on providers who may
23 provide covered services, including utilization
24 controls (such as preadmission certification).

1 “(3) FORM OF INQUIRY.—Each verification sys-
2 tem shall be capable of accepting inquiries under
3 this subsection from health care providers in a vari-
4 ety of electronic and other forms, including—

5 “(A) through electronic transmission of in-
6 formation on the uniform health claims card (in
7 a manner similar to that for verification of
8 credit card purchases),

9 “(B) through the use of a touch-tone tele-
10 phone line, and

11 “(C) through the use of a computer
12 modem.

13 The system shall also provide, for an additional fee,
14 for the acceptance of inquiries in a nonelectronic
15 form.

16 “(4) FORM OF RESPONSE.—Each such system
17 shall be capable of responding to such inquiries
18 under this subsection in a variety of electronic and
19 other forms, including—

20 “(A) through modem transmission of infor-
21 mation,

22 “(B) through computer synthesized voice
23 communication, and

24 “(C) through transmission of information
25 to a facsimile (fax) machine.

1 The system shall also provide, for an additional fee,
2 for the response to inquiries in a nonelectronic form.

3 “(5) LIMITATION ON FEES.—Neither the Sec-
4 retary nor a Mediplan supplemental may impose a
5 fee for the acceptance or response to an inquiry
6 under this subsection except where the acceptance or
7 response is in a nonelectronic form.

8 “(6) PUBLIC DOMAIN SOFTWARE TO PROVID-
9 ERS.—The Secretary shall provide for the develop-
10 ment, and shall make available without charge to
11 health service providers and Mediplan supplemental
12 plans, such computer software as will enable—

13 “(A) such providers to make inquiries, and
14 receive responses, electronically respecting the
15 eligibility and benefits of an individual under
16 plans, and

17 “(B) such plans to make inquiries, and re-
18 ceive responses, electronically respecting liability
19 of other plans for the provision or payment of
20 benefits.

21 “(7) DEADLINE.—The Secretary shall first es-
22 tablish the standards under this subsection (and
23 shall develop and make available the software under
24 paragraph (6)) by not later than 12 months after
25 the date of the enactment of this title.

1 “(d) APPLICATION TO MEDICARE AND MEDICAID
2 PROGRAMS.—

3 “(1) MEDICARE PROGRAM.—The Secretary
4 shall provide, in regulations promulgated to carry
5 out the medicare program, that there is established
6 an entitlement verification system that meets the
7 standards established under subsection (c), by not
8 later than the deadline specified in subsection (a)(2).

9 “(2) STATE MEDICAID PLANS.—As a condition
10 for the approval of a State plan under the medicaid
11 program, effective for calendar quarters beginning
12 on or after the deadline specified in subsection
13 (a)(2), each such plan shall provide, in accordance
14 with regulations of the Secretary, that there is es-
15 tablished an entitlement verification system that
16 meets the standards established under subsection
17 (c).

18 **“SEC. 2152. REQUIREMENTS FOR UNIFORM CLAIMS AND**
19 **ELECTRONIC CLAIMS DATA SET.**

20 “(a) REQUIREMENTS.—

21 “(1) SUBMISSION OF CLAIMS.—Each health
22 service provider that furnishes services in the United
23 States for which payment may be made under this
24 title or under a Mediplan supplemental plan shall
25 submit any claim for payment for such services only

1 in a form and manner consistent with standards es-
2 tablished under subsection (c).

3 “(2) ACCEPTANCE OF CLAIMS.—The Secretary
4 and a Mediplan supplemental plan may not reject a
5 claim for payment under this title or the plan on the
6 basis of the form or manner in which the claim is
7 submitted if the claim is submitted in accordance
8 with the standards established under subsection (c).

9 “(3) EFFECTIVE DATE.—This subsection shall
10 apply to claims for services furnished on or after the
11 date that is 6 months after the date standards are
12 established under subsection (c).

13 “(b) ENFORCEMENT THROUGH CIVIL MONEY PEN-
14 ALTIES.—

15 “(1) IN GENERAL.—

16 “(A) PROVIDERS.—In the case of a health
17 service provider that submits a claim in viola-
18 tion of subsection (a)(1), the provider is subject
19 to a civil money penalty of not to exceed \$100
20 (or, if greater, the amount of the claim) for
21 each such violation.

22 “(B) PLANS.—In the case of a Mediplan
23 supplemental plan that rejects a claim in viola-
24 tion of subsection (a)(2), the plan is subject to
25 a civil money penalty of not to exceed \$100 (or,

1 if greater, the amount of the claim) for each
2 such violation.

3 “(2) PROCESS.—The provisions of section
4 1128A of the Social Security Act (other than sub-
5 sections (a) and (b)) shall apply to a civil money
6 penalty under paragraph (1) in the same manner as
7 such provisions apply to a penalty or proceeding
8 under section 1128A(a) of such Act.

9 “(3) SUNSET FOR PENALTY.—No civil money
10 penalty may be imposed under this subsection for
11 submission (or rejection) of any claim on or after
12 the date that is 36 months after the effective date
13 specified in subsection (a)(3).

14 “(c) STANDARDS RELATING TO UNIFORM CLAIMS
15 AND ELECTRONIC CLAIMS DATA SET.—

16 “(1) ESTABLISHMENT OF STANDARDS.—The
17 Secretary shall establish standards that—

18 “(A) relate to the form and manner of sub-
19 mission of claims for benefits under this title
20 and under a Mediplan supplemental plan, and

21 “(B) define the data elements to be con-
22 tained in a uniform electronic claims data set to
23 be used with respect to such claims.

24 “(2) SCOPE OF INFORMATION.—

1 “(A) IN GENERAL.—The standards under
2 this subsection are intended to cover substan-
3 tially most claims that are filed under this title
4 and under Mediplan supplemental plans. Such
5 information need not include all elements that
6 may potentially be required to be reported
7 under utilization review provisions of such
8 plans.

9 “(B) ENSURING ACCOUNTABILITY FOR
10 CLAIMS SUBMITTED ELECTRONICALLY.—In es-
11 tablishing such standards, the Secretary, in
12 consultation with appropriate agencies, shall in-
13 clude such methods of ensuring provider re-
14 sponsibility and accountability for claims sub-
15 mitted electronically that are designed to con-
16 trol fraud and abuse in the submission of such
17 claims.

18 “(C) COMPONENTS.—In establishing such
19 standards the Secretary shall—

20 “(i) with respect to data elements, de-
21 fine data fields, formats, and medical no-
22 menclature, and plan benefit and insurance
23 information;

1 “(ii) develop a single, uniform coding
2 system for diagnostic and procedure codes;
3 and

4 “(iii) provide for standards for the
5 uniform electronic transmission of such
6 elements.

7 “(3) COORDINATION WITH STANDARDS FOR
8 ELECTRONIC MEDICAL RECORDS.—In establishing
9 standards under this subsection, the Secretary shall
10 assure that—

11 “(A) the development of such standards is
12 coordinated with the development of the stand-
13 ards for electronic medical records under sec-
14 tion 2153, and

15 “(B) the coding of data elements under the
16 uniform electronic claims data set and the cod-
17 ing of the same elements in the uniform hos-
18 pital clinical data set are consistent.

19 “(4) USE OF TASK FORCES.—In adopting
20 standards under this subsection—

21 “(A) the Secretary shall take into account
22 the recommendations of current task forces, in-
23 cluding at least the Workgroup on Electronic
24 Data Interchange, National Uniform Billing
25 Committee, the Uniform Claim Task Force, and

1 the Computer-based Patient Record Institute,
2 and

3 “(B) the Secretary shall provide that the
4 electronic transmission standards are consist-
5 ent, to the extent practicable, with the applica-
6 ble standards established by the Accredited
7 Standards Committee X-12 of the American
8 National Standards Institute.

9 “(5) UNIFORM, UNIQUE PROVIDER IDENTIFICA-
10 TION CODES.—In establishing standards under this
11 subsection—

12 “(A) the Secretary shall provide for a
13 unique identifier code for each health service
14 provider that furnishes services for which a
15 claim may be submitted under this title or
16 under a Mediplan supplemental plan, and

17 “(B) in the case of a provider that has a
18 unique identifier issued for purposes of title
19 XVIII, the code provided under subparagraph
20 (A) shall be the same as such unique identifier.

21 “(6) PUBLIC DOMAIN SOFTWARE TO PROVID-
22 ERS.—The Secretary shall provide for the develop-
23 ment, and shall make available without charge to
24 health service providers, such computer software as

1 will enable the providers to submit claims and to re-
2 ceive verification of claims status electronically.

3 “(7) STANDARDS FOR PAPER CLAIMS.—The
4 standards shall provide for a uniform paper claims
5 form which is consistent with data elements required
6 for the submission of claims electronically.

7 “(8) STANDARDS FOR CLAIMS FOR CLINICAL
8 LABORATORY TESTS.—The standards shall provide
9 that claims for clinical laboratory tests for which
10 benefits are provided under this title or under a
11 Mediplan supplemental plan shall be submitted di-
12 rectly by the person or entity that performed (or su-
13 pervised the performance of) the tests to the plan in
14 a manner consistent with (and subject to such excep-
15 tions as are provided under) the requirement for di-
16 rect submission of such claims under title XVIII.

17 “(9) DEADLINE.—The Secretary shall first pro-
18 vide for the standards for the uniform claims under
19 this subsection (and shall develop and make avail-
20 able the software under paragraph (6)) by not later
21 than 1 year after the date of the enactment of this
22 title.

23 “(d) USE UNDER THIS TITLE AND MEDICARE AND
24 MEDICAID PROGRAMS.—

1 “(1) REQUIREMENT FOR PROVIDERS.—In the
2 case of a health service provider that submits a
3 claim for services furnished under this title in viola-
4 tion of subsection (a)(1), no payment shall be made
5 under this title for such services.

6 “(2) REQUIREMENTS OF INTERMEDIARIES AND
7 CARRIERS UNDER MEDICARE PROGRAM.—The Sec-
8 retary shall provide, in regulations promulgated to
9 carry out this title, that the claims process provided
10 under this title conforms to the standards estab-
11 lished under subsection (c).

12 “(3) REQUIREMENTS OF STATE MEDICAID
13 PLANS.—As a condition for the approval of State
14 plans under the medicaid program, effective as of
15 the effective date specified in subsection (a)(3), each
16 such plan shall provide, in accordance with regula-
17 tions of the Secretary, that the claims process pro-
18 vided under the plan is modified to the extent re-
19 quired to conform to the standards established under
20 subsection (c).

21 **“SEC. 2153. ELECTRONIC MEDICAL RECORDS AND REPORT-**
22 **ING.**

23 “(a) STANDARDS FOR ELECTRONIC MEDICAL
24 RECORDS FOR HOSPITALS.—

25 “(1) PROMULGATION OF STANDARDS.—

1 “(A) IN GENERAL.—Between July 1,
2 1994, and January 1, 1995, the Secretary shall
3 promulgate standards described in paragraph
4 (2) for hospitals concerning electronic medical
5 records.

6 “(B) REVISION.—The Secretary may from
7 time to time revise the standards promulgated
8 under this paragraph.

9 “(2) CONTENTS OF STANDARDS.—The stand-
10 ards promulgated under paragraph (1) shall include
11 at least the following:

12 “(A) A definition of a uniform hospital
13 clinical data set, including a definition of the
14 set of comprehensive data elements, for use by
15 utilization and quality control peer review orga-
16 nizations.

17 “(B) Standards for an electronic patient
18 care information system with data obtained at
19 the point of care.

20 “(C) A specification of, and manner of
21 presentation of, the individual data elements of
22 the set and system under this paragraph.

23 “(D) Standards concerning the trans-
24 mission of electronic medical data.

1 “(E) Standards relating to confidentiality
2 of patient-specific information, which include
3 the physical security of electronic data and the
4 use of keys, passwords, encryption, and other
5 means to ensure the protection of the confiden-
6 tiality and privacy of electronic data.

7 “(3) COORDINATION WITH STANDARDS FOR
8 UNIFORM ELECTRONIC CLAIMS DATA SET.—In es-
9 tablishing standards under this subsection, the Sec-
10 retary shall assure that—

11 “(A) the development of such standards is
12 coordinated with the development of the stand-
13 ards for the uniform electronic claims data set
14 under subsection (b), and

15 “(B) the coding of data elements under the
16 uniform hospital clinical data set and the cod-
17 ing of the same elements under the uniform
18 electronic claims data set are consistent.

19 “(4) CONSULTATION.—In establishing stand-
20 ards under this subsection, the Secretary shall—

21 “(A) consult with the American National
22 Standards Institute, hospitals, health benefit
23 plans, and other interested parties, and

24 “(B) take into consideration, in developing
25 standards under paragraph (2)(A), the data set

1 used by the utilization and quality control peer
2 review program under part B of title XI.

3 “(b) REQUIREMENT FOR APPLICATION OF ELEC-
4 TRONIC RECORDS STANDARDS TO HOSPITALS.—

5 “(1) AS CONDITION OF MEDICARE PARTICIPA-
6 TION.—As of January 1, 1996, each hospital, as a
7 requirement of each participation agreement under
8 this title, shall, in accordance with the standards
9 promulgated under subsection (a)(1)—

10 “(A) maintain clinical data included in the
11 uniform hospital clinical data set under sub-
12 section (a)(2)(A) in electronic form on all inpa-
13 tients,

14 “(B) upon request of the Secretary or of a
15 utilization and quality control peer review orga-
16 nization (with which the Secretary has entered
17 into a contract under part B of title XI), trans-
18 mit electronically data requested from such
19 data set, and

20 “(C) upon request of the Secretary, or of
21 a fiscal intermediary or carrier, transmit elec-
22 tronically any data (with respect to a claim)
23 from such data set.

24 “(2) APPLICATION OF PRESENTATION AND
25 TRANSMISSION STANDARDS TO ELECTRONIC TRANS-

1 MISSION TO FEDERAL AGENCIES.—Effective Janu-
2 ary 1, 1996, if a hospital is required under a Fed-
3 eral program to transmit a data element that is sub-
4 ject to a standard, promulgated under subsection
5 (a)(1), described in subparagraph (C) or (D) of sub-
6 section (a)(2), the head of the Federal agency re-
7 sponsible for such program (if not otherwise author-
8 ized) is authorized to require the provider to present
9 and transmit the data element electronically in ac-
10 cordance with such a standard.

11 “(c) LIMITATION ON DATA REQUIREMENTS WHERE
12 STANDARDS IN EFFECT.—

13 “(1) IN GENERAL.—On or after January 1,
14 1996, the Secretary under this title or under title
15 XVIII (including any carrier or fiscal intermediary
16 or nor any utilization and quality control peer review
17 organization) and a Mediplan supplemental plan
18 may not require, for the purpose of utilization review
19 or as a condition of providing benefits or making
20 payments under this title, title XVIII, or the plan,
21 that a hospital—

22 “(A) provide any data element not in the
23 uniform hospital clinical data set specified
24 under the standards promulgated under sub-
25 section (a), or

1 “(B) transmit or present any such data
2 element in a manner inconsistent with such
3 standards applicable to such transmission or
4 presentation.

5 “(2) COMPLIANCE.—The Secretary may impose
6 a civil money penalty on any Mediplan supplemental
7 plan that fails to comply with paragraph (1) in an
8 amount not to exceed \$100 for each such failure.
9 The provisions of section 1128A of the Social Secu-
10 rity Act (other than the first sentence of subsection
11 (a) and other than subsection (b)) shall apply to a
12 civil money penalty under this paragraph in the
13 same manner as such provisions apply to a penalty
14 or proceeding under section 1128A(a) of such Act.

15 “(3) APPLICATION TO MEDICAID PROGRAM.—As
16 a condition for the approval of State plans under the
17 medicaid program and in accordance with regula-
18 tions of the Secretary, effective as of January 1,
19 1996, each such plan may not require that a hos-
20 pital, for the purpose of utilization review or as a
21 condition of providing benefits or making payments
22 under the plan—

23 “(A) provide any data element not in the
24 uniform hospital clinical data set specified

1 under the standards promulgated under sub-
2 section (a), or

3 “(B) transmit or present any such data
4 element in a manner inconsistent with such
5 standards applicable to such transmission or
6 presentation.

7 “(d) PREEMPTION OF STATE QUILL PEN LAWS.—

8 “(1) IN GENERAL.—Any provision of State law
9 that requires medical or health insurance records
10 (including billing information) to be maintained in
11 written, rather than electronic, form shall deemed to
12 be satisfied if the records are maintained in an elec-
13 tronic form that meets standards established by the
14 Secretary under paragraph (2).

15 “(2) SECRETARIAL AUTHORITY.—Not later
16 than 1 year after the date of the enactment of this
17 title, the Secretary shall issue regulations to carry
18 out paragraph (1). The regulations shall provide for
19 an electronic substitute that is in the form of a
20 unique identifier (assigned to each authorized indi-
21 vidual) that serves the functional equivalent of a sig-
22 nature. The regulations may provide for such excep-
23 tions to paragraph (1) as the Secretary determines
24 to be necessary to prevent fraud and abuse, to pre-
25 vent the illegal distribution of controlled substances,

1 and in such other cases as the Secretary deems ap-
2 propriate.

3 “(3) EFFECTIVE DATE.—Paragraph (1) shall
4 take effect on the first day of the first month that
5 begins more than 30 days after the date the Sec-
6 retary issues the regulations referred to in para-
7 graph (2).

8 **“SEC. 2154. UNIFORM HOSPITAL COST REPORTING.**

9 “Each hospital, as a requirement under a participa-
10 tion agreement under this title for each cost reporting pe-
11 riod beginning during or after fiscal year 1993, shall pro-
12 vide for the reporting of information to the Secretary with
13 respect to any hospital care provided in a uniform manner
14 consistent with standards established by the Secretary to
15 carry out section 4007(c) of the Omnibus Budget Rec-
16 onciliation Act of 1987 and in an electronic form consist-
17 ent with standards established by the Secretary.

18 **“SEC. 2155. HEALTH SERVICE PROVIDER DEFINED.**

19 “In this part, the term ‘health service provider’ in-
20 cludes a provider of services (as defined in section
21 1861(u)), physician, supplier, and other person furnishing
22 health care services.

1 “PART E—GENERAL PROVISIONS
2 **“SEC. 2161. DEFINITIONS RELATING TO BENEFICIARIES**
3 **AND INCOME.**

4 “(a) TERMS RELATING TO BENEFICIARIES.—In this
5 title:

6 “(1) CHILD.—The term ‘child’ means an indi-
7 vidual who throughout a month has not attained 23
8 years of age.

9 “(2) LOW-INCOME INDIVIDUAL.—The term
10 ‘low-income individual’ means an individual whose
11 applicable modified gross income (as defined in sub-
12 section (b)(1)) is less than 100 percent of the pov-
13 erty level (as defined in subsection (b)(2)).

14 “(3) PREGNANT WOMAN.—The term ‘pregnant
15 woman’ means a woman who has been certified by
16 a physician (in a manner specified by the Secretary)
17 as being pregnant, until the last day of the month
18 in which the 60-day period (beginning on the date
19 of termination of the pregnancy) ends.

20 “(b) TERMS RELATING TO INCOME.—In this title:

21 “(1) APPLICABLE MODIFIED GROSS INCOME.—

22 “(A) IN GENERAL.—Except as provided in
23 this paragraph, the term ‘applicable modified
24 gross income’ means, for a calendar year for an
25 individual, the modified gross income (as de-

1 fined in section 59B(c) of the Internal Revenue
2 Code of 1986) of the taxpayer (or the taxpayer
3 for whom the individual may be claimed as a
4 dependent) for the taxable year ending in the
5 second previous calendar year.

6 “(B) APPLICATION OF CURRENT YEAR
7 MODIFIED GROSS INCOME.—

8 “(i) IN GENERAL.—Subject to clause
9 (ii), the Secretary shall establish a proce-
10 dure under which an individual may file a
11 declaration of estimated modified gross in-
12 come for a taxable year ending in a cal-
13 endar year, which modified gross income
14 will apply under this subsection as the ap-
15 plicable modified gross income for the cal-
16 endar year. Subject to clause (ii), such pro-
17 cedure shall be applicable regardless of
18 whether or not the individual filed a tax
19 return for the taxable year ending in the
20 second previous calendar year.

21 “(ii) LIMITATION ON APPLICATION.—
22 The Secretary may limit the application of
23 clause (i), in the case of individuals who
24 have filed tax returns for the taxable year
25 ending in the second previous calendar

1 year, to individuals with respect to whom
2 the applicable modified gross income will
3 be reduced by at least 20 percent as a re-
4 sult of the application of such clause.

5 “(iii) REQUIREMENT FOR RETURN.—

6 Any individual who has filed a declaration
7 under clause (i) for a calendar year is re-
8 quired to file an income tax return for the
9 taxable year in the calendar year, regard-
10 less of whether any income tax is actually
11 owed for the year. The failure of the indi-
12 vidual to file such a return makes the indi-
13 vidual liable for overpayments under this
14 title under clause (iv) in the same manner
15 as if this paragraph had not applied.

16 “(iv) COLLECTION FOR OVERPAY-

17 MENTS.—If a declaration of estimated
18 modified gross income is made applicable
19 to a calendar year under clause (i) and the
20 actual modified gross income for that tax-
21 able year exceeds such estimated modified
22 gross income, the individual shall be liable
23 to the United States for 110 percent of the
24 amount of additional payments made
25 under this title as a result of the use of

1 that no payment shall be made under this title except on
2 the basis of bills or charges that are submitted electroni-
3 cally in a manner specified by the Secretary.

4 “(b) DEFINITIONS.—Except as otherwise provided in
5 this title, the definitions contained in section 1861 shall
6 apply for purposes of this title in the same manner as they
7 apply for purposes of title XVIII.

8 “(c) CERTIFICATION, PROVIDER QUALIFICATION,
9 ETC.—The provisions of sections 1863 through 1875, sec-
10 tions 1877 through 1880, section 1883, section 1885, and
11 sections 1887 through 1892 shall apply to this title in the
12 same manner as they apply to title XVIII.

13 “(d) HEALTH MAINTENANCE ORGANIZATIONS AND
14 COMPETITIVE MEDICAL PLANS.—

15 “(1) IN GENERAL.—Except as provided in this
16 subsection, section 1876 shall apply to individuals
17 entitled to benefits under this title in the same man-
18 ner as such section applies to individuals entitled to
19 benefits under part A, and enrolled under part B, of
20 title XVIII.

21 “(2) APPLICATION.—In applying section 1876
22 under this section—

23 “(A) the provisions of such section relating
24 only to individuals enrolled under part B of title
25 XVIII shall not apply;

1 “(B) any reference to a Trust Fund estab-
2 lished under title XVIII and to benefits under
3 such title is deemed a reference to the Mediplan
4 Trust Fund and to benefits under this title;

5 “(C) the adjusted average per capita cost
6 and the adjusted community rate shall be deter-
7 mined on the basis of benefits and payment
8 rates under this title; and

9 “(D) subsection (f) shall not apply.

10 “(e) TITLE XI PROVISIONS.—The following provi-
11 sions shall apply to this title in the same manner as they
12 apply to title XVIII:

13 “(1) Sections 1124, 1126, and 1128 through
14 1128B (relating to fraud and abuse).

15 “(2) Section 1134 (relating to nonprofit hos-
16 pital philanthropy).

17 “(3) Section 1138 (relating to hospital proto-
18 cols for organ procurement and standards for organ
19 procurement agencies).

20 “(4) Section 1142 (relating to research on out-
21 comes of health care services and procedures), ex-
22 cept that any reference in such section to a Trust
23 Fund is deemed a reference to the Mediplan Trust
24 Fund.

1 “(5) Part B of title XI (relating to peer review
2 of the utilization and quality of health care services).

3 “(f) OTHER PROVISIONS.—The provisions of section
4 201(i) shall apply to this title and the Mediplan Trust
5 Fund in the same manner as they apply to title XVIII
6 and the Federal Hospital Insurance Trust Fund.

7 **“SEC. 2163. STATE MAINTENANCE OF EFFORT PAYMENTS.**

8 “(a) CONDITION OF COVERAGE.—Notwithstanding
9 any other provision of this title, no individual who is a
10 resident of a State is eligible for benefits under this title
11 for a month in a calendar year, unless the State provides
12 (in a manner and at a time specified by the Secretary)
13 for payment to the Mediplan Trust Fund of $\frac{1}{12}$ th of the
14 amount specified in subsection (b) for the year.

15 “(b) MAINTENANCE OF EFFORT AMOUNT.—The
16 amount of payment specified in this subsection for a State
17 for a year is equal to the amount of payment (net of Fed-
18 eral payments) made by a State under its State plan under
19 title XIX for 1993 for medical assistance with respect to
20 which benefits would have been payable under this title
21 for low-income individuals if this title were in effect in that
22 year, increased to the year involved by the compounded
23 sum of the increase in the consumer price index for all
24 urban consumers (U.S. City average, as published by the

1 Bureau of Labor Statistics of the Department of Labor)
2 for each year after 1993 and up to the year involved.

3 **“SEC. 2164. MODIFICATION OF MEDICAID AND OTHER PRO-**
4 **GRAMS TO AVOID DUPLICATION OF BENE-**
5 **FITS.**

6 “Notwithstanding any other provision of law—

7 “(1) a State plan under title XIX shall not pro-
8 vide any medical assistance for benefits with respect
9 to which any payments may be made under this
10 title;

11 “(2) a health benefits plan under chapter 89 of
12 title 5, United States Code, shall not provide bene-
13 fits for which any payment may be made under this
14 title; and

15 “(3) health benefits shall not be available under
16 the Civilian Health and Medical Program of the
17 Uniformed Services (as defined in section 1072(4) of
18 title 10, United States Code) for services for which
19 payment may be made under this title.

20 **“SEC. 2165. MAINTENANCE OF ADDITIONAL BENEFITS FOR**
21 **CURRENT BENEFICIARIES UNDER GROUP**
22 **HEALTH PLANS.**

23 “(a) IN GENERAL.—In the case of a group health
24 plan (as defined in section 5000(b)(1) of the Internal Rev-
25 enue Code of 1986) that, as of the date of the enactment

1 of this title, provides any health benefit to an employee
2 or former employee or a family member of an employee
3 or former employee that is additional to the benefits pro-
4 vided under this title, the group health plan must continue
5 to make available such an additional benefit to such an
6 individual notwithstanding the enactment of this title.

7 “(b) LIMITATION TO CURRENT BENEFICIARIES.—
8 Subsection (a) shall not apply to an individual who is not
9 entitled to benefits under the group health plan as of the
10 date of the enactment of this title.

11 “(c) ENFORCEMENT.—There is established a private
12 cause of action for damages (which shall be in an amount
13 triple the amount otherwise provided) in the case of a
14 group health plan that fails to continue to provide benefits
15 in accordance with subsection (a).

16 “PART F—REGULATION OF MEDIPLAN SUPPLEMENTAL
17 POLICIES

18 “**SEC. 2171. STANDARDS AND REQUIREMENTS FOR**
19 **MEDIPLAN SUPPLEMENTAL POLICIES.**

20 “(a) CERTIFICATION REQUIRED.—

21 “(1) IN GENERAL.—No Mediplan supplemental
22 policy (as defined in section 2179(4)) may be issued
23 on or after the effective date specified in subsection
24 (d) (and no new contract may be offered under such
25 policy with respect to any individual or group begin-

1 ning on or after such effective date) unless the pol-
2 icy has been certified—

3 “(A) by the Secretary (in accordance with
4 such procedures as the Secretary establishes),
5 or

6 “(B) by a State regulatory program (ap-
7 proved under subsection (b)),
8 as meeting the standards established under section
9 2172 by such effective date.

10 “(2) POLICY DISAPPROVED.—If the Secretary
11 (or, in the case of a policy certified by a State regu-
12 latory program, the State) determines that a
13 Mediplan supplemental policy does not meet the ap-
14 plicable standards of this title on or after such effec-
15 tive date, no coverage may be provided under the
16 plan to individuals not enrolled as of the date of the
17 determination and the policy may not be continued
18 for policy years beginning after the date of such de-
19 termination until the Secretary (or program) deter-
20 mines that such policy is in compliance with such
21 standards.

22 “(b) STATE APPROVED PROGRAMS.—

23 “(1) IN GENERAL.—If the Secretary determines
24 that a State has in effect an effective regulatory pro-
25 gram for the application of the standards established

1 under section 2172 to Mediplan supplemental poli-
2 cies, the Secretary may approve such program for
3 purposes of certification of Mediplan supplemental
4 policies under this title.

5 “(2) ANNUAL REPORTS.—As a condition for the
6 continued approval of such a regulatory program,
7 the State shall report to the Secretary annually such
8 information as the Secretary may require with re-
9 spect to the performance of the program. Such infor-
10 mation shall include a list of the Mediplan supple-
11 mental policies certified under the program, the
12 compliance of such policies with the standards estab-
13 lished under section 2172, and enforcement actions
14 taken to ensure such compliance.

15 “(3) PERIODIC SECRETARIAL REVIEW OF STATE
16 REGULATORY PROGRAMS.—The Secretary annually
17 shall review State regulatory programs approved
18 under paragraph (1) to determine if they continue to
19 apply and enforce the standards. If the Secretary
20 initially determines that a State regulatory program
21 no longer is applying and enforcing such standards,
22 the Secretary shall provide the State an opportunity
23 to adopt such a plan of correction that would bring
24 such program into compliance. If the Secretary
25 makes a final determination that the State regu-

1 latory program, fails to apply and enforce such
2 standards after such an opportunity, the Secretary
3 shall disapprove such program and reassume respon-
4 sibility for certification of all Mediplan supplemental
5 policies in that State.

6 “(4) GAO AUDITS.—The Comptroller General
7 shall conduct periodic reviews on a sample of State
8 regulatory programs approved under paragraph (1)
9 to determine their compliance with the requirements
10 of such paragraph. The Comptroller General shall
11 report to the Secretary and Congress on the findings
12 of such reviews.

13 “(c) EXCISE TAX SANCTIONS.—Nonqualified
14 Mediplan supplemental policies are subject to an excise tax
15 under section 5000A of the Internal Revenue Code of
16 1986.

17 “(d) EFFECTIVE DATE SPECIFIED.—

18 “(1) IN GENERAL.—Subject to paragraph (2),
19 the effective date specified in this subsection for a
20 State is the earlier of—

21 “(A) the date the State changes its stat-
22 utes or regulations to establish a regulatory
23 program that meets the requirements of this
24 part, or

1 “(B) 1 year after the date the Secretary
2 first publishes standards under section 2172.

3 “(2) ADDITIONAL LEGISLATIVE ACTION RE-
4 QUIRED.—In the case of a State which the Secretary
5 identifies as—

6 “(A) requiring State legislation (other than
7 legislation appropriating funds) to establish a
8 regulatory program that meets the require-
9 ments of this part, but

10 “(B) having a legislature which is not
11 scheduled to meet in 1994 in a legislative ses-
12 sion in which such legislation may be consid-
13 ered,

14 the effective date specified in this subsection is the
15 first day of the first calendar quarter beginning
16 after the close of the first legislative session of the
17 State legislature that begins on or after January 1,
18 1994. For purposes of the previous sentence, in the
19 case of a State that has a 2-year legislative session,
20 each year of such session shall be deemed to be a
21 separate regular session of the State legislature.

22 **“SEC. 2172. ESTABLISHMENT OF STANDARDS.**

23 “(a) ESTABLISHMENT OF STANDARDS.—The Sec-
24 retary shall develop and publish, by not later than 9
25 months after the the date of the enactment of this title,

1 specific standards to implement the requirements of this
2 title and to be applied under section 5000A of the Internal
3 Revenue Code of 1986.

4 “(b) MORE STRINGENT STATE STANDARDS PER-
5 MITTED.—In the case of insured Mediplan supplemental
6 policies (as defined in section 2174(c)(2)), a State may
7 implement standards that are more stringent than the
8 standards established under this section.

9 “(c) APPLICATION TO ERISA.—The Secretary shall
10 consult with the Secretary of Labor concerning the appli-
11 cation of the requirements of this title to employee welfare
12 benefit plans under title I of the Employee Retirement In-
13 come Security Act of 1974.

14 **“SEC. 2173. REQUIREMENTS APPLICABLE TO ALL**
15 **MEDIPLAN SUPPLEMENTAL POLICIES.**

16 “(a) NO DISCRIMINATION BASED ON HEALTH STA-
17 TUS.—

18 “(1) PROVISION OF SERVICES.—Except as pro-
19 vided under subsection (b), a Mediplan supplemental
20 policy may not deny, limit, or condition the coverage
21 under (or benefits of) the plan based on the health
22 status, claims experience, receipt of health care,
23 medical history, or lack of evidence of insurability,
24 of an individual.

1 “(2) PREMIUM CHARGES.—A Mediplan supple-
2 mental policy may not vary premiums charged based
3 on the health status, claims experience, receipt of
4 health care, medical history, or lack of evidence of
5 insurability, of an individual.

6 “(b) TREATMENT OF PRE-EXISTING CONDITION EX-
7 CLUSIONS FOR ALL SERVICES.—

8 “(1) IN GENERAL.—Subject to the succeeding
9 provisions of this subsection, a Mediplan supple-
10 mental policy may exclude coverage with respect to
11 services related to treatment of a pre-existing condi-
12 tion, but the period of such exclusion may not ex-
13 ceed 6 months.

14 “(2) NONAPPLICATION TO NEWBORNS.—The
15 exclusion of coverage permitted under paragraph (1)
16 shall not apply to services furnished to newborns.

17 “(3) CREDITING OF PREVIOUS COVERAGE.—

18 “(A) IN GENERAL.—If an individual is in
19 a period of continuous coverage (as defined in
20 subparagraph (B)(i)) with respect to particular
21 services as of the date of initial coverage under
22 a plan, any period of exclusion of coverage with
23 respect to a pre-existing condition for such serv-
24 ices or type of services shall be reduced by 1

1 month for each month in the period of continu-
2 ous coverage.

3 “(B) DEFINITIONS.—In this paragraph:

4 “(i) PERIOD OF CONTINUOUS COV-
5 ERAGE.—The term ‘period of continuous
6 coverage’ means, with respect to particular
7 services, the period beginning on the date
8 an individual is enrolled under a Mediplan
9 supplemental policy or health benefit plan
10 or program (including the medicare pro-
11 gram, a State plan under title XIX, con-
12 tinuation coverage under section 4980B of
13 the Internal Revenue Code of 1986, or a
14 State general medical assistance program)
15 which provides the same or substantially
16 similar benefits with respect to such serv-
17 ices and ends on the date the individual is
18 not so enrolled for a continuous period of
19 more than 3 months.

20 “(ii) PRE-EXISTING CONDITION.—The
21 term ‘pre-existing condition’ means, with
22 respect to coverage under a policy, a condi-
23 tion which has been diagnosed or treated
24 during the 3-month period ending on the
25 day before the first date of such coverage,

1 except that such term does not include a
2 condition which was first diagnosed or
3 treated during a period of continuous cov-
4 erage.

5 “(C) STANDARDS FOR SIMILAR BENE-
6 FITS.—The Secretary shall establish such cri-
7 teria for determining if benefits are substan-
8 tially similar as may be necessary to carry out
9 this subsection.

10 “(c) SIMPLIFICATION OF BENEFITS.—

11 “(1) IN GENERAL.—Each Mediplan supple-
12 mental policy shall only offer benefits consistent with
13 the standards promulgated under paragraph (2).

14 “(2) STANDARDS.—The Secretary shall promul-
15 gate standards providing for—

16 “(A) limitations on the groups or packages
17 of benefits that may be offered under a
18 Mediplan supplemental policy consistent with
19 paragraphs (3) and (4) of this subsection,

20 “(B) uniform language and definitions to
21 be used with respect to such benefits, and

22 “(C) uniform format to be used in the pol-
23 icy with respect to such benefits.

24 “(3) BASIS.—The standards under paragraph
25 (2) shall provide—

1 “(A) for such groups or packages of bene-
2 fits as may be appropriate taking into account
3 the considerations specified in paragraph (4)
4 and the requirements of the succeeding sub-
5 paragraphs,

6 “(B) for identification of a core group of
7 basic benefits common to all policies, and

8 “(C) that, subject to paragraph (5), the
9 total number of different benefit packages
10 (counting the core group of basic benefits de-
11 scribed in subparagraph (B) and each other
12 combination of benefits that may be offered as
13 a separate benefit package) that may be estab-
14 lished in all the States and by all issuers shall
15 not exceed 10.

16 “(4) INNOVATION.—With the approval of the
17 Secretary, the issuer of a Mediplan supplemental
18 policy may offer new or innovative benefits in addi-
19 tion to the benefits provided in a policy that other-
20 wise complies with the standards. Any such new or
21 innovative benefits may include benefits that are not
22 otherwise available and are cost effective and shall
23 be offered in a manner which is consistent with the
24 goal of simplification of Mediplan supplemental poli-
25 cies.

1 “(5) FURTHER LIMITATIONS.—

2 “(A) IN GENERAL.—Except as provided in
3 subparagraph (B), this subsection shall not be
4 construed as preventing a State from restricting
5 the groups of benefits that may be offered in
6 Mediplan supplemental policies in the State.

7 “(B) LIMITATION.—A State with a regu-
8 latory program approved under section
9 2171(b)(1) may not restrict under subpara-
10 graph (A) the offering of a Mediplan supple-
11 mental policy consisting only of the core group
12 of benefits described in paragraph (3)(B).

13 “(6) CONSTRUCTION.—This subsection shall
14 not be construed as preventing an issuer of a
15 Mediplan supplemental policy who otherwise meets
16 the requirements of this section from providing,
17 through an arrangement with a vendor, for dis-
18 counts from that vendor to the policyholder or
19 certificateholders for the purchase of items or serv-
20 ices not covered under its Mediplan supplemental
21 policies.

22 “(7) MAKING BASIC POLICY AVAILABLE.—

23 “(A) IN GENERAL.—Anyone who sells a
24 Mediplan supplemental policy to an individual
25 shall make available for sale to the individual a

1 Mediplan supplemental policy with only the core
2 group of basic benefits (described in paragraph
3 (3)(B)).

4 “(B) OUTLINE OF COVERAGE.—Anyone
5 who sells a Mediplan supplemental policy to an
6 individual shall provide the individual, before
7 the sale of the policy, an outline of coverage
8 which describes the benefits under the policy.
9 Such outline shall be on a standard form ap-
10 proved by the Secretary consistent with the
11 standards promulgated under this subsection.

12 “(8) PENALTY.—Whoever sells or issues a
13 Mediplan supplemental policy in violation of the re-
14 quirements of this subsection is subject to a civil
15 money penalty of not to exceed \$25,000 (or \$15,000
16 in the case of a seller who is not the issuer of the
17 policy) for each such violation.

18 “(d) MINIMUM LOSS RATIO REQUIRED.—

19 “(1) IN GENERAL.—A Mediplan supplemental
20 policy, a specific disease policy (as defined by the
21 Secretary), or a hospital confinement indemnity pol-
22 icy (as defined by the Secretary) may not be issued
23 or renewed (or otherwise provide coverage after the
24 effective date specified in section 2171(d)) unless—

1 “(A) the policy can be expected for periods
2 after the effective date of these provisions (as
3 estimated for the entire period for which rates
4 are computed to provide coverage, on the basis
5 of incurred claims experience and earned pre-
6 miums for such periods, and in accordance with
7 a uniform methodology, including uniform re-
8 porting standards, developed by the Secretary)
9 to return to policyholders in the form of aggre-
10 gate benefits provided under the policy, at least
11 80 percent of the aggregate amount of pre-
12 miums collected in the case of group policies or
13 at least 70 percent in the case of individual
14 policies; and

15 “(B) the issuer of the policy provides for
16 the issuance of a proportional refund, or a cred-
17 it against future premiums of a proportional
18 amount, based on the premium paid and in ac-
19 cordance with paragraph (2), of the amount of
20 premiums received necessary to assure that the
21 ratio of aggregate benefits provided to the ag-
22 gregate premiums collected (net of such refunds
23 or credits) complies with the expectation re-
24 quired under subparagraph (A), treating poli-

1 cies of the same type as a single policy for each
2 standard package.

3 For purposes of subparagraph (A) only, policies is-
4 sued as a result of solicitations of individuals
5 through the mails or by mass media advertising (in-
6 cluding both print and broadcast advertising) shall
7 be deemed to be individual policies. For the purpose
8 of calculating the refund or credit required under
9 paragraph (1)(B) for a policy issued before the ef-
10 fective date specified in section 2171(d), the refund
11 or credit calculation shall be based on the aggregate
12 benefits provided and premiums collected under all
13 such policies issued by an insurer in a State (sepa-
14 rated as to individual and group policies) and shall
15 be based only on aggregate benefits provided and
16 premiums collected under such policies after such
17 date.

18 “(2) APPLICATION.—Paragraph (1)(B) shall be
19 applied with respect to each type of policy by stand-
20 ard package. Paragraph (1)(B) shall not apply to a
21 policy until 12 months following issue. In the case
22 of a policy issued before the effective date specified
23 in section 2171(d), paragraph (1)(B) shall not apply
24 until 1 year after such date.

25 “(3) TIMING OF REFUND OR CREDIT.—

1 “(A) IN GENERAL.—A refund or credit re-
2 quired under paragraph (1)(B) shall be made to
3 each policyholder insured under the applicable
4 policy as of the last day of the year involved.

5 “(B) INTEREST.— Such a refund shall in-
6 clude interest from the end of the calendar year
7 involved until the date of the refund or credit
8 at a rate as specified by the Secretary for this
9 purpose from time to time which is not less
10 than the average rate of interest for 13-week
11 Treasury notes.

12 “(C) DEADLINE.— For purposes of this
13 paragraph and paragraph (1)(B), refunds or
14 credit against premiums due shall be made,
15 with respect to a calendar year, not later than
16 the third quarter of the succeeding calendar
17 year.

18 “(4) NO PREEMPTION.—The provisions of this
19 subsection do not preempt a State from requiring a
20 higher percentage than that specified in paragraph
21 (1)(A).

22 “(5) AUDITS.—The Comptroller General shall
23 periodically, not less often than every 3 years, per-
24 form audits with respect to the compliance of
25 Mediplan supplemental policies and dread disease

1 policies with the loss ratio requirements of this sub-
2 section and shall report the results of such audits to
3 any State involved and to the Secretary.

4 “(6) SANCTIONS.—

5 “(A) IN GENERAL.—A person who fails to
6 provide refunds or credits as required in para-
7 graph (1)(B) is subject to a civil money penalty
8 of not to exceed \$25,000 for each policy issued
9 for which such failure occurred.

10 “(B) LIABILITY.—Each issuer of a policy
11 subject to the requirements of paragraph (1)(B)
12 shall be liable to the policyholder or, in the case
13 of a group policy, to the certificateholder for
14 credits required under such paragraph.

15 “(e) GUARANTEED RENEWABILITY.—

16 “(1) IN GENERAL.—Each Mediplan supple-
17 mental policy shall be guaranteed renewable and—

18 “(A) the issuer may not cancel or
19 nonrenew the policy solely on the ground of
20 health status of the individual, and

21 “(B) the issuer shall not cancel or
22 nonrenew the policy for any reason other than
23 nonpayment of premium or material misrep-
24 sentation.

1 “(2) RIGHT OF CONVERSION UPON TERMI-
2 NATION OF GROUP POLICY.—If the Mediplan supple-
3 mental policy is terminated by the group policy-
4 holder and is not replaced as provided under para-
5 graph (4), the issuer shall offer certificateholders an
6 individual Mediplan supplemental policy which (at
7 the option of the certificateholder)—

8 “(A) provides for continuation of the bene-
9 fits contained in the group policy, or

10 “(B) provides for such benefits as other-
11 wise meets the requirements of this part.

12 “(3) RIGHT OF CONVERSION UPON TERMI-
13 NATION OF MEMBERSHIP IN A GROUP.—If an indi-
14 vidual is a certificateholder in a group Mediplan sup-
15 plemental policy and the individual terminates mem-
16 bership in the group, the issuer shall—

17 “(A) offer the certificateholder the conver-
18 sion opportunity described in paragraph (2), or

19 “(B) at the option of the group policy-
20 holder, offer the certificateholder continuation
21 of coverage under the group policy.

22 “(4) REPLACEMENT.—If a group Mediplan sup-
23 plemental policy is replaced by another group
24 Mediplan supplemental policy purchased by the same
25 policyholder, the succeeding issuer shall offer cov-

1 erage to all persons covered under the old group pol-
2 icy on its date of termination. Coverage under the
3 new group policy shall not result in any exclusion for
4 preexisting conditions that would have been covered
5 under the group policy being replaced.

6 “(5) SUSPENSION OF POLICY FOR CERTAIN
7 LOW-INCOME INDIVIDUALS.—

8 “(A) IN GENERAL.—Each Mediplan sup-
9 plemental policy shall provide that benefits and
10 premiums under the policy shall be suspended
11 at the request of the policyholder for the period
12 (not to exceed 24 months) in which the policy-
13 holder is determined to be entitled for benefits
14 under this title as a low-income individual, but
15 only if the policyholder notifies the issuer of
16 such policy within 90 days after the date the in-
17 dividual becomes so entitled. If such suspension
18 occurs and if the policyholder or
19 certificateholder loses such entitlement, such
20 policy shall be automatically reinstated (effec-
21 tive as of the date of termination of such enti-
22 tlement) under the following terms, if the pol-
23 icyholder provides notice of such loss of entitle-
24 ment within 90 days after the date of such loss:

1 “(i) There is no waiting period with
2 respect to treatment of pre-existing condi-
3 tions.

4 “(ii) Coverage is substantially equiva-
5 lent to coverage in effect before the date of
6 the termination.

7 “(iii) The classification of premiums
8 are on terms which are at least as favor-
9 able to the policyholder or certificateholder
10 as the premium classification terms that
11 would have applied to the policyholder or
12 certificateholder had the coverage never
13 terminated.

14 “(B) PENALTY.—Any person who issues a
15 Mediplan supplemental policy and fails to com-
16 ply with the requirements of subparagraph (A)
17 is subject to a civil money penalty of not to ex-
18 ceed \$25,000 for each such violation.

19 **“SEC. 2174. STANDARDS APPLICABLE ONLY TO INSURED**
20 **MEDIPLAN SUPPLEMENTAL POLICIES.**

21 “(a) OPEN ENROLLMENT.—

22 “(1) IN GENERAL.—Subject to the succeeding
23 provisions of this subsection, a carrier that offers an
24 insured Mediplan supplemental policy (as defined in
25 subsection (c)) to individuals residing (or to groups

1 located) in a State must offer the same policy to any
2 other resident of (or group located in) the State.
3 Such requirement shall apply on a continuous, year-
4 round basis.

5 “(2) RESTRICTIONS OF ENROLLMENT IN THE
6 CASE OF CERTAIN ASSOCIATION COVERAGE.—In the
7 case of an insured Mediplan supplemental policy of-
8 fered through an association which is composed ex-
9 clusively of employers (which may include self-em-
10 ployed individuals) and which has been formed for
11 purposes other than obtaining health insurance, the
12 carrier is not required to offer the policy to individ-
13 uals or employers who are not employees of such
14 employers or self-employed members of the associa-
15 tion, or their dependents.

16 “(3) TREATMENT OF HEALTH MAINTENANCE
17 ORGANIZATIONS.—

18 “(A) GEOGRAPHIC LIMITATIONS.—A
19 health maintenance organization may deny en-
20 rollment with respect to an individual if the in-
21 dividual is residing outside the service area of
22 the organization, but only if such denial is ap-
23 plied uniformly without regard to health status
24 or insurability.

1 “(B) SIZE LIMITS.—A health maintenance
2 organization may apply to the Secretary to
3 cease enrolling new employer groups or individ-
4 uals in its insured Mediplan supplemental policy
5 (or in a geographic area served by the policy)
6 if—

7 “(i) it ceases to enroll any new em-
8 ployer groups or individuals, and

9 “(ii) it can demonstrate that its finan-
10 cial or administrative capacity to serve pre-
11 viously enrolled groups and individuals
12 (and additional individuals who will be ex-
13 pected to enroll because of affiliation with
14 such previously enrolled groups) will be im-
15 paired if it is required to enroll new em-
16 ployer groups or individuals.

17 “(b) NOTICES AND RENEWAL PERIODS.—

18 “(1) NOTICE AND SPECIFICATION OF RATES
19 AND ADMINISTRATIVE CHANGES.—

20 “(A) NOTICE.—The carrier of an insured
21 Mediplan supplemental policy shall provide for
22 notice, at least 30 days before the date of expi-
23 ration of the policy, of the terms for renewal of
24 the policy. Except with respect to rates and ad-
25 ministrative changes, the terms of renewal (in-

1 cluding benefits) shall be the same as the terms
2 of issuance.

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

8 “(2) PERIOD OF RENEWAL.—The period of re-
9 newal of each insured Mediplan supplemental policy
10 shall be for a period of not less than 12 months.

11 “(c) DEFINITIONS.—In this section (and section
12 2172):

13 “(1) CARRIER.—The term ‘carrier’ means any
14 person that offers a Mediplan supplemental policy,
15 whether through insurance or otherwise, including a
16 licensed insurance company, a prepaid hospital or
17 medical service plan, a health maintenance organiza-
18 tion, and a multiple employer welfare arrangement
19 (as defined in section 3(40) of the Employee Retire-
20 ment Income Security Act of 1974).

21 “(2) INSURED MEDIPLAN SUPPLEMENTAL POL-
22 ICY.—The term ‘insured Mediplan supplemental pol-
23 icy’ means any Mediplan supplemental policy pro-
24 vided through insurance, and includes a prepaid hos-
25 pital or medical service plan, a health maintenance

1 organization, and a multiple employer welfare ar-
2 rangement (as defined in section 3(40) of the Em-
3 ployee Retirement Income Security Act of 1974).

4 **“SEC. 2175. PROHIBITION OF DUPLICATION.**

5 “(a) IN GENERAL.—

6 (1) IN GENERAL.—It is unlawful for a person
7 to sell or issue to an individual entitled to benefits
8 under this title—

9 “(A) a health insurance policy with knowl-
10 edge that the policy duplicates health benefits
11 to which the individual is otherwise entitled
12 under this title (including special benefits as a
13 low-income individual),

14 “(B) a Mediplan supplemental policy with
15 knowledge that the individual is entitled to ben-
16 efits under another Mediplan supplemental pol-
17 icy, or

18 “(C) a health insurance policy (other than
19 a Mediplan supplemental policy) with knowledge
20 that the policy duplicates health benefits to
21 which the individual is otherwise entitled, other
22 than benefits to which the individual is entitled
23 under a requirement of State or Federal law.

24 “(2) EXCEPTION.—Paragraph (1) shall not
25 apply with respect to—

1 “(A) the sale or issuance of a group policy
2 or plan of one or more employers or labor orga-
3 nizations, or of the trustees of a fund estab-
4 lished by one or more employers or labor orga-
5 nizations (or combination thereof), for employ-
6 ees or former employees (or combination there-
7 of) or for members or former members (or com-
8 bination thereof) of the labor organizations,

9 “(B) the sale or issuance of a policy de-
10 scribed in paragraph (1)(A) (other than a
11 Mediplan supplemental policy to an individual
12 entitled to benefits as a low-income individual)
13 under which all the benefits are fully payable
14 directly to or on behalf of the individual without
15 regard to other health benefit coverage of the
16 individual but only if there is disclosed in a
17 prominent manner as part of (or together with)
18 the application the applicable statement (speci-
19 fied under subsection (d)) of the extent to
20 which benefits payable under the policy dupli-
21 cate benefits under this title, or

22 “(C) the sale or issuance of a policy de-
23 scribed in paragraph (1)(C) under which all the
24 benefits are fully payable directly to or on be-

1 half of the individual without regard to other
2 health benefit coverage of the individual.

3 “(b) ADDITIONAL PROHIBITION.—Whoever violates
4 subsection (a) shall be fined under title 18, United States
5 Code, or imprisoned not more than 5 years, or both, and,
6 in addition to or in lieu of such a criminal penalty, is sub-
7 ject to a civil money penalty of not to exceed \$25,000 (or
8 \$15,000 in the case of a seller who is not the issuer of
9 the policy) for each such prohibited act.

10 “(c) RULE.—A seller (who is not the issuer of a
11 health insurance policy) shall not be considered to violate
12 subsection (a) with respect to the sale of a Mediplan sup-
13 plemental policy if the policy is sold in compliance with
14 subsection (d).

15 “(d) DISCLOSURE.—

16 “(1) IN GENERAL.—It is unlawful for a person
17 to issue or sell a Mediplan supplemental policy to an
18 individual entitled to benefits under this title, wheth-
19 er directly, through the mail, or otherwise, unless—

20 “(A) the person obtains from the individ-
21 ual, as part of the application for the issuance
22 or purchase and on a form described in sub-
23 paragraph (B), a written statement (in a form
24 specified by the Secretary) signed by the indi-
25 vidual stating, to the best of the individual’s

1 knowledge, what health insurance policies the
2 individual has, from what source, and whether
3 the individual is a low-income individual, and

4 “(B) the written statement is accompanied
5 by a written acknowledgment (in a form speci-
6 fied by the Secretary), signed by the seller of
7 the policy, of the request for and receipt of such
8 statement.

9 “(2) STATEMENT.—The statement required by
10 paragraph (1) shall be made on a form that—

11 “(A) states in substance that an individual
12 entitled to benefits under this title does not
13 need more than one Mediplan supplemental pol-
14 icy,

15 “(B) states in substance that low-income
16 individuals usually do not need a Mediplan sup-
17 plemental policy and that benefits and pre-
18 miums under any such policy shall be sus-
19 pended upon request of the policyholder during
20 the period (of not longer than 24 months) of
21 entitlement to benefits under this title as a low-
22 income individual and may be reinstated upon
23 no longer being a low-income individual, and

24 “(C) states that counseling services may be
25 available in the State to provide advice concern-

1 ing the purchase of Mediplan supplemental poli-
2 cies and may provide the telephone number for
3 such services.

4 “(3) NEED FOR STATEMENT.—

5 “(A) IN GENERAL.—Except as provided in
6 subparagraph (B), if the statement required by
7 paragraph (2) is not obtained or indicates that
8 the individual has another Mediplan supple-
9 mental policy or indicates that the individual is
10 entitled to benefits under this title as a low-in-
11 come individual, the sale of a Mediplan supple-
12 mental policy shall be considered to be a viola-
13 tion of subsection (a).

14 “(B) EXCEPTION.—Subparagraph (A)
15 shall not apply in the case of an individual who
16 has a Mediplan supplemental policy, if the indi-
17 vidual indicates in writing, as part of the appli-
18 cation for purchase, that the policy being pur-
19 chased replaces such other policy and indicates
20 an intent to terminate the policy being replaced
21 when the new policy becomes effective and the
22 issuer or seller certifies in writing that such
23 policy will not, to the best of the issuer’s or sell-
24 er’s knowledge, duplicate coverage (taking into
25 account any such replacement).

1 “(C) PENALTY.—Whoever issues or sells a
2 Mediplan supplemental policy in violation of
3 this paragraph shall be fined under title 18,
4 United States Code, or imprisoned not more
5 than 5 years, or both, and, in addition to or in
6 lieu of such a criminal penalty, is subject to a
7 civil money penalty of not to exceed \$25,000 (or
8 \$15,000 in the case of a seller who is not the
9 issuer of the policy) for each such violation.

10 **“SEC. 2176. ADDITIONAL PROHIBITIONS.**

11 “(a) IN GENERAL.—Whoever knowingly and willfully
12 makes or causes to be made or induces or seeks to induce
13 the making of any false statement or representation of a
14 material fact with respect to compliance of any policy with
15 the standards and requirements set forth in section 2173
16 or in regulations promulgated pursuant to such section
17 shall be fined under title 18, United States Code, or im-
18 prisoned not more than 5 years, or both, and, in addition
19 to or in lieu of such a criminal penalty, is subject to a
20 civil money penalty of not to exceed \$5,000 for each such
21 prohibited act.

22 “(b) FALSE REPRESENTATION.—Whoever falsely as-
23 sumes or pretends to be acting, or misrepresents in any
24 way that he is acting, under the authority of or in associa-
25 tion with, the program of health insurance established

1 under this title, or any Federal agency, for the purpose
2 of selling or attempting to sell insurance, or in such pre-
3 tended character demands, or obtains money, paper, docu-
4 ments, or anything of value, shall be fined under title 18,
5 United States Code, or imprisoned not more than 5 years,
6 or both, and, in addition to or in lieu of such a criminal
7 penalty, is subject to a civil money penalty of not to exceed
8 \$5,000 for each such prohibited act.

9 “(c) APPLICATION OF CIVIL MONEY PENALTY PRO-
10 CEDURES.— The provisions of section 1128A (other than
11 the first sentence of subsection (a) and other than sub-
12 section (b)) shall apply to a civil money penalty under this
13 part in the same manner as such provisions apply to a
14 penalty or proceeding under section 1128A(a).

15 **“SEC. 2177. INFORMATION DISCLOSURE.**

16 “(a) IN GENERAL.—The Secretary shall provide, to
17 all individuals entitled to benefits under this title such in-
18 formation as will permit such individuals to evaluate the
19 value of Mediplan supplemental policies to them and the
20 relationship of any such policies to benefits provided under
21 this title.

22 “(b) INFORMATION ON PROHIBITIONS.—The Sec-
23 retary shall—

24 “(1) inform all individuals entitled to benefits
25 under this title of—

1 “(A) the actions and practices that are
2 subject to sanctions under this part and

3 “(B) the manner in which they may report
4 any such action or practice to an appropriate
5 official of the Department of Health and
6 Human Services (or to an appropriate State of-
7 ficial), and

8 “(2) publish the toll-free number for individuals
9 to report suspected violations of the provision of this
10 part.

11 “(c) COUNSELING NUMBERS.—The Secretary shall
12 provide individuals entitled to benefits under this title with
13 a listing of the addresses and telephone numbers of State
14 and Federal agencies and offices that provide information
15 and assistance to individuals with respect to the selection
16 of Mediplan supplemental policies.

17 **“SEC. 2178. LIMITATIONS ON SALES COMMISSIONS.**

18 “(a) IN GENERAL.—It is unlawful for a person who
19 provides for a commission or other compensation to an
20 agent or other representatives with respect to the sale of
21 a Mediplan supplemental policy (or certificate)—

22 “(1) to provide for a first year commission or
23 other first year compensation that exceeds 200 per-
24 cent of the commission or other compensation for

1 the selling or servicing of the policy or certificate in
2 a second or subsequent year, or

3 “(2) to provide for compensation with respect
4 to replacement of such a policy or certificate that is
5 greater than the compensation that would apply to
6 the renewal of the policy or certificate.

7 “(b) PENALTY.—Whoever violates subsection (a)
8 shall be fined under title 18, United States Code, or im-
9 prisoned not more than 5 years, or both, and, in addition
10 to or in lieu of such a criminal penalty, is subject to a
11 civil money penalty of not to exceed \$25,000 for each such
12 prohibited act.

13 “(c) DEFINITION.—In this section, the term ‘com-
14 pensation’ includes pecuniary and nonpecuniary com-
15 pensation of any kind relating to the sale or renewal of
16 a policy or certificate and specifically includes bonuses,
17 gifts, prizes, awards, and finders’ fees.

18 **“SEC. 2179. DEFINITIONS.**

19 “In this part:

20 “(1) GROUP.—The term ‘group’ means 2 or
21 more employees of the same employer who normally
22 perform on a monthly basis at least 17½ hours of
23 service per week for that employer.

24 “(2) HEALTH MAINTENANCE ORGANIZATION.—
25 The term ‘health maintenance organization’ has the

1 meaning given the term ‘eligible organization’ in sec-
2 tion 1876(b).

3 “(3) MEDIPLAN SUPPLEMENTAL POLICY.—The
4 term ‘Mediplan supplemental policy’ is a health in-
5 surance policy or other health benefit plan offered by
6 a private entity to individuals who are entitled to
7 have payment made under this title, which provides
8 reimbursement for expenses incurred for services
9 and items for which payment may be made under
10 this title but which are not reimbursable by reason
11 of the application of deductibles, coinsurance
12 amounts, or other limitations imposed pursuant to
13 this title; but does not include—

14 “(A) any such policy or plan of the trust-
15 ees of a fund established by one or more em-
16 ployers or labor organizations (or combination
17 thereof) if the policy or plan offers benefits as
18 a direct service organization under section
19 1833, or

20 “(B) a policy or plan of a health mainte-
21 nance organization which offers benefits under
22 this title under section 2162(d).

23 For purposes of this title, the term ‘policy’ includes
24 a certificate issued under such policy.

1 “(4) STATE.—The term ‘State’ means the 50
2 States and the District of Columbia.

3 “PART G—STATE OPT OUT

4 **“SEC. 2181. ELECTION.**

5 “(a) IN GENERAL.—A State may elect, in accordance
6 with this part, to have health care benefits made available
7 to residents of the State under a State alternative health
8 care program under this part instead of under the other
9 provisions of this title. Such an election shall not be effec-
10 tive unless—

11 “(1) the State submits to the Secretary an ap-
12 plication for election, in a form and manner specified
13 by the Secretary, and

14 “(2) the Secretary determines that the proposed
15 health care program meets the requirements speci-
16 fied in sections 2182 and 2183.

17 “(b) NO APPLICATION OF ELECTION ON OUT-OF-
18 STATE RESIDENTS.—An election of a State under this
19 part shall not affect the entitlement of individuals who are
20 not residents of the State to receive benefits under this
21 title for services furnished in the State on the same terms
22 and conditions as though such an election had not been
23 made.

1 **“SEC. 2182. REQUIREMENTS FOR STATE ALTERNATIVE**
2 **HEALTH CARE PROGRAMS.**

3 “The requirements, with respect to a State alter-
4 native health care program are as follows:

5 “(1) ELIGIBILITY.—Each individual who is a
6 resident of the State (as determined by the Sec-
7 retary) is entitled to benefits under the program.

8 “(2) ENROLLMENT AND MEDIPLAN CARDS.—
9 The program provides for enrollment of eligible indi-
10 viduals, and the issuance of Mediplan cards, in a
11 manner consistent with section 2102.

12 “(3) SCOPE OF BENEFITS.—

13 “(A) IN GENERAL.—The scope of benefits
14 under the program shall not be less than the
15 scope of benefits specified in section 2121 (in-
16 cluding additional services for children, preg-
17 nancy-related services and special provisions for
18 lower-income individuals).

19 “(B) EXCLUSIONS.—The exclusions from
20 benefits shall be no more restrictive than the
21 exclusions specified in section 2122. Pursuant
22 to section 2122(b)(2), payments under the pro-
23 gram shall be secondary to payments under the
24 medicare program.

25 “(C) OUT-OF-STATE BENEFITS.—The pro-
26 gram shall provide for coverage of medically

1 necessary services furnished outside the State,
2 except in such cases as the Secretary may
3 specify. In specifying such cases, the Secretary
4 shall take into account the requirements of
5 health maintenance organization for coverage of
6 services outside the organization's service area.
7 Any such out-of-State coverage shall be pro-
8 vided in a manner consistent with the provision
9 of benefits under this title to individuals who
10 are not residents of the State.

11 “(4) LIMITATION ON COST-SHARING.—The pro-
12 gram does not impose cost-sharing in excess of the
13 cost-sharing that would be permitted under section
14 2141.

15 “(5) ENTITLEMENT VERIFICATION SYSTEM.—
16 The program provides for an entitlement verification
17 system that meets the requirements of section
18 2151(c).

19 “(6) UNIFORM CLAIMS AND ELECTRONIC DATA
20 SET.—The program provides for use of uniform
21 claims and electronic data set in accordance with the
22 standards established under section 2152(c).

23 “(7) ELECTRONIC MEDICAL RECORDS AND RE-
24 PORTING; UNIFORM HOSPITAL COST REPORTING.—
25 The program requires hospitals in the State to meet

1 the standards for electronic medical records and uni-
2 form hospital cost reporting in accordance with sec-
3 tions 2153 and 2154.

4 “(8) REPORTING SYSTEM.—The program pro-
5 vides for such reporting of information on the pro-
6 gram as the Secretary may require in order to as-
7 sure that the program meets the requirements of
8 this section.

9 “(9) MAINTENANCE OF EFFORT PAYMENTS.—
10 The State is providing for payment to the Mediplan
11 Trust Fund in accordance with section 2163.

12 “(10) USE OF FUNDS AND SAVINGS.—The
13 State will comply with the requirements of section
14 2185(b).

15 **“SEC. 2183. CONTROL OF AGGREGATE EXPENDITURES.**

16 “(a) ASSURANCES REQUIRED.—

17 “(1) IN GENERAL.—A State election under this
18 part may not be approved until the Secretary has
19 been provided satisfactory assurances that under the
20 program, during a 3-year period (the first such pe-
21 riod beginning with the first month in which this
22 section applies to that program in the State) the ag-
23 gregate expenditures for required health care serv-
24 ices under the program will not exceed the applicable
25 total limit specified in paragraph (2).

1 “(2) APPLICABLE TOTAL LIMIT.—The applica-
2 ble total limit specified in this paragraph is the total
3 of the maximum amount of payments that would be
4 payable in the State for the required health care
5 services under this title if the State election were not
6 in effect.

7 “(3) SPECIAL RULE FOR EXPENDITURES FOR
8 HMOS.—In determining aggregate expenditures for
9 purposes of paragraph (1), the Secretary shall ex-
10 clude expenditures for services of staff or group
11 model health maintenance organizations if the State
12 program provides that such organizations may nego-
13 tiate directly with providers of services covered
14 under the program with respect to the organization’s
15 rate of payment for such services and, in determin-
16 ing the applicable limits under paragraph (2), the
17 Secretary shall exclude payments for services of such
18 organizations.

19 “(b) ANNUAL DETERMINATION BY SECRETARY.—
20 The Secretary shall annually determine whether a State
21 program met the assurances required under subsection (a)
22 for the most recent 3-year period for which the State
23 election was in effect.

24 “(c) TREATMENT OF STATES FAILING TO CONTROL
25 AGGREGATE EXPENDITURES.—

1 “(1) IN GENERAL.—The Secretary shall termi-
2 nate approval of a State election under this part or
3 impose a sanction described in paragraph (2) on a
4 State if the Secretary determines that, with respect
5 to a State program under this part for a 3-year pe-
6 riod the aggregate expenditures for required health
7 care services under the program exceeded the appli-
8 cable total limit specified in subsection (a)(2).

9 “(2) SANCTIONS.—The sanction described in
10 this paragraph is a reduction in the aggregate
11 amount otherwise payable to the State under section
12 2185 for the following year (or for the following 3-
13 year period, if the Secretary determines that a re-
14 duction for such period is appropriate in the case of
15 a State) in an amount equal to the amount by which
16 the aggregate expenditures for the preceding 3-year
17 period under the program exceeded the applicable
18 total limit.

19 “(3) NOTICE.—The Secretary may not impose
20 any sanction against a state under paragraph (2)
21 unless the Secretary has provided the State with no-
22 tice of the Secretary’s determination under para-
23 graph (1) and intent to impose the sanction under
24 paragraph (2).

1 **“SEC. 2184. TERMINATION OF APPROVAL OF STATE ELEC-**
2 **TION.**

3 “(a) PROCESS REQUIREMENTS.—

4 “(1) NOTICE.—The Secretary may terminate
5 the approval of a State’s election under this part
6 only after the expiration of a 90-day period begin-
7 ning on the date the Secretary informs the State of
8 the Secretary’s intention to terminate such approval,
9 unless, during such 90-day period, the State re-
10 quests a hearing with the Secretary.

11 “(2) HEARING.—If the State requests a hearing
12 during the 90-day period described in paragraph (1),
13 the Secretary shall conduct a hearing during which
14 the State may present evidence showing that the
15 Secretary should not terminate the approval of the
16 election. If the Secretary decides to reject such evi-
17 dence, the Secretary shall terminate the approval of
18 the State’s election beginning with the first day of
19 the first month that begins after the Secretary’s
20 decision.

21 “(3) JUDICIAL REVIEW PROHIBITED.—There
22 shall be no administrative or judicial review of a de-
23 cision by the Secretary to terminate the approval of
24 a State election under this subsection.

25 “(b) EFFECT OF TERMINATION ON PAYMENT RATES
26 APPLICABLE TO SERVICES IN STATE.—

1 “(1) IN GENERAL.—If the Secretary terminates
2 the approval of a State election under this section,
3 the maximum payment rates applicable to required
4 health services shall be the maximum payment rates
5 otherwise applicable to the services subject to the
6 adjustment described in paragraph (2).

7 “(2) RECAPTURE OF EXCESS SPENDING.—The
8 Secretary shall reduce the maximum payment rates
9 applicable under this title to required health services
10 by such factor as the Secretary determines necessary
11 to decrease the amount of aggregate expenditures
12 that would otherwise be made for services provided
13 in the State by the amount by which the aggregate
14 expenditures for the preceding 3-year period under
15 the program exceeded the applicable total limit spec-
16 ified in section 2183(a)(2).

17 **“SEC. 2185. PAYMENTS TO STATES.**

18 “(a) IN GENERAL.—In the case of a State with a
19 State alternative health care program approved under this
20 part, the Secretary shall provide for payment to the State,
21 on a monthly basis, of such amounts as the Secretary de-
22 termines to be equivalent to the payments that would have
23 been made under this title with respect to residents in the
24 State if the program had not been so approved. Such pay-
25 ments shall not include any amount attributable to

1 amounts paid under the medicare program under title
2 XVIII for residents of the State.

3 “(b) USE OF FUNDS AND SAVINGS.—

4 “(1) USE OF FUNDS.—A State alternative
5 health care program may only use funds provided
6 under subsection (a) for payment of covered bene-
7 fits, for the administration of the program under
8 this part, and, if applicable, for the expansion of
9 benefits or reduction of cost-sharing under para-
10 graph (2).

11 “(2) APPLICATION OF SAVINGS.—In the case of
12 a State for which the aggregate expenditures (de-
13 scribed in section 2183) for required health services
14 are less than the applicable total limit specified in
15 section 2183(a)(2), the State shall provide for such
16 increase in the scope of benefits (which may include
17 a reduction in cost-sharing) as will assure the ex-
18 penditure of funds consistent with paragraph (1).

19 **“SEC. 2186. NO IMPACT ON MEDICARE BENEFITS.**

20 “Nothing in this part shall be construed as affecting
21 the entitlement of individuals to medicare benefits under
22 title XVIII.”.

23 (b) EFFECTIVE DATE FOR BENEFITS.—Title XXI of
24 the Social Security Act shall apply to items and services
25 furnished on or after January 1, 1995.

1 (c) EXCISE TAX ON PREMIUMS RECEIVED ON
2 MEDIPLAN SUPPLEMENTAL POLICIES WHICH DO NOT
3 MEET CERTAIN REQUIREMENTS.—

4 (1) IN GENERAL.—Chapter 47 of the Internal
5 Revenue Code of 1986 (relating to taxes on group
6 health plans) is amended by adding at the end there-
7 of the following new section:

8 **“SEC. 5000A. FAILURE TO SATISFY CERTAIN STANDARDS**
9 **FOR MEDIPLAN SUPPLEMENTAL POLICIES.**

10 “(a) IMPOSITION OF TAX.—

11 “(1) GENERAL RULE.—There is hereby imposed
12 a tax on any nonqualified Mediplan supplemental
13 policy.

14 “(2) NONQUALIFIED MEDIPLAN SUPPLE-
15 MENTAL POLICY DEFINED.—For purposes of this
16 section, the term ‘nonqualified Mediplan supple-
17 mental policy’ means any Mediplan supplemental
18 policy that—

19 “(A) is not certified under section 21711
20 of the Social Security Act, or

21 “(B) the Secretary of Health and Human
22 Services determines is providing coverage in vio-
23 lation of section 2171(a) of such Act.

24 “(b) AMOUNT OF TAX.—

1 “(1) IN GENERAL.—The amount of tax imposed
2 by subsection (a) shall be equal to—

3 “(A) in the case of an insured Mediplan
4 supplemental policy, 50 percent of the gross
5 premiums received by the issuer which are at-
6 tributable to the period during which the policy
7 is a nonqualified Mediplan supplemental policy,
8 and

9 “(B) in the case of a self-insured Mediplan
10 supplemental policy, 50 percent of the expendi-
11 tures under such policy during the period that
12 the policy is a nonqualified Mediplan supple-
13 mental policy.

14 “(2) GROSS PREMIUMS.—For purposes of para-
15 graph (1)(A), gross premiums shall include any con-
16 sideration received with respect to any insured
17 Mediplan supplemental policy.

18 “(3) CONTROLLED GROUPS.—For purposes of
19 paragraph (1)—

20 “(A) CONTROLLED GROUP OF CORPORA-
21 TIONS.—All corporations which are members of
22 the same controlled group of corporations shall
23 be treated as 1 person. For purposes of the pre-
24 ceding sentence, the term ‘controlled group of

1 corporations' has the meaning given to such
2 term by section 1563(a), except that—

3 “(i) ‘more than 50 percent’ shall be
4 substituted for ‘at least 80 percent’ each
5 place it appears in section 1563(a)(1), and

6 “(ii) the determination shall be made
7 without regard to subsections (a)(4) and
8 (e)(3)(C) of section 1563.

9 “(B) PARTNERSHIPS, PROPRIETORSHIPS,
10 ETC., WHICH ARE UNDER COMMON CONTROL.—
11 Under regulations prescribed by the Secretary,
12 all trades or business (whether or not incor-
13 porated) which are under common control shall
14 be treated as 1 person. The regulations pre-
15 scribed under this subparagraph shall be based
16 on principles similar to the principles which
17 apply in the case of subparagraph (A).

18 “(c) LIABILITY FOR TAX.—

19 “(1) INSURED POLICY.—In the case of an in-
20 sured Mediplan supplemental policy, the issuer of
21 the insurance or subscriber contract under which
22 such policy is provided shall be liable for the tax im-
23 posed by this section.

24 “(2) SELF-INSURED POLICY.—In the case of a
25 self-insured policy—

1 “(A) IN GENERAL.—Except as provided in
2 subparagraph (B), the employer maintaining
3 such policy shall be liable for the tax imposed
4 by this section.

5 “(B) MULTIEmployer POLICIES, ETC.—In
6 the case of a multiemployer policy or any other
7 policy not maintained by an employer, the is-
8 suer of the policy shall be liable for the tax im-
9 posed by this section.

10 “(d) INCORPORATION OF DEFINITIONS.—For pur-
11 poses of this section, the terms ‘Mediplan supplemental
12 policy’, ‘insured Mediplan supplemental policy’, and ‘self-
13 insured Mediplan supplemental policy’ have the meanings
14 given such terms in section 2175 of the Social Security
15 Act.”.

16 (2) NONDEDUCTIBILITY OF TAX.—Subsection
17 (a) of section 275 of such Code (relating to
18 nondeductibility of certain taxes) is amended by add-
19 ing at the end thereof the following new paragraph:

20 “(7) Taxes imposed by section 5000A (failure
21 to satisfy certain standards for Mediplan supple-
22 mental policies).”

23 (3) CLERICAL AMENDMENTS.—

1 (A) So much of chapter 47 of such Code
 2 as precedes subsection (a) of section 5000 is
 3 amended to read as follows:

4 **“CHAPTER 47—TAXES RELATING TO**
 5 **HEALTH BENEFIT PLANS**

“Sec. 5000. Contributions to nonconforming large group health plans.

“Sec. 5000A. Failure to satisfy certain standards for Mediplan supplemental policies.

6 **“SEC. 5000. CONTRIBUTIONS TO NONCONFORMING LARGE**
 7 **GROUP HEALTH PLANS.”**

8 (B) The table of chapters for subtitle D of
 9 such Code is amended by striking the item re-
 10 lating to chapter 47 and inserting the following
 11 new item:

“Chapter 47. Taxes relating to health benefit plans.”

12 **TITLE II—COST CONTAINMENT**

13 **SEC. 201. NATIONAL MEDIPLAN EXPENDITURE BUDGET.**

14 (a) ESTABLISHMENT.—

15 (1) IN GENERAL.—For each calendar year (be-
 16 ginning with 1995), there is established a national
 17 Mediplan expenditure budget (in the amount speci-
 18 fied under paragraph (2)).

19 (2) AMOUNT.—

20 (A) 1995.—The total amount of the na-
 21 tional Mediplan expenditure budgets for 1995 is
 22 equal to the Mediplan budget baseline (deter-

1 mined under subsection (b) for 1994) multiplied
2 by the applicable adjustment factor (specified
3 under subsection (c)) for 1995.

4 (B) SUBSEQUENT YEARS.—The total
5 amount of such budget for each year after 1995
6 is equal to the budget determined under this
7 paragraph for the previous year multiplied by
8 the applicable adjustment factor (specified
9 under subsection (c)) for the year involved.

10 (3) PUBLICATION.—The Secretary of Health
11 and Human Services shall publish in the Federal
12 Register and report to the Congress, by not later
13 than April 1 before each year, the amount of the na-
14 tional Mediplan expenditure budget for the year.

15 (b) MEDIPLAN BUDGET BASELINE.—The Secretary
16 shall compute a Mediplan budget baseline under this sub-
17 section for 1994 as follows:

18 (1) 1993 ACTUAL EXPENDITURES.—The Sec-
19 retary shall determine (on the basis of the best data
20 available) the amount of the aggregate Mediplan ex-
21 penditures (as defined in subsection (d)(1)) during
22 1993.

23 (2) PROJECTION FOR 1994.—The Secretary
24 shall increase such amount by the Secretary's esti-
25 mate of the percentage increase in the aggregate

1 Medioplan expenditures between the midpoint of 1993
2 and the midpoint of 1994.

3 (c) APPLICABLE ADJUSTMENT FACTOR.—The appli-
4 cable adjustment factor under this subsection for each
5 year is 1 plus the sum (expressed as a fraction) of—

6 (1) the average annual percentage increase in
7 the gross domestic product (in current dollars, as
8 published by the Secretary of Commerce) during the
9 5-year period ending with the second previous year;
10 plus

11 (2)(A) for 1995, 3.5 percentage points,

12 (B) for 1996, 2.5 percentage points,

13 (C) for 1997, 1.5 percentage points,

14 (D) for 1998, 0.5 percentage point, and

15 (E) for each year thereafter, 0 percentage
16 points.

17 (d) AGGREGATE MEDIPLAN EXPENDITURES DE-
18 FINED.—In this Act, the term “aggregate Medioplan ex-
19 penditures” means, with respect to health care services or
20 a class of services, expenditures made under the medicare
21 program or under Medioplan with respect to the provision
22 of such services or class of services, and also includes re-
23 ceipts of providers with respect to amounts payable as
24 deductibles, coinsurance, or other amounts for which the
25 beneficiary is liable with respect to items and services cov-

1 ered under either such program provided to a beneficiary,
2 and including payments made under a contract under sec-
3 tion 1833(a)(1) or section 1876 of the Social Security Act,
4 or comparable provisions of title XXI of such Act (other
5 than the portion of such payments that is attributable to
6 administrative costs).

7 **SEC. 202. CLASSES OF HEALTH CARE SERVICES.**

8 (a) ESTABLISHMENT OF CLASSES.—

9 (1) IN GENERAL.—

10 (A) SPECIFIED SERVICES.—In the case of
11 items and services specified in a subparagraph
12 under paragraph (2), all of the items and serv-
13 ices described in that subparagraph shall be
14 considered to be a “separate” class of health
15 care services.

16 (B) OVERLAPPING SERVICES.—Except as
17 the Secretary may provide, items and services
18 specified in a subparagraph of paragraph (2)
19 shall be considered to be excluded from the sub-
20 sequent subparagraphs of that paragraph.

21 (2) SPECIFIED HEALTH CARE SERVICES.—The
22 items and services specified in this paragraph are as
23 follows:

24 (A) Inpatient hospital services, other than
25 mental health services.

1 (B) Outpatient hospital services and ambu-
2 latory facility services (including renal dialysis
3 facility services), other than mental health serv-
4 ices.

5 (C) Diagnostic testing services (including
6 clinical laboratory services and x-ray services).

7 (D) Physicians' services and other profes-
8 sional medical services, other than mental
9 health services.

10 (E) Home health services and hospice care.

11 (F) Rehabilitation services, such as phys-
12 ical therapy, occupational and speech therapy.

13 (G) Durable medical equipment and sup-
14 plies.

15 (H) Prescription drugs and biologicals and
16 insulin.

17 (I) Nursing facility services, including
18 skilled nursing facility services and intermediate
19 care facility services, other than mental health
20 services.

21 (J) Mental health services.

22 (K) Other covered services.

23 (b) PUBLICATION.—

24 (1) IN GENERAL.—The Secretary shall pub-
25 lish—

1 (A) by not later than April 1, 1994, pro-
2 posed regulations defining the health care serv-
3 ices and establishing the classes of services
4 under this section, and

5 (B) by not later than June 1, 1994, final
6 regulations defining the health care services and
7 establishing such classes.

8 (2) ITEMS INCLUDED IN REGULATIONS.—In
9 such regulations, the Secretary shall define—

10 (A) the class or classes to be established
11 under subsection (a)(1),

12 (B) the services to be included within each
13 class, and

14 (C) the methods and sources of data for
15 computing, for purposes of this title, aggregate
16 Mediplan expenditures for services within the
17 class.

18 (3) CHANGES.—

19 (A) NO CHANGES AUTHORIZED.—After the
20 Secretary has established classes of services
21 under paragraph (1)(B), the Secretary may not
22 change such classes (or the services included in
23 such classes), except in the case of services not
24 previously classified. Any such services not pre-

1 viously classified shall be classified within one
2 of the classes previously established.

3 (B) RECOMMENDED CHANGES.—If the
4 Secretary determines that a change in the clas-
5 sification established under this section may be
6 appropriate, the Secretary shall submit to the
7 Congress a report proposing such change. The
8 Secretary shall include in the report an expla-
9 nation of—

10 (i) the rationale for such change, and

11 (ii) the impact of such change on the
12 total aggregate Mediplan expenditures per-
13 mitted for classes of services that would be
14 affected by the change.

15 (4) COMMISSION REPORTS.—

16 (A) INITIAL REPORTS.—With respect to
17 the establishment of classes of services under
18 this section, each applicable Commission (as de-
19 fined in section 208(1))—

20 (i) by not later than March 1, 1994,
21 shall report its recommendations to the
22 Secretary and Congress concerning such
23 classes, and

24 (ii) by not later than May 1, 1994,
25 shall report to the Secretary and the Con-

1 gress its comments concerning the classi-
2 fication proposed by the Secretary under
3 paragraph (1)(A).

4 (B) PERIODIC REPORTS.—Each applicable
5 Commission shall periodically report to Con-
6 gress on changes in the system of classification
7 under this section that should be made to pro-
8 mote the more efficient provision of medically
9 appropriate health care services.

10 **SEC. 203. ALLOCATION OF HEALTH BUDGET BY CLASS OF**
11 **SERVICE.**

12 (a) ALLOCATION.—

13 (1) IN GENERAL.—The Secretary shall allocate
14 the national Mediplan expenditure budget under sec-
15 tion 201 for a year among classes of services speci-
16 fied under section 202.

17 (2) PROPORTIONAL ALLOCATION BASED ON
18 HISTORICAL PROJECTED EXPENDITURES.—The per-
19 cent of the budget allocated to each class for a year
20 shall be equal to the quotient (expressed as a per-
21 centage) of—

22 (A) the historical projected Mediplan ex-
23 penditures for the class for the year (as deter-
24 mined under subsection (b)(1)), divided by

1 (B) the sum of such historical projected
2 Mediplan expenditures for all the classes for the
3 year.

4 (3) PUBLICATION.—

5 (A) IN GENERAL.—The Secretary shall, in
6 conjunction with the publication of budget
7 under section 201(a)(3) for a year and by not
8 later than April 1 before the year, publish in
9 the Federal Register and report to the Congress
10 the allocation of the budget among the classes
11 of services under this subsection.

12 (B) EXCEPTION FOR 1995.—For 1995,
13 the Secretary shall publish and report the allo-
14 cation of the budget among the classes of
15 services under this subsection not later than
16 August 1, 1994.

17 (b) HISTORICAL PROJECTED EXPENDITURES.—

18 (1) DETERMINATION.—For purposes of sub-
19 section (a)—

20 (A) FOR 1994.—The historical projected
21 Mediplan expenditures for a class of services for
22 1994 is equal to the portion of the amount of
23 aggregate Mediplan expenditures during 1993
24 (as determined under section 201(b)(1)) which
25 is attributable to the class of services, multi-

1 plied by the trend factor (described in para-
2 graph (2)) for the class for 1994.

3 (B) SUBSEQUENT YEARS.—The historical
4 projected Mediplan expenditures for a class of
5 services for a year after 1994 is equal to the
6 amount of the allocation for the class under
7 subsection (a)(2) for the preceding year multi-
8 plied by the trend factor (described in subpara-
9 graph (B)) for the class for the year involved.

10 (2) TREND FACTOR.—In paragraph (1), the
11 “trend factor”, for a class of services, is 1 plus the
12 average annual rate of increase in aggregate
13 Mediplan expenditures for the class of services dur-
14 ing the 5-year period ending with 1993.

15 (3) PUBLICATION OF TREND FACTORS.—The
16 Secretary shall publish, by not later than August 1,
17 1994, the trend factors for the different classes of
18 services.

19 (c) REVIEW AND CHANGES IN ALLOCATION.—

20 (1) IN GENERAL.—

21 (A) NO ADMINISTRATIVE AUTHORITY TO
22 CHANGE.—Except as specifically provided by
23 law enacted after the enactment of this Act, the
24 Secretary has no authority to change the alloca-

1 tion or trend factors from the allocation and
2 trend factors provided under this section.

3 (B) RECOMMENDED CHANGES.—If the
4 Secretary determines that a change in the allo-
5 cation of the budget among classes is appro-
6 priate, the Secretary shall submit to the Con-
7 gress a report proposing such change. The Sec-
8 retary shall include in the report an explanation
9 of—

10 (i) the rationale for such change, and

11 (ii) the impact of such change on the
12 total aggregate Mediplan expenditures per-
13 mitted for classes of services that would be
14 affected by the change.

15 (2) COMMISSION REVIEW.—Each applicable
16 Commission shall annually review and report to Con-
17 gress, in its report submitted under section
18 202(b)(4), on the effect of the trend factors used in
19 the allocation of the budget among classes of serv-
20 ices. Such report shall include such recommenda-
21 tions for appropriate adjustments in the trend fac-
22 tors as the applicable Commission considers appro-
23 priate to properly take into account at least—

24 (A) changes in health care technology,

1 (B) changes in the patterns and practices
2 relating to health care delivery found to be ap-
3 propriate,

4 (C) changes in the distribution of health
5 care services, and

6 (D) the special health care needs of under-
7 served rural and inner city populations.

8 **SEC. 204. NATIONAL HEALTH EXPENDITURES REPORTING**
9 **SYSTEM.**

10 (a) IN GENERAL.—The Secretary shall establish a
11 national health expenditures reporting system (in this sec-
12 tion referred to as the “system”) for purposes of—

13 (1) establishing the national health expendi-
14 tures budget,

15 (2) allocating the health budgets among classes
16 of services,

17 (3) determining payment rates, and

18 (4) monitoring expenditures in States which
19 have elections in effect under part G.

20 (b) INFORMATION REPORTING.—

21 (1) BY PROVIDER.—Under the system, provid-
22 ers of health care services shall report (beginning
23 not later than January 1, 1995) such information
24 relating to the provision of health care services (in-
25 cluding the volume and receipts for such services) in

1 such form and manner (including the use of elec-
2 tronic transmission), by such classification, and at
3 such periodic intervals, as the Secretary shall specify
4 in regulation.

5 (2) USE OF REPORTING MECHANISMS.—To the
6 maximum extent practicable and appropriate, report-
7 ing under such system shall be done through report-
8 ing mechanisms (such as uniform hospital reports
9 provided under section 2255 of the Social Security
10 Act) and using data bases otherwise in use.

11 (3) USE OF SURVEYS.—The Secretary may,
12 where appropriate, provide for the collection of infor-
13 mation under the system through surveys of a sam-
14 ple of health care providers or with respect to a sam-
15 ple of information with respect to such providers.

16 (4) CONFIDENTIALITY.—Information gathered
17 pursuant to the authority provided under this sec-
18 tion shall not be disclosed in a manner that identi-
19 fies individual providers of services.

20 (5) TRANSITION.—Before January 1, 1995, for
21 purposes of this title, the Secretary may use such
22 other data collection and estimation techniques as
23 may be appropriate for purposes described in sub-
24 section (a).

1 (c) ENFORCEMENT.—If a provider of health services
2 is required, under the system under this section, to report
3 information and refuses, after being requested by the Sec-
4 retary, to provide the information required, or deliberately
5 provides information that is false, the Secretary may im-
6 pose a civil money penalty of not to exceed \$10,000 for
7 each such refusal or provision of false information. The
8 provisions of section 1128A of the Social Security Act
9 (other than subsections (a) and (b)) shall apply to civil
10 money penalties under the previous sentence in the same
11 manner as such provisions apply to a penalty or proceed-
12 ing under section 1128A(a) of such Act.

13 (d) INCLUSION OF HEALTH MAINTENANCE ORGANI-
14 ZATIONS.—In this section, the term “provider of health
15 care services” includes health maintenance organizations.

16 **SEC. 205. CONFORMING MEDICARE PAYMENT RATES TO**
17 **MEDIPLAN HEALTH EXPENDITURE ALLOCA-**
18 **TIONS; TRANSITION.**

19 (a) IN GENERAL.—Notwithstanding any other provi-
20 sion of law, the Secretary shall substitute for the payment
21 rate or allowance (or, in the absence of such a rate, pay-
22 ment amount) otherwise applied under the medicare pro-
23 gram (and any maximum charge limits or payment limits
24 imposed under such program) for any health care service

1 in a class of services the amount specified by the Secretary
2 under subsection (b) for the class for the year involved.

3 (b) AMOUNT.—

4 (1) IN GENERAL.—At the same time as the
5 Secretary establishes payment rates under section
6 2141 of the Social Security Act, the Secretary shall
7 compute and publish, for each class of services for
8 each year, an amount under this subsection deter-
9 mined as follows:

10 (A) FIRST YEAR.—During the first year in
11 which benefits are available under title XXI of
12 the Social Security Act, the amount shall be the
13 sum of—

14 (i) 20 percent of the payment amount
15 established under such title for the class of
16 services, and

17 (ii) 80 percent of the amount estab-
18 lished under title XVIII of such Act.

19 (B) SECOND YEAR.—During the second
20 year in which benefits are available under title
21 XXI of the Social Security Act, the amount
22 shall be the sum of—

23 (i) 40 percent of the payment amount
24 established under such title for the class of
25 services, and

1 (ii) 60 percent of the amount estab-
2 lished under title XVIII of such Act.

3 (C) THIRD YEAR.—During the third year
4 in which benefits are available under title XXI
5 of the Social Security Act, the amount shall be
6 the sum of—

7 (i) 60 percent of the payment amount
8 established under such title for the class of
9 services, and

10 (ii) 40 percent of the amount estab-
11 lished under title XVIII of such Act.

12 (D) FOURTH YEAR.—During the fourth
13 year in which benefits are available under title
14 XXI of the Social Security Act, the amount
15 shall be the sum of—

16 (i) 80 percent of the payment amount
17 established under such title for the class of
18 services, and

19 (ii) 20 percent of the amount estab-
20 lished under title XVIII of such Act.

21 (E) FIFTH AND SUBSEQUENT YEARS.—
22 During the fifth year in which benefits are
23 available under title XXI of the Social Security
24 Act, and any subsequent year the amount shall
25 be the 100 percent of the payment amount es-

1 “(II) 1.0, in the case of a resi-
2 dent who is not a primary care resi-
3 dent and who specializes in internal
4 medicine or pediatrics,

5 “(III) .9, in the case of a resi-
6 dent who is not described in subclause
7 (I) or (II) and who is in the initial 3
8 years of the residency period, or

9 “(IV) .8, in the case of a resident
10 not described in subclause (I), (II), or
11 (III),”.

12 (2) PRIMARY CARE RESIDENT DEFINED.—Para-
13 graph (5) of such section is amended—

14 (A) by redesignating subparagraph (H) as
15 subparagraph (I), and

16 (B) by inserting after subparagraph (G)
17 the following new subparagraph:

18 “(H) PRIMARY CARE RESIDENT.—The
19 term ‘primary care resident’ means (in accord-
20 ance with criteria established by the Secretary)
21 a resident being trained in a distinct program
22 of family practice medicine, general practice,
23 general internal medicine, or general pediat-
24 rics.”.

1 (b) EFFECTIVE DATE.—The amendments made by
2 subsection (a) shall apply to cost reporting periods begin-
3 ning on or after October 1, 1993.

4 **SEC. 207. DEFINITIONS.**

5 In this title:

6 (1) APPLICABLE COMMISSION.—The term “ap-
7 plicable Commission” means—

8 (A) with respect to services included in a
9 class of services furnished by a hospital, other
10 institutional provider, or home health provider,
11 the Prospective Payment Assessment Commis-
12 sion, and

13 (B) with respect to other health care serv-
14 ices, the Physician Payment Review Commis-
15 sion.

16 (2) CLASS OF SERVICES.—The term “class”
17 means, with respect to health care services, a class
18 established under section 202.

19 (3) HEALTH CARE SERVICES.—The term
20 “health care services” means the items and services
21 described in section 202(a)(2).

22 (4) HEALTH MAINTENANCE ORGANIZATION.—
23 The term “health maintenance organization” means
24 an eligible organization with a contract under sec-
25 tion 1876 of the Social Security Act or a qualified

1 health maintenance organization (as defined in sec-
2 tion 1310(d) of the Public Health Service Act).

3 (5) MEDICARE PROGRAM; MEDICARE BENE-
4 FICIARY.—(A) The term “medicare program” means
5 the programs established under parts A and B of
6 title XVIII of the Social Security Act.

7 (B) The term “medicare beneficiary” means an
8 individual entitled to benefits under part A or B, or
9 both, of the medicare program.

10 (6) MEDICAID PROGRAM.—The term “medicaid
11 program” means any State plan approved under title
12 XIX of the Social Security Act and includes a State
13 program operating under a waiver under section
14 1115 of such Act.

15 (7) NATIONAL MEDIPLAN EXPENDITURE BUDG-
16 ET.—The term “national Mediplan expenditure
17 budget” means the budget established under section
18 201.

19 (8) SECRETARY.—The term “Secretary” means
20 the Secretary of Health and Human Services.

21 (9) STATE.—The term “State” means the 50
22 States and the District of Columbia.

23 (10) UNITED STATES.—The term “United
24 States” means the 50 States and the District of
25 Columbia.

1 **TITLE III—FINANCING**
2 **PROVISIONS**

3 **SEC. 301. INCOME TAXES FOR MEDIPLAN HEALTH CARE.**

4 (a) IN GENERAL.—Subchapter A of chapter 1 of the
5 Internal Revenue Code of 1986 is amended by adding at
6 the end thereof the following new part:

7 **“PART VIII—INCOME TAXES FOR MEDIPLAN**
8 **HEALTH CARE**

 “Sec. 59B. Tax on individuals.

 “Sec. 59C. Tax on gross receipts of health service providers from
 providing covered benefits.

9 **“SEC. 59B. TAX ON INDIVIDUALS.**

10 “(a) IMPOSITION OF TAX.—In the case of an individ-
11 ual, there is hereby imposed (in addition to other taxes)
12 for each taxable year on the modified gross income of the
13 taxpayer a tax equal to the Mediplan health care premium
14 determined under subsection (b) for such year.

15 “(b) MEDIPLAN HEALTH CARE PREMIUM.—The
16 Mediplan health care premium for the taxable year shall
17 be equal the lesser of—

18 “(1) \$1,500 (\$3,000 in the case of a joint re-
19 turn), or

20 “(2) 12.5 percent of the excess (if any) of the
21 modified gross income of the taxpayer over \$8,000
22 (\$16,000 in the case of a joint return).

1 “(c) MODIFIED GROSS INCOME.—For purposes of
2 this section, the term ‘modified gross income’ means the
3 adjusted gross income of the taxpayer for the taxable year
4 determined—

5 “(1) without regard to paragraphs (6), (7), and
6 (11) of section 62(a) and without regard to sections
7 911, 931, and 933, and

8 “(2) increased by—

9 “(A) the amount of interest received or ac-
10 crued by the taxpayer during the taxable year
11 which is exempt from tax,

12 “(B) the amount of social security benefits
13 (as defined in section 86(d)) received during the
14 taxable year which is not includible in gross in-
15 come under section 86,

16 “(C) the amount of qualified military bene-
17 fits (as defined in section 134(b)) received dur-
18 ing the taxable year, and

19 “(D) the amounts described in paragraphs
20 (7) and (8) of section 6051(a) which are not in-
21 cludible in gross income.

22 “(d) MEDICARE BENEFICIARIES EXEMPT FROM
23 TAX.—

24 “(1) IN GENERAL.—The tax imposed by this
25 section shall not apply to any individual who is a

1 medicare-eligible individual for more than 6 full
2 months beginning in the taxable year.

3 “(2) MEDICARE-ELIGIBLE INDIVIDUAL.—For
4 purposes of this subsection, the term ‘medicare-eli-
5 ble individual’ means, with respect to any month,
6 any individual who is entitled to (or, on application
7 without the payment of an additional premium,
8 would be entitled to) benefits under part A of title
9 XVIII of the Social Security Act.

10 “(3) SPECIAL RULES FOR JOINT RETURNS
11 WHERE ONLY 1 SPOUSE IS MEDICARE-ELIGIBLE.—In
12 the case of a joint return where only 1 spouse is a
13 medicare-eligible individual, this section shall be ap-
14 plied—

15 “(A) as if such return were the return of
16 an unmarried individual, and

17 “(B) by taking into account one-half of the
18 modified gross income determined under the
19 joint return.

20 “(e) COST-OF-LIVING ADJUSTMENT.—In the case of
21 any taxable year beginning in a calendar year after 1995,
22 the \$8,000 and \$16,000 amounts contained in this section
23 shall be increased by an amount equal to—

24 “(1) such dollar amount, multiplied by

1 “(2) the cost-of-living adjustment determined
2 under section 1(f)(3), for the calendar year in which
3 the taxable year begins, by substituting ‘calendar
4 year 1993’ for ‘calendar year 1987’ in subparagraph
5 (B) thereof.

6 “(f) COORDINATION WITH OTHER PROVISIONS.—

7 “(1) NOT TREATED AS MEDICAL EXPENSE.—
8 For purposes of section 213, the tax imposed by this
9 section shall not be treated as an expense for medi-
10 cal care.

11 “(2) NOT TREATED AS TAX FOR CERTAIN PUR-
12 POSES.—The taxes imposed by this section shall not
13 be treated as taxes imposed by this chapter for pur-
14 poses of determining—

15 “(A) the amount of any credit allowable
16 under this chapter, or

17 “(B) the amount of the minimum tax im-
18 posed by section 55.

19 **“SEC. 59C. TAX ON GROSS RECEIPTS OF HEALTH SERVICE**
20 **PROVIDERS FROM PROVIDING COVERED**
21 **BENEFITS.**

22 “(a) TAX IMPOSED.—In addition to other taxes,
23 there is hereby imposed a tax on every health service pro-
24 vider for the taxable year an amount equal to 10 percent

1 of the gross receipts of such provider for such taxable year
2 attributable to covered benefits provided by such provider.

3 “(b) HEALTH SERVICE PROVIDER.—For purposes of
4 this section—

5 “(1) IN GENERAL.—The term ‘health service
6 provider’ means any person entitled to submit a
7 claim under section 2152 of the Social Security Act
8 for services provided by such person.

9 “(2) PERSON.—The term ‘person’ includes—

10 “(A) any entity exempt from tax under
11 section 501(a), and

12 “(B) the United States, any State or polit-
13 ical subdivision thereof, the District of Colum-
14 bia, and any agency or instrumentality of the
15 foregoing.

16 “(c) COVERED BENEFITS.—The term ‘covered bene-
17 fit’ means any benefit to which an individual is entitled
18 by reason of section 2121 of the Social Security Act.

19 “(d) NOT TREATED AS TAX FOR CERTAIN PUR-
20 POSES.—The taxes imposed by this section shall not be
21 treated as taxes imposed by this chapter for purposes of
22 determining—

23 “(1) the amount of any credit allowable under
24 this chapter, or

1 “(2) the amount of the minimum tax imposed
2 by section 55.”

3 (b) TAXES INCLUDED IN ESTIMATED TAX.—

4 (1) Subparagraph (A) of section 6655(g)(1) of
5 such Code is amended by striking “plus” at the end
6 of clause (iii), by redesignating clause (iv) as clause
7 (v), and by inserting after clause (iii) the following
8 new clause:

9 “(iv) the tax imposed by section 59C,
10 plus”.

11 (2) Section 6655 of such Code is amended by
12 redesignating subsection (j) as subsection (k) and by
13 inserting after subsection (i) the following new sub-
14 section:

15 “(j) EXEMPT ENTITIES TREATED AS CORPORATIONS
16 FOR MEDIPLAN TAX.—Each entity referred to in section
17 59C(b)(2) shall be treated as a corporation for purposes
18 of applying this section with respect to the tax imposed
19 by section 59C.”

20 (c) CERTAIN INFORMATION INCLUDED ON W-2.—

21 Subsection (a) of section 6051 of such Code is amended
22 by striking “and” at the end of paragraph (8), by striking
23 the period at the end of paragraph (9) and inserting “,
24 and”, and by inserting after paragraph (9) the following
25 new paragraph:

1 “(10) the total amount of qualified military
2 benefits (as defined in section 134(b)).”

3 (d) CLERICAL AMENDMENT.—The table of parts for
4 such subchapter A of chapter 1 of such Code is amended
5 by adding at the end thereof the following new item:

 “Part VIII. Income taxes for Mediplan health care.”

6 (e) EFFECTIVE DATE.—The amendments made by
7 this section shall apply to taxable years beginning after
8 December 31, 1994.

9 (f) SECTION 15 NOT TO APPLY.—Section 15 of the
10 Internal Revenue Code of 1986 shall not apply to the taxes
11 imposed by part VIII of subchapter A of chapter 1 of such
12 Code.

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