

104TH CONGRESS
2D SESSION

H. R. 3125

To provide for improvements in financial security for senior citizens.

IN THE HOUSE OF REPRESENTATIVES

MARCH 20, 1996

Mr. ENGLISH of Pennsylvania (for himself, Mr. HASTERT, Mr. FOX of Pennsylvania, Mr. CHRISTENSEN, Mr. STOCKMAN, and Mr. HOSTETTLER) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committees on Commerce, the Judiciary, Rules, Government Reform and Oversight, and the Budget, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To provide for improvements in financial security for senior citizens.

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 AND TABLE OF CONTENTS.**

4 This Act may be cited as the “Senior Citizens Bill
5 of Rights Act of 1996”.

Sec. 1. Short title and table of contents.

TITLE I—LONG-TERM CARE

Sec. 101. Treatment of long-term care insurance.

Sec. 102. Qualified long-term care services treated as medical care.

- Sec. 103. Certain exchanges of life insurance contracts for long-term care insurance contracts not taxable.
- Sec. 104. Exclusion from gross income for amounts withdrawn from certain retirement plans for long-term care insurance.
- Sec. 105. Credit for taxpayers with certain persons requiring custodial care in their households.

TITLE II—SOCIAL SECURITY BENEFITS

- Sec. 201. Increases in monthly exempt amount for purposes of the social security earnings limit.
- Sec. 202. Revocation by members of the clergy of exemption from social security coverage.

TITLE III—INDEPENDENT COMMISSION ON MEDICARE

- Sec. 301. Establishment of Commission.
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- Sec. 303. Expedited congressional consideration of recommendations.
- Sec. 304. No termination of Commission.
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- Sec. 306. Enforcement of limits through sequestration.

TITLE IV—HEALTH CARE FRAUD PREVENTION

Subtitle A—All-Payer Fraud and Abuse Control Program

- Sec. 401. All-payer fraud and abuse control program.
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- Sec. 403. Health care fraud and abuse guidance.
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- Sec. 411. Mandatory exclusion from participation in medicare and State health care programs.
- Sec. 412. Establishment of minimum period of exclusion for certain individuals and entities subject to permissive exclusion from medicare and State health care programs.
- Sec. 413. Permissive exclusion of individuals with ownership or control interest in sanctioned entities.
- Sec. 414. Sanctions against practitioners and persons for failure to comply with statutory obligations.
- Sec. 415. Intermediate sanctions for medicare health maintenance organizations.
- Sec. 416. Effective date.

Subtitle C—Administrative and Miscellaneous Provisions

- Sec. 421. Establishment of the health care fraud and abuse data collection program.

Subtitle D—Civil Monetary Penalties

- Sec. 431. Civil monetary penalties.

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- Sec. 441. Health care fraud.
- Sec. 442. Forfeitures for Federal health care offenses.
- Sec. 443. Injunctive relief relating to Federal health care offenses.
- Sec. 444. Grand jury disclosure.
- Sec. 445. False statements.
- Sec. 446. Voluntary disclosure program.
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- Sec. 448. Theft or embezzlement.
- Sec. 449. Laundering of monetary instruments.

Subtitle F—Payments for State Health Care Fraud Control Units

- Sec. 451. Establishment of State fraud units.
- Sec. 452. Requirements for State fraud units.
- Sec. 453. Scope and purpose.
- Sec. 454. Payments to States.

1 **TITLE I—LONG-TERM CARE**

2 **SEC. 101. TREATMENT OF LONG-TERM CARE INSURANCE.**

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

6 **“SEC. 7702B. TREATMENT OF LONG-TERM CARE INSUR-** 7 **ANCE.**

8 “(a) IN GENERAL.—For purposes of this title—

9 “(1) a long-term care insurance contract shall
10 be treated as an accident and health insurance con-
11 tract,

12 “(2) amounts (other than policyholder divi-
13 dends, as defined in section 808, or premium re-
14 funds) received under a long-term care insurance
15 contract shall be treated as amounts received for
16 personal injuries and sickness and shall be treated
17 as reimbursement for expenses actually incurred for
18 medical care (as defined in section 213(d)),

1 “(3) any plan of an employer providing cov-
2 erage under a long-term care insurance contract
3 shall be treated as an accident and health plan with
4 respect to such coverage,

5 “(4) except as provided in subsection (d)(3),
6 amounts paid for a long-term care insurance con-
7 tract providing the benefits described in subsection
8 (b)(2)(A) shall be treated as payments made for in-
9 surance for purposes of section 213(d)(1)(D), and

10 “(5) a long-term care insurance contract shall
11 be treated as a guaranteed renewable contract sub-
12 ject to the rules of section 816(e).

13 “(b) LONG-TERM CARE INSURANCE CONTRACT.—
14 For purposes of this title—

15 “(1) IN GENERAL.—The term ‘long-term care
16 insurance contract’ means any insurance contract
17 if—

18 “(A) the only insurance protection pro-
19 vided under such contract is coverage of quali-
20 fied long-term care services,

21 “(B) such contract does not pay or reim-
22 burse expenses incurred for services or items to
23 the extent that such expenses are reimbursable
24 under title XVIII of the Social Security Act or

1 would be so reimbursable but for the applica-
2 tion of a deductible or coinsurance amount,

3 “(C) such contract is guaranteed renew-
4 able,

5 “(D) such contract does not provide for a
6 cash surrender value or other money that can
7 be—

8 “(i) paid, assigned, or pledged as col-
9 lateral for a loan, or

10 “(ii) borrowed,
11 other than as provided in subparagraph (E) or
12 paragraph (2)(C), and

13 “(E) all refunds of premiums, and all pol-
14 icyholder dividends or similar amounts, under
15 such contract are to be applied as a reduction
16 in future premiums or to increase future bene-
17 fits.

18 “(2) SPECIAL RULES.—

19 “(A) PER DIEM, ETC. PAYMENTS PER-
20 MITTED.—A contract shall not fail to be de-
21 scribed in subparagraph (A) or (B) of para-
22 graph (1) by reason of payments being made on
23 a per diem or other periodic basis without re-
24 gard to the expenses incurred during the period
25 to which the payments relate.

1 “(B) SPECIAL RULES RELATING TO MEDI-
2 CARE.—

3 “(i) Paragraph (1)(B) shall not apply
4 to expenses which are reimbursable under
5 title XVIII of the Social Security Act only
6 as a secondary payor.

7 “(ii) No provision of law shall be con-
8 strued or applied so as to prohibit the of-
9 fering of a long-term care insurance con-
10 tract on the basis that the contract coordi-
11 nates its benefits with those provided
12 under such title.

13 “(C) REFUNDS OF PREMIUMS.—Paragraph
14 (1)(E) shall not apply to any refund on the
15 death of the insured, or on a complete surren-
16 der or cancellation of the contract, which can-
17 not exceed the aggregate premiums paid under
18 the contract. Any refund on a complete surren-
19 der or cancellation of the contract shall be in-
20 cludible in gross income to the extent that any
21 deduction or exclusion was allowable with re-
22 spect to the premiums.

23 “(c) QUALIFIED LONG-TERM CARE SERVICES.—For
24 purposes of this section—

1 “(1) IN GENERAL.—The term ‘qualified long-
2 term care services’ means necessary diagnostic, pre-
3 ventive, therapeutic, curing, treating, mitigating, and
4 rehabilitative services, and maintenance or personal
5 care services, which—

6 “(A) are required by a chronically ill indi-
7 vidual, and

8 “(B) are provided pursuant to a plan of
9 care prescribed by a licensed health care practi-
10 tioner.

11 “(2) CHRONICALLY ILL INDIVIDUAL.—

12 “(A) IN GENERAL.—The term ‘chronically
13 ill individual’ means any individual who has
14 been certified by a licensed health care practi-
15 tioner as—

16 “(i) being unable to perform (without
17 substantial assistance from another indi-
18 vidual) at least 2 activities of daily living
19 for a period of at least 90 days due to a
20 loss of functional capacity or to cognitive
21 impairment, or

22 “(ii) having a level of disability simi-
23 lar (as determined by the Secretary in con-
24 sultation with the Secretary of Health and

1 Human Services) to the level of disability
2 described in clause (i).

3 Such term shall not include any individual oth-
4 erwise meeting the requirements of the preced-
5 ing sentence unless within the preceding 12-
6 month period a licensed health care practitioner
7 has certified that such individual meets such re-
8 quirements.

9 “(B) ACTIVITIES OF DAILY LIVING.—For
10 purposes of subparagraph (A), each of the fol-
11 lowing is an activity of daily living:

12 “(i) Eating.

13 “(ii) Toileting.

14 “(iii) Transferring.

15 “(iv) Bathing.

16 “(v) Dressing.

17 “(vi) Continence.

18 Nothing in this section shall be construed to re-
19 quire a contract to take into account all of the
20 preceding activities of daily living.

21 “(3) MAINTENANCE OR PERSONAL CARE SERV-
22 ICES.—The term ‘maintenance or personal care serv-
23 ices’ means any care the primary purpose of which
24 is the provision of needed assistance with any of the
25 disabilities as a result of which the individual is a

1 chronically ill individual (including the protection
2 from threats to health and safety due to severe cog-
3 nitive impairment).

4 “(4) LICENSED HEALTH CARE PRACTI-
5 TIONER.—The term ‘licensed health care practi-
6 tioner’ means any physician (as defined in section
7 1861(r)(1) of the Social Security Act) and any reg-
8 istered professional nurse, licensed social worker, or
9 other individual who meets such requirements as
10 may be prescribed by the Secretary.

11 “(d) TREATMENT OF COVERAGE PROVIDED AS PART
12 OF A LIFE INSURANCE CONTRACT.—Except as otherwise
13 provided in regulations prescribed by the Secretary, in the
14 case of any long-term care insurance coverage (whether
15 or not qualified) provided by a rider on a life insurance
16 contract—

17 “(1) IN GENERAL.—This section shall apply as
18 if the portion of the contract providing such cov-
19 erage is a separate contract.

20 “(2) APPLICATION OF 7702.—Section
21 7702(c)(2) (relating to the guideline premium limi-
22 tation) shall be applied by increasing the guideline
23 premium limitation with respect to a life insurance
24 contract, as of any date—

1 “(A) by the sum of any charges (but not
2 premium payments) against the life insurance
3 contract’s cash surrender value (within the
4 meaning of section 7702(f)(2)(A)) for such cov-
5 erage made to that date under the contract, less

6 “(B) any such charges the imposition of
7 which reduces the premiums paid for the con-
8 tract (within the meaning of section
9 7702(f)(1)).

10 “(3) APPLICATION OF SECTION 213.—No deduc-
11 tion shall be allowed under section 213(a) for
12 charges against the life insurance contract’s cash
13 surrender value described in paragraph (2), unless
14 such charges are includible in income as a result of
15 the application of section 72(e)(10) and the rider is
16 a long-term care insurance contract under sub-
17 section (b).

18 “(4) PORTION DEFINED.—For purposes of this
19 subsection, the term ‘portion’ means only the terms
20 and benefits under a life insurance contract that are
21 in addition to the terms and benefits under the con-
22 tract without regard to the coverage under a long-
23 term care insurance contract.”

24 (b) RESERVE METHOD.—Clause (iii) of section
25 807(d)(3)(A) of such Code is amended by inserting

1 “(other than a long-term care insurance contract, as de-
2 fined in section 7702B(b))” after “insurance contract”.

3 (c) LONG-TERM CARE INSURANCE NOT PERMITTED
4 UNDER CAFETERIA PLANS OR FLEXIBLE SPENDING AR-
5 RANGEMENTS.—

6 (1) CAFETERIA PLANS.—Section 125(f) of such
7 Code is amended by adding at the end the following
8 new sentence: “Such term shall not include any
9 long-term care insurance contract (as defined in sec-
10 tion 7702B(b)).”

11 (2) FLEXIBLE SPENDING ARRANGEMENTS.—
12 The text of section 106 of such Code (relating to
13 contributions by employer to accident and health
14 plans) is amended to read as follows:

15 “(a) GENERAL RULE.—Except as provided in sub-
16 section (b), gross income of an employee does not include
17 employer-provided coverage under an accident or health
18 plan.

19 “(b) INCLUSION OF LONG-TERM CARE BENEFITS
20 PROVIDED THROUGH FLEXIBLE SPENDING ARRANGE-
21 MENTS.—

22 “(1) IN GENERAL.—Effective on and after Jan-
23 uary 1, 1996, gross income of an employee shall in-
24 clude employer-provided coverage for qualified long-
25 term care services (as defined in section 7702B(e))

1 to the extent that such coverage is provided through
2 a flexible spending or similar arrangement.

3 “(2) FLEXIBLE SPENDING ARRANGEMENT.—

4 For purposes of this subsection, a flexible spending
5 arrangement is a benefit program which provides
6 employees with coverage under which—

7 “(A) specified incurred expenses may be
8 reimbursed (subject to reimbursement maxi-
9 mums and other reasonable conditions), and

10 “(B) the maximum amount of reimburse-
11 ment which is reasonably available to a partici-
12 pant for such coverage is less than 500 percent
13 of the value of such coverage.

14 In the case of an insured plan, the maximum
15 amount reasonably available shall be determined on
16 the basis of the underlying coverage.”

17 (d) CONTINUATION COVERAGE EXCISE TAX NOT TO
18 APPLY.—Subsection (f) of section 4980B of such Code is
19 amended by adding at the end the following new para-
20 graph:

21 “(9) CONTINUATION OF LONG-TERM CARE COV-
22 ERAGE NOT REQUIRED.—A group health plan shall
23 not be treated as failing to meet the requirements of
24 this subsection solely by reason of failing to provide

1 coverage under any long-term care insurance con-
2 tract (as defined in section 7702B(b)).”

3 (e) AMOUNTS PAID TO RELATIVES TREATED AS NOT
4 PAID FOR MEDICAL CARE.—Section 213(d) of such Code
5 is amended by adding at the end the following new para-
6 graph:

7 “(10) CERTAIN PAYMENTS TO RELATIVES
8 TREATED AS NOT PAID FOR MEDICAL CARE.—An
9 amount paid for a qualified long-term care service
10 (as defined in section 7702B(c)) provided to an indi-
11 vidual shall be treated as not paid for medical care
12 if such service is provided—

13 “(A) by a relative (directly or through a
14 partnership, corporation, or other entity) unless
15 the relative is a licensed professional with re-
16 spect to such services, or

17 “(B) by a corporation or partnership which
18 is related (within the meaning of section 267(b)
19 or 707(b)) to the individual.

20 For purposes of this paragraph, the term ‘relative’
21 means an individual bearing a relationship to the in-
22 dividual which is described in any of paragraphs (1)
23 through (8) of section 152(a). This paragraph shall
24 not apply for purposes of section 105(b) with respect
25 to reimbursements through insurance.”

1 (f) CLERICAL AMENDMENT.—The table of sections
2 for chapter 79 of such Code is amended by inserting after
3 the item relating to section 7702A the following new item:

“Sec. 7702B. Treatment of long-term care insurance.”.

4 (g) EFFECTIVE DATE.—

5 (1) IN GENERAL.—The amendments made by
6 this section shall apply to contracts issued after De-
7 cember 31, 1996.

8 (2) CONTINUATION OF EXISTING POLICIES.—In
9 the case of any contract issued before January 1,
10 1997, which met the long-term care insurance re-
11 quirements of the State in which the contract was
12 issued at the time the contract was issued—

13 (A) such contract shall be treated for pur-
14 poses of the Internal Revenue Code of 1986 as
15 a long-term care insurance contract (as defined
16 in section 7702B(b) of such Code), and

17 (B) services provided under, or reimbursed
18 by, such contract shall be treated for such pur-
19 poses as qualified long-term care services (as
20 defined in section 7702B(e) of such Code).

21 (3) EXCHANGES OF EXISTING POLICIES.—If,
22 after the date of enactment of this Act and before
23 January 1, 1997, a contract providing for long-term
24 care insurance coverage is exchanged solely for a
25 long-term care insurance contract (as defined in sec-

1 tion 7702B(b) of such Code), no gain or loss shall
2 be recognized on the exchange. If, in addition to a
3 long-term care insurance contract, money or other
4 property is received in the exchange, then any gain
5 shall be recognized to the extent of the sum of the
6 money and the fair market value of the other prop-
7 erty received. For purposes of this paragraph, the
8 cancellation of a contract providing for long-term
9 care insurance coverage and reinvestment of the can-
10 cellation proceeds in a long-term care insurance con-
11 tract within 60 days thereafter shall be treated as
12 an exchange.

13 (4) ISSUANCE OF CERTAIN RIDERS PER-
14 MITTED.—For purposes of applying sections 101(f),
15 7702, and 7702A of the Internal Revenue Code of
16 1986 to any contract—

17 (A) the issuance of a rider which is treated
18 as a long-term care insurance contract under
19 section 7702B, and

20 (B) the addition of any provision required
21 to conform any other long-term care rider to be
22 so treated,
23 shall not be treated as a modification or material
24 change of such contract.

1 **SEC. 102. QUALIFIED LONG-TERM CARE SERVICES TREAT-**
2 **ED AS MEDICAL CARE.**

3 (a) GENERAL RULE.—Paragraph (1) of section
4 213(d) of the Internal Revenue Code of 1986 (defining
5 medical care) is amended by striking “or” at the end of
6 subparagraph (B), by redesignating subparagraph (C) as
7 subparagraph (D), and by inserting after subparagraph
8 (B) the following new subparagraph:

9 “(C) for qualified long-term care services
10 (as defined in section 7702B(c)), or”.

11 (b) TECHNICAL AMENDMENTS.—

12 (1) Subparagraph (D) of section 213(d)(1) of
13 such Code (as redesignated by subsection (a)) is
14 amended by striking “subparagraphs (A) and (B)”
15 and inserting “subparagraphs (A), (B), and (C)”.

16 (2)(A) Paragraph (1) of section 213(d) of such
17 Code is amended by adding at the end the following
18 new flush sentence:

19 “In the case of a long-term care insurance contract
20 (as defined in section 7702B(b)), only eligible long-
21 term care premiums (as defined in paragraph (11))
22 shall be taken into account under subparagraph
23 (D).”

24 (B) Subsection (d) of section 213 of such Code
25 is amended by adding at the end the following new
26 paragraph:

1 “(11) ELIGIBLE LONG-TERM CARE PRE-
2 MIUMS.—

3 “(A) IN GENERAL.—For purposes of this
4 section, the term ‘eligible long-term care pre-
5 miums’ means the amount paid during a tax-
6 able year for any long-term care insurance con-
7 tract (as defined in section 7702B(b)) covering
8 an individual, to the extent such amount does
9 not exceed the limitation determined under the
10 following table:

“In the case of an individual with an attained age before the close of the taxable year of:	The limitation is:
40 or less	\$200
More than 40 but not more than 50	375
More than 50 but not more than 60	750
More than 60 but not more than 70	2,000
More than 70	2,500.

11 “(B) INDEXING.—

12 “(i) IN GENERAL.—In the case of any
13 taxable year beginning in a calendar year
14 after 1996, each dollar amount contained
15 in subparagraph (A) shall be increased by
16 the medical care cost adjustment of such
17 amount for such calendar year. If any in-
18 crease determined under the preceding sen-
19 tence is not a multiple of \$10, such in-
20 crease shall be rounded to the nearest mul-
21 tiple of \$10.

1 “(ii) MEDICAL CARE COST ADJUST-
2 MENT.—For purposes of clause (i), the
3 medical care cost adjustment for any cal-
4 endar year is the percentage (if any) by
5 which—

6 “(I) the medical care component
7 of the Consumer Price Index (as de-
8 fined in section 1(f)(5)) for August of
9 the preceding calendar year, exceeds

10 “(II) such component for August
11 of 1995.

12 The Secretary shall, in consultation with
13 the Secretary of Health and Human Serv-
14 ices, prescribe an adjustment which the
15 Secretary determines is more appropriate
16 for purposes of this paragraph than the
17 adjustment described in the preceding sen-
18 tence, and the adjustment so prescribed
19 shall apply in lieu of the adjustment de-
20 scribed in the preceding sentence.”

21 (3) Paragraph (6) of section 213(d) of such
22 Code is amended—

23 (A) by striking “subparagraphs (A) and
24 (B)” and inserting “subparagraphs (A), (B),
25 and (C)”, and

1 (B) by striking “paragraph (1)(C)” in sub-
2 paragraph (A) and inserting “paragraph
3 (1)(D)”.

4 (4) Paragraph (7) of section 213(d) of such
5 Code is amended by striking “subparagraphs (A)
6 and (B)” and inserting “subparagraphs (A), (B),
7 and (C)”.

8 (c) EFFECTIVE DATE.—The amendments made by
9 this section shall apply to taxable years beginning after
10 December 31, 1996.

11 **SEC. 103. CERTAIN EXCHANGES OF LIFE INSURANCE CON-**
12 **TRACTS FOR LONG-TERM CARE INSURANCE**
13 **CONTRACTS NOT TAXABLE.**

14 (a) IN GENERAL.—Subsection (a) of section 1035 of
15 the Internal Revenue Code of 1986 (relating to certain
16 exchanges of insurance contracts) is amended by striking
17 the period at the end of paragraph (3) and inserting “;
18 or”, and by adding at the end the following new para-
19 graph:

20 “(4) a contract of life insurance or an endow-
21 ment or annuity contract for a long-term care insur-
22 ance contract (as defined in section 7702B(b)).”

23 (b) EFFECTIVE DATE.—The amendment made by
24 this section shall apply to taxable years beginning after
25 December 31, 1996.

1 **SEC. 104. EXCLUSION FROM GROSS INCOME FOR AMOUNTS**
2 **WITHDRAWN FROM CERTAIN RETIREMENT**
3 **PLANS FOR LONG-TERM CARE INSURANCE.**

4 (a) IN GENERAL.—Part III of subchapter B of chap-
5 ter 1 of the Internal Revenue Code of 1986 (relating to
6 items specifically excluded from gross income) is amended
7 by redesignating section 137 as section 138 and by insert-
8 ing after section 136 the following new section:

9 **“SEC. 137. DISTRIBUTIONS FROM CERTAIN RETIREMENT**
10 **PLANS FOR LONG-TERM CARE INSURANCE.**

11 “(a) GENERAL RULE.—The amount which would
12 (but for this section) be includible in the gross income of
13 an individual for the taxable year by reason of eligible dis-
14 tributions during the taxable year shall be reduced (but
15 not below zero) by the aggregate premiums paid by such
16 individual during such taxable year for any long-term care
17 insurance contract (as defined in section 7702B(b)) for
18 coverage of such individual or the spouse of such individ-
19 ual.

20 “(b) ELIGIBLE DISTRIBUTION.—For purposes of this
21 section, the term ‘eligible distribution’ means any distribu-
22 tion or payment to an individual from—

23 “(1) an individual retirement plan of such indi-
24 vidual,

25 “(2) amounts attributable to employer contribu-
26 tions made pursuant to elective deferrals described

1 in subparagraph (A) or (C) of section 402(g)(3) or
2 section 501(c)(18)(D)(iii), or

3 “(3) amounts deferred under section 457(a).”

4 (b) CONFORMING AMENDMENTS.—

5 (1) Section 401(k)(2)(B)(i) of such Code is
6 amended by striking “or” at the end of subclause
7 (III), by striking “and” at the end of subclause (IV)
8 and inserting “or”, and by inserting after subclause
9 (IV) the following new subclause:

10 “(V) the date distributions for
11 premiums for a long-term care insur-
12 ance contract (as defined in section
13 7702B(b)) for coverage of such indi-
14 vidual or the spouse of such individual
15 are made, and”.

16 (2) Section 403(b)(11) of such Code is amend-
17 ed by striking “or” at the end of subparagraph (A),
18 by striking the period at the end of subparagraph
19 (B) and inserting “, or”, and by inserting after sub-
20 paragraph (B) the following new subparagraph:

21 “(C) for the payment of premiums for a
22 long-term care insurance contract (as defined in
23 section 7702B(b)) for coverage of the employee
24 or the spouse of the employee.”

1 **“SEC. 25B. CREDIT FOR TAXPAYERS WITH CERTAIN PER-**
2 **SONS REQUIRING CUSTODIAL CARE IN THEIR**
3 **HOUSEHOLDS.**

4 “(a) ALLOWANCE OF CREDIT.—In the case of an in-
5 dividual who maintains a household which includes as a
6 member one or more qualified persons, there shall be al-
7 lowed as a credit against the tax imposed by this chapter
8 for the taxable year an amount equal to \$1,000 for each
9 such person.

10 “(b) QUALIFIED PERSON.—For purposes of this sec-
11 tion, the term ‘qualified person’ means any individual—

12 “(1) who is a father or mother of the taxpayer,
13 his spouse, or his former spouse or who is an ances-
14 tor of such a father or mother,

15 “(2) who is physically or mentally incapable of
16 caring for himself,

17 “(3) who has as his principal place of abode for
18 more than half of the taxable year the home of the
19 taxpayer, and

20 “(4) whose name and TIN are included on the
21 taxpayer’s return for the taxable year.

22 For purposes of paragraph (1), a stepfather or stepmother
23 shall be treated as a father or mother.

24 “(c) SPECIAL RULES.—For purposes of this section,
25 rules similar to the rules of paragraphs (1), (2), (3), and
26 (4) of section 21(e) shall apply.”

1 (b) CLERICAL AMENDMENT.—The table of sections
 2 for subpart A of part IV of subchapter A of chapter 1
 3 of such Code is amended by inserting after the item relat-
 4 ing to section 25A the following new item:

“Sec. 25B. Credit for taxpayers with certain persons requiring
 custodial care in their households.”

5 (c) EFFECTIVE DATE.—The amendments made by
 6 this section shall apply to taxable years beginning after
 7 December 31, 1996.

8 **TITLE II—SOCIAL SECURITY**
 9 **BENEFITS**

10 **SEC. 201. INCREASES IN MONTHLY EXEMPT AMOUNT FOR**
 11 **PURPOSES OF THE SOCIAL SECURITY EARN-**
 12 **INGS LIMIT.**

13 (a) INCREASE IN MONTHLY EXEMPT AMOUNT FOR
 14 INDIVIDUALS WHO HAVE ATTAINED RETIREMENT
 15 AGE.—Section 203(f)(8)(D) of the Social Security Act (42
 16 U.S.C. 403(f)(8)(D)) is amended to read as follows:

17 “(D) Notwithstanding any other provision of
 18 this subsection, the exempt amount which is applica-
 19 ble to an individual who has attained retirement age
 20 (as defined in section 216(l)) before the close of the
 21 taxable year involved shall be—

22 “(i) for each month of any taxable year
 23 ending after 1996 and before 1998,
 24 \$1,466.66²/₃,

1 “(ii) for each month of any taxable year
2 ending after 1997 and before 1999, \$1,875.00,

3 “(iii) for each month of any taxable year
4 ending after 1998 and before 2000,
5 \$2,333.33 $\frac{1}{3}$,

6 “(iv) for each month of any taxable year
7 ending after 1999 and before 2001,
8 \$2,791.66 $\frac{2}{3}$,

9 “(v) for each month of any taxable year
10 ending after 2000 and before 2002, \$3,250.00,

11 “(vi) for each month of any taxable year
12 ending after 2001 and before 2003,
13 \$3,708.33 $\frac{1}{3}$, and

14 “(vii) for each month of any taxable year
15 ending after 2002 and before 2004,
16 \$4,166.66 $\frac{2}{3}$.”.

17 (b) CONFORMING AMENDMENTS.—

18 (1) Section 203(f)(8)(B)(ii) of such Act (42
19 U.S.C. 403(f)(8)(B)(ii)) is amended—

20 (A) by striking “the taxable year ending
21 after 1993 and before 1995” and inserting “the
22 taxable year ending after 2002 and before 2004
23 (with respect to individuals described in sub-
24 paragraph (D)) or the taxable year ending after

1 1993 and before 1995 (with respect to other in-
2 dividuals)”; and

3 (B) in subclause (II), by striking “for
4 1992” and inserting “for 2001 (with respect to
5 individuals described in subparagraph (D)) or
6 1992 (with respect to other individuals)”.

7 (2) The second sentence of section 223(d)(4)(A)
8 of such Act (42 U.S.C. 423(d)(4)(A)) is amended by
9 striking “the exempt amount under section 203(f)(8)
10 which is applicable to individuals described in sub-
11 paragraph (D) thereof” and inserting the following:
12 “an amount equal to the exempt amount which
13 would be applicable under section 203(f)(8), to indi-
14 viduals described in subparagraph (D) thereof, if
15 section 201 of the Senior Citizens Bill of Rights Act
16 of 1996 had not been enacted”.

17 (c) EFFECTIVE DATE.—The amendments made by
18 this section shall apply with respect to taxable years end-
19 ing after 1996.

20 **SEC. 202. REVOCATION BY MEMBERS OF THE CLERGY OF**
21 **EXEMPTION FROM SOCIAL SECURITY COV-**
22 **ERAGE.**

23 (a) IN GENERAL.—Notwithstanding section
24 1402(e)(4) of the Internal Revenue Code of 1986, any ex-
25 emption which has been received under section 1402(e)(1)

1 of such Code by a duly ordained, commissioned, or li-
2 censed minister of a church, a member of a religious order,
3 or a Christian Science practitioner, and which is effective
4 for the taxable year in which this Act is enacted, may be
5 revoked by filing an application therefor (in such form and
6 manner, and with such official, as may be prescribed in
7 regulations made under chapter 2 of such Code), if such
8 application is filed no later than the due date of the Fed-
9 eral income tax return (including any extension thereof)
10 for the applicant's second taxable year beginning after De-
11 cember 31, 1996. Any such revocation shall be effective
12 (for purposes of chapter 2 of the Internal Revenue Code
13 of 1986 and title II of the Social Security Act), as speci-
14 fied in the application, either with respect to the appli-
15 cant's first taxable year beginning after December 31,
16 1996, or with respect to the applicant's second taxable
17 year beginning after such date, and for all succeeding tax-
18 able years; and the applicant for any such revocation may
19 not thereafter again file application for an exemption
20 under such section 1402(e)(1). If the application is filed
21 after the due date of the applicant's Federal income tax
22 return for a taxable year and is effective with respect to
23 that taxable year, it shall include or be accompanied by
24 payment in full of an amount equal to the total of the
25 taxes that would have been imposed by section 1401 of

1 the Internal Revenue Code of 1986 with respect to all of
2 the applicant's income derived in that taxable year which
3 would have constituted net earnings from self-employment
4 for purposes of chapter 2 of such Code (notwithstanding
5 section 1402 (c)(4) or (c)(5) of such Code) except for the
6 exemption under section 1402(e)(1) of such Code.

7 (b) EFFECTIVE DATE.—Subsection (a) shall apply
8 with respect to service performed (to the extent specified
9 in such subsection) in taxable years beginning after De-
10 cember 31, 1996, and with respect to monthly insurance
11 benefits payable under title II of the Social Security Act
12 on the basis of the wages and self-employment income of
13 any individual for months in or after the calendar year
14 in which such individual's application for revocation (as
15 described in such subsection) is effective (and lump-sum
16 death payments payable under such title on the basis of
17 such wages and self-employment income in the case of
18 deaths occurring in or after such calendar year).

19 **TITLE III—INDEPENDENT**
20 **COMMISSION ON MEDICARE**

21 **SEC. 301. ESTABLISHMENT OF COMMISSION.**

22 (a) IN GENERAL.—There is established a commission
23 to be known as the Independent Commission on Medicare
24 (in this title referred to as the “Commission”).

25 (b) MEMBERSHIP.—

1 (1) COMPOSITION.—The Commission shall be
2 composed of 7 members appointed by the President,
3 by and with the advice and consent of the Senate.

4 (2) CHAIR.—The President shall designate one
5 of the members to chair the Commission.

6 (3) QUALIFICATIONS.—The membership of the
7 Commission shall consist of individuals with national
8 recognition for expertise in fields related to health
9 care.

10 (c) TERMS.—

11 (1) IN GENERAL.—Except as provided in para-
12 graphs (2) and (3), each member of the Commission
13 shall be appointed for a term of 9 years.

14 (2) TERMS OF INITIAL APPOINTMENT.—As des-
15 ignated by the President at the time of appointment,
16 of the members first appointed—

17 (A) 3 shall be appointed for a term of 3
18 years; and

19 (B) 3 shall be appointed for a term of 6
20 years.

21 (3) VACANCIES.—Any member appointed to fill
22 a vacancy occurring before the expiration of the
23 term for which the member's predecessor was ap-
24 pointed shall be appointed only for the remainder of
25 that term. A vacancy in the Commission shall be

1 filled in the manner in which the original appoint-
2 ment was made.

3 (4) EXCLUSIVE EMPLOYMENT.—During the
4 term of appointment, members shall serve as em-
5 ployees of the Federal Government and shall hold no
6 other employment.

7 (5) COMPENSATION OF BOARD MEMBERS.—
8 Each member of the Commission (other than the
9 chair) shall receive an annual salary at the annual
10 rate payable from time to time for level IV of the
11 Executive Schedule. The chair of the Commission,
12 during the period of service as chair, shall receive an
13 annual salary at the annual rate payable from time
14 to time for level III of the Executive Schedule.

15 (6) REMOVAL.—A member of the Commission
16 may be removed by the President only for neglect of
17 duty or malfeasance in office.

18 (d) MEETINGS.—Each meeting of the Commission
19 shall be open to the public, except that the Commission
20 may meet in executive session to address matters relating
21 to personnel and other internal matters of the Commission
22 unrelated to the duties specified in section 302.

23 (e) STAFF.—

24 (1) IN GENERAL.—The Commission shall ap-
25 point a Director, who shall be paid at a rate the

1 Commission considers appropriate. The Director
2 may appoint and fix the pay of such additional per-
3 sonnel as the Director (with the approval of the
4 Chair of the Commission) considers appropriate,
5 without regard to provisions of title 5, United States
6 Code, governing appointments in the competitive
7 service.

8 (2) EXPERTS AND CONSULTANTS.—The Com-
9 mission may procure temporary and intermittent
10 services under section 3109(b) of title 5, United
11 States Code.

12 (3) STAFF OF FEDERAL AGENCIES.—Upon re-
13 quest of the Director, the head of any Federal de-
14 partment or agency may detail, on a reimbursable
15 basis, any of the personnel of that department or
16 agency to the Commission to assist it in carrying out
17 its duties under this title.

18 (f) POWERS.—

19 (1) HEARINGS AND SESSIONS.—The Commis-
20 sion may, for the purpose of carrying out its duties
21 under this title, hold hearings, sit and act at times
22 and places, take testimony, and receive evidence as
23 the Commission considers appropriate. The Commis-
24 sion may administer oaths or affirmations to wit-
25 nesses appearing before it.

1 (2) POWERS OF MEMBERS AND AGENTS.—Any
2 member or agent of the Commission may, if author-
3 ized by the Commission, take any action which the
4 Commission is authorized to take by this section.

5 (3) OBTAINING OFFICIAL DATA.—The Commis-
6 sion may secure directly from any department or
7 agency of the United States information necessary
8 to enable it to carry out this title. Upon request of
9 the Chair of the Commission, the head of that de-
10 partment or agency shall furnish that information to
11 the Commission.

12 (4) GIFTS, BEQUESTS, AND DEVISES.—The
13 Commission may accept, use, and dispose of gifts,
14 bequests, or devises of services or property, both real
15 and personal, for the purpose of aiding or facilitat-
16 ing the work of the Commission. Gifts, bequests, or
17 devises of money and proceeds from sales of other
18 property received as gifts, bequests, or devises shall
19 be deposited in the Treasury and shall be available
20 for disbursement upon order of the Chair of the
21 Commission.

22 (5) MAILS.—The Commission may use the
23 United States mails in the same manner and under
24 the same conditions as other departments and agen-
25 cies of the United States.

1 (6) ADMINISTRATIVE SUPPORT SERVICES.—
2 Upon the request of the Commission, the Adminis-
3 trator of General Services shall provide to the Com-
4 mission, on a reimbursable basis, the administrative
5 support services necessary for the Commission to
6 carry out its duties under this title.

7 **SEC. 302. DUTIES OF THE COMMISSION.**

8 (a) IN GENERAL.—The Commission shall—

9 (1) transmit to Congress and the President
10 during December of each year (beginning with 1996)
11 a report on the aspects of the Medicare program
12 specified in subsection (b); and

13 (2) transmit to Congress during July of each
14 year (beginning with 1997) a report containing spe-
15 cific recommendations on the matters specified in
16 subsection (c).

17 (b) ASPECTS OF MEDICARE.—

18 (1) IN GENERAL.—The report transmitted pur-
19 suant to subsection (a)(1) during December of a
20 year shall include information on the following:

21 (A) The total outlays made under the med-
22 icare program for each of the 10 most recently
23 completed fiscal years.

24 (B) Projections of the outlays under such
25 program for the fiscal year beginning on Octo-

1 ber 1 of the next calendar year and each of the
2 4 succeeding fiscal years, on an aggregate and
3 a per capita basis.

4 (C) Projections of the actuarial value of
5 the package of benefits provided to medicare
6 beneficiaries for each of the fiscal years speci-
7 fied in subparagraph (B), on an aggregate and
8 a per capita basis.

9 (D) A comparison of each of the projec-
10 tions made under subparagraph (B) for a fiscal
11 year with the projections made for the year
12 under subparagraph (C).

13 (E) The health status of medicare bene-
14 ficiaries, the access of beneficiaries to health
15 services covered under the medicare program,
16 and the utilization of such services by bene-
17 ficiaries.

18 (F) Methods to improve the methodologies
19 used to determine the payments made under
20 the medicare program to or on behalf of medi-
21 care beneficiaries (including the use of risk ad-
22 justment in the determination of the amount of
23 such payments) and methods to encourage effi-
24 ciency and cost-effectiveness in the delivery of
25 health care services.

1 (G) Such other matters as the Commission
2 determines to be appropriate.

3 (2) ACTUARIAL VALUE DEFINED.—For pur-
4 poses of projecting the actuarial value of the pack-
5 age of benefits provided to medicare beneficiaries
6 under paragraph (1)(C), the Commission shall deter-
7 mine actuarial value by measuring the costs of re-
8 sources used to provide health care services covered
9 under the medicare program and adjusting such
10 costs to take into account—

11 (A) inflation in the costs of health care
12 services and all costs generally;

13 (B) demographic changes in the population
14 of beneficiaries, including population growth,
15 age distribution, health status, and access to
16 care;

17 (C) changes in the mix and intensity of
18 services provided to beneficiaries and the sites
19 at which services are furnished;

20 (D) scientific and technological advances;

21 (E) the quality of care provided, including
22 the effect on quality of the overutilization of
23 services and other factors;

24 (F) other factors affecting the demand of
25 beneficiaries for services; and

1 (G) such other factors as the Commission
2 considers appropriate.

3 (c) **RECOMMENDATIONS ON CONTROLLING OUT-**
4 **LAYS.**—The report transmitted to Congress pursuant to
5 subsection (a)(2) during July of a year shall include spe-
6 cific recommendations on changes in the medicare pro-
7 gram, including changes in eligibility, benefits (including
8 the mode of delivery of such benefits), cost-sharing, or
9 payments made to or on behalf of beneficiaries, sufficient
10 to ensure that total outlays for the program for the fiscal
11 year beginning on the following October 1 do not exceed
12 the limit established for that fiscal year under section 305,
13 except that such recommendations may not include
14 changes relating to the payment of payroll taxes for fi-
15 nancing the program.

16 **SEC. 303. EXPEDITED CONGRESSIONAL CONSIDERATION**
17 **OF RECOMMENDATIONS.**

18 (a) **IN GENERAL.**—The recommendations submitted
19 by the Commission under section 302(c) for a fiscal year
20 shall take effect if a joint resolution (described in sub-
21 section (b)) approving such recommendations is enacted,
22 in accordance with the provisions of subsection (c), before
23 the first day of the fiscal year.

24 (b) **JOINT RESOLUTION OF APPROVAL.**—A joint res-
25 olution described in this paragraph means only a joint res-

1 olution which is introduced within the 10-day period be-
 2 ginning on the date on which the Commission submits rec-
 3 ommendations under section 302(c) and—

4 (1) which does not have a preamble;

5 (2) the matter after the resolving clause of
 6 which is as follows: “That Congress approves the
 7 recommendations of the Independent Commission on
 8 Medicare concerning methods to control outlays
 9 under the medicare program for fiscal year
 10 _____, as submitted by the Commission on
 11 _____.”, the first blank space being filled
 12 in with the appropriate fiscal year and the second
 13 blank space being filled in with the appropriate date;
 14 and

15 (3) the title of which is as follows: “Joint reso-
 16 lution approving recommendations of the Independ-
 17 ent Commission on Medicare concerning methods to
 18 control outlays under the medicare program for fis-
 19 cal year _____, as submitted by the Commission
 20 on _____.”, the first blank space being
 21 filled in with the appropriate fiscal year and the sec-
 22 ond blank space being filled in with the appropriate
 23 date.

24 (c) PROCEDURES FOR CONSIDERATION OF RESOLU-
 25 TION OF APPROVAL.—Subject to subsection (d), the provi-

1 sions of section 2908 (other than subsection (a)) of the
2 Defense Base Closure and Realignment Act of 1990 shall
3 apply to the consideration of a joint resolution described
4 in subsection (b) in the same manner as such provisions
5 apply to a joint resolution described in section 2908(a)
6 of such Act.

7 (d) SPECIAL RULES.—For purposes of applying sub-
8 section (c) with respect to such provisions—

9 (1) any reference to the Committee on Armed
10 Services of the House of Representatives shall be
11 deemed a reference to an appropriate committee of
12 the House of Representatives (specified by the
13 Speaker of the House of Representatives at the time
14 of submission of recommendations under subsection
15 (c)) and any reference to the Committee on Armed
16 Services of the Senate shall be deemed a reference
17 to an appropriate committee of the Senate (specified
18 by the majority leader of the Senate at the time of
19 submission of recommendations by the Commission
20 under section 302(c)); and

21 (2) any reference to the date on which the
22 President transmits a report shall be deemed a ref-
23 erence to the date on which the Commission submits
24 recommendations under section 302(c).

1 **SEC. 304. NO TERMINATION OF COMMISSION.**

2 Section 14(a)(2)(B) of the Federal Advisory Commit-
3 tee Act (5 U.S.C. App.; relating to the termination of advi-
4 sory committees) shall not apply to the Commission.

5 **SEC. 305. ESTABLISHMENT OF ANNUAL LIMITS ON OUT-**
6 **LAYS.**

7 Not later than April 15 of each year (beginning with
8 1997), Congress shall in the concurrent resolution on the
9 budget for the fiscal year beginning on the following Octo-
10 ber 1 establish a limit on total outlays to be made under
11 the medicare program for the fiscal year.

12 **SEC. 306. ENFORCEMENT OF LIMITS THROUGH SEQUES-**
13 **TRATION.**

14 (a) IN GENERAL.—Part C of the Balanced Budget
15 and Emergency Deficit Control Act of 1985 (2 U.S.C. 900
16 et seq.) is amended by inserting after section 252 the fol-
17 lowing new section:

18 **“SEC. 252A. SEQUESTRATION WITH RESPECT TO MEDICARE.**

19 “(a) SEQUESTRATION.—If, with respect to a fiscal
20 year (beginning with fiscal year 1998), Congress has not
21 enacted a joint resolution under section 303(b) of the Sen-
22 ior Citizens Bill of Rights Act of 1996 before the first
23 day of the fiscal year, there shall be a sequestration to
24 eliminate any budgetary excess in the medicare program
25 as described in subsection (b).

26 “(b) ELIMINATING A BUDGETARY EXCESS.—

1 “(1) IN GENERAL.—Outlays under the medicare
2 program shall be reduced during a fiscal year as
3 provided by paragraph (2), as necessary to eliminate
4 any amount by which estimated outlays under the
5 program in the year exceed the limit for such out-
6 lays established for the year by Congress pursuant
7 to section 305 of the Senior Citizens Bill of Rights
8 Act of 1996.

9 “(2) REDUCTIONS DESCRIBED.—In carrying
10 out paragraph (1), the President shall—

11 “(A) reduce payments made under the
12 medicare program by a uniform percentage suf-
13 ficient to reduce 50 percent of the amount de-
14 scribed in paragraph (1); and

15 “(B) increase premiums, deductibles,
16 copayments, and coinsurance required to be
17 paid under the program by a uniform percent-
18 age sufficient to reduce 50 percent of the
19 amount described in paragraph (1).

20 “(c) PART-YEAR APPROPRIATIONS AND OMB ESTI-
21 MATES.—Paragraphs (4) and (7) of section 251(a) shall
22 apply to sequestration of amounts under this section in
23 the same manner as those paragraphs apply to discre-
24 tionary appropriations and sequestrations under that sec-
25 tion.

1 “(d) COORDINATION WITH OTHER SEQUESTRA-
2 TION.—

3 “(1) IN GENERAL.—Reductions under sub-
4 section (b) for a fiscal year shall supersede any re-
5 duction otherwise made under section 252 or 253.

6 “(2) REPORTS.—On the dates specified in sec-
7 tion 254(a), OMB and CBO shall issue preview, up-
8 date, and final reports on medicare sequestration
9 under this section. Such reports shall specify—

10 “(A) the estimated amount described in
11 subsection (b)(1) for the fiscal year;

12 “(B) the estimated uniform percentage de-
13 scribed in subsection (b)(2)(A) of the fiscal
14 year; and

15 “(C) the estimated uniform percentage de-
16 scribed in subsection (b)(2)(B) of the fiscal
17 year.

18 “(3) RULES FOR APPLICATION OF REDUC-
19 TIONS.—The provisions of section 256(d) shall apply
20 to reductions under this section.”.

21 (b) CLERICAL AMENDMENT.—The table of contents
22 for part C of the Balanced Budget and Emergency Deficit
23 Control Act of 1985 (2 U.S.C. 900 et seq.) is amended
24 by inserting after the item relating to section 252 the fol-
25 lowing:

“Sec. 252A. Sequestration with respect to medicare.”.

1 **TITLE IV—HEALTH CARE FRAUD**
2 **PREVENTION**

3 **Subtitle A—All-Payer Fraud and**
4 **Abuse Control Program**

5 **SEC. 401. ALL-PAYER FRAUD AND ABUSE CONTROL PRO-**
6 **GRAM.**

7 (a) ESTABLISHMENT OF PROGRAM.—

8 (1) IN GENERAL.—Not later than January 1,
9 1997, the Secretary of Health and Human Services
10 (in this title referred to as the “Secretary”), acting
11 through the Office of the Inspector General of the
12 Department of Health and Human Services, and the
13 Attorney General shall establish a program—

14 (A) to coordinate Federal, State, and local
15 law enforcement programs to control fraud and
16 abuse with respect to the delivery of and pay-
17 ment for health care in the United States,

18 (B) to conduct investigations, audits, eval-
19 uations, and inspections relating to the delivery
20 of and payment for health care in the United
21 States,

22 (C) to facilitate the enforcement of the
23 provisions of sections 1128, 1128A, and 1128B
24 of the Social Security Act and other statutes
25 applicable to health care fraud and abuse, and

1 (D) to provide for the modification and es-
2 tablishment of safe harbors and to issue inter-
3 pretative rulings and special fraud alerts pursu-
4 ant to section 403.

5 (2) COORDINATION WITH HEALTH PLANS.—In
6 carrying out the program established under para-
7 graph (1), the Secretary and the Attorney General
8 shall consult with, and arrange for the sharing of
9 data with representatives of health plans.

10 (3) REGULATIONS.—

11 (A) IN GENERAL.—The Secretary and the
12 Attorney General shall by regulation establish
13 standards to carry out the program under para-
14 graph (1).

15 (B) INFORMATION STANDARDS.—

16 (i) IN GENERAL.—Such standards
17 shall include standards relating to the fur-
18 nishing of information by health plans,
19 providers, and others to enable the Sec-
20 retary and the Attorney General to carry
21 out the program (including coordination
22 with health plans under paragraph (2)).

23 (ii) CONFIDENTIALITY.—Such stand-
24 ards shall include procedures to assure
25 that such information is provided and uti-

1 lized in a manner that appropriately pro-
2 tects the confidentiality of the information
3 and the privacy of individuals receiving
4 health care services and items.

5 (iii) QUALIFIED IMMUNITY FOR PRO-
6 VIDING INFORMATION.—The provisions of
7 section 1157(a) of the Social Security Act
8 (relating to limitation on liability) shall
9 apply to a person providing information to
10 the Secretary or the Attorney General in
11 conjunction with their performance of du-
12 ties under this section.

13 (C) DISCLOSURE OF OWNERSHIP INFOR-
14 MATION.—

15 (i) IN GENERAL.—Such standards
16 shall include standards relating to the dis-
17 closure of ownership information described
18 in clause (ii) by any entity providing health
19 care services and items.

20 (ii) OWNERSHIP INFORMATION DE-
21 SCRIBED.—The ownership information de-
22 scribed in this clause includes—

23 (I) a description of such items
24 and services provided by such entity;

1 (II) the names and unique physi-
2 cian identification numbers of all phy-
3 sicians with a financial relationship
4 (as defined in section 1877(a)(2) of
5 the Social Security Act) with such en-
6 tity;

7 (III) the names of all other indi-
8 viduals with such an ownership or in-
9 vestment interest in such entity; and

10 (IV) any other ownership and re-
11 lated information required to be dis-
12 closed by such entity under section
13 1124 or section 1124A of the Social
14 Security Act, except that the Sec-
15 retary shall establish procedures
16 under which the information required
17 to be submitted under this subclause
18 will be reduced with respect to health
19 care provider entities that the Sec-
20 retary determines will be unduly bur-
21 dened if such entities are required to
22 comply fully with this subclause.

23 (4) AUTHORIZATION OF APPROPRIATIONS FOR
24 INVESTIGATORS AND OTHER PERSONNEL.—In addi-
25 tion to any other amounts authorized to be appro-

1 appropriated to the Secretary, the Attorney General, the
2 Director of the Federal Bureau of Investigation, and
3 the Inspectors General of the Departments of De-
4 fense, Labor, and Veterans Affairs and of the Office
5 of Personnel Management, for health care anti-fraud
6 and abuse activities for a fiscal year, there are au-
7 thorized to be appropriated additional amounts,
8 from the Health Care Fraud and Abuse Account de-
9 scribed in subsection (b) of this section, as may be
10 necessary to enable the Secretary, the Attorney Gen-
11 eral, and such Inspectors General to conduct inves-
12 tigations and audits of allegations of health care
13 fraud and abuse and otherwise carry out the pro-
14 gram established under paragraph (1) in a fiscal
15 year.

16 (5) ENSURING ACCESS TO DOCUMENTATION.—
17 The Inspector General of the Department of Health
18 and Human Services is authorized to exercise the
19 authority described in paragraphs (4) and (5) of sec-
20 tion 6 of the Inspector General Act of 1978 (relating
21 to subpoenas and administration of oaths) with re-
22 spect to the activities under the all-payer fraud and
23 abuse control program established under this sub-
24 section to the same extent as such Inspector General

1 may exercise such authorities to perform the func-
2 tions assigned by such Act.

3 (6) AUTHORITY OF INSPECTOR GENERAL.—
4 Nothing in this Act shall be construed to diminish
5 the authority of any Inspector General, including
6 such authority as provided in the Inspector General
7 Act of 1978.

8 (7) HEALTH PLAN DEFINED.—For the purposes
9 of this subsection, the term “health plan” shall have
10 the meaning given such term in section 1128(i) of
11 the Social Security Act.

12 (b) HEALTH CARE FRAUD AND ABUSE CONTROL AC-
13 COUNT.—

14 (1) ESTABLISHMENT.—

15 (A) IN GENERAL.—There is hereby estab-
16 lished an account to be known as the “Health
17 Care Fraud and Abuse Control Account” (in
18 this section referred to as the “Anti-Fraud Ac-
19 count”). The Anti-Fraud Account shall consist
20 of—

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

23 (ii) such amounts as may be deposited
24 in the Anti-Fraud Account as provided in
25 subsection (a)(4), sections 441(b) and

1 442(b), and title XI of the Social Security
2 Act; and

3 (iii) such amounts as are transferred
4 to the Anti-Fraud Account under subpara-
5 graph (C).

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

13 (C) TRANSFER OF AMOUNTS.—The Sec-
14 retary of the Treasury shall transfer to the
15 Anti-Fraud Account an amount equal to the
16 sum of the following:

17 (i) Criminal fines imposed in cases in-
18 volving a Federal health care offense (as
19 defined in section 982(a)(6)(B) of title 18,
20 United States Code).

21 (ii) Administrative penalties and as-
22 sessments imposed under titles XI, XVIII,
23 and XIX of the Social Security Act (except
24 as otherwise provided by law).

1 (iii) Amounts resulting from the for-
2 feiture of property by reason of a Federal
3 health care offense.

4 (iv) Penalties and damages imposed
5 under the False Claims Act (31 U.S.C.
6 3729 et seq.), in cases involving claims re-
7 lated to the provision of health care items
8 and services (other than funds awarded to
9 a relator or for restitution).

10 (2) USE OF FUNDS.—

11 (A) IN GENERAL.—Amounts in the Anti-
12 Fraud Account shall be available to carry out
13 the health care fraud and abuse control pro-
14 gram established under subsection (a) (includ-
15 ing the administration of the program), and
16 may be used to cover costs incurred in operat-
17 ing the program, including costs (including
18 equipment, salaries and benefits, and travel and
19 training) of—

20 (i) prosecuting health care matters
21 (through criminal, civil, and administrative
22 proceedings);

23 (ii) investigations;

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

1 (iv) inspections and other evaluations;
2 and
3 (v) provider and consumer education
4 regarding compliance with the provisions of
5 this title.

6 (B) FUNDS USED TO SUPPLEMENT AGEN-
7 CY APPROPRIATIONS.—It is intended that dis-
8 bursements made from the Anti-Fraud Account
9 to any Federal agency be used to increase and
10 not supplant the recipient agency's appro-
11 priated operating budget.

12 (3) ANNUAL REPORT.—The Secretary and the
13 Attorney General shall submit jointly an annual re-
14 port to Congress on the amount of revenue which is
15 generated and disbursed by the Anti-Fraud Account
16 in each fiscal year.

17 (4) USE OF FUNDS BY INSPECTOR GENERAL.—

18 (A) REIMBURSEMENTS FOR INVESTIGA-
19 TIONS.—The Inspector General is authorized to
20 receive and retain for current use reimburse-
21 ment for the costs of conducting investigations,
22 when such restitution is ordered by a court, vol-
23 untarily agreed to by the payer, or otherwise.

24 (B) CREDITING.—Funds received by the
25 Inspector General or the Inspectors General of

1 the Departments of Defense, Labor, and Veter-
2 ans Affairs and of the Office of Personnel Man-
3 agement, as reimbursement for costs of con-
4 ducting investigations shall be deposited to the
5 credit of the appropriation from which initially
6 paid, or to appropriations for similar purposes
7 currently available at the time of deposit, and
8 shall remain available for obligation for 1 year
9 from the date of their deposit.

10 **SEC. 402. APPLICATION OF CERTAIN FEDERAL HEALTH**
11 **ANTI-FRAUD AND ABUSE SANCTIONS TO**
12 **FRAUD AND ABUSE AGAINST ANY HEALTH**
13 **PLAN.**

14 (a) CRIMES.—

15 (1) SOCIAL SECURITY ACT.—Section 1128B of
16 the Social Security Act (42 U.S.C. 1320a–7b) is
17 amended as follows:

18 (A) In the heading, by adding at the end
19 the following: “OR HEALTH PLANS”.

20 (B) In subsection (a)(1)—

21 (i) by striking “title XVIII or” and
22 inserting “title XVIII,” and

23 (ii) by adding at the end the follow-
24 ing: “or a health plan (as defined in sec-
25 tion 1128(i))”.

1 (C) In subsection (a)(5), by striking “title
2 XVIII or a State health care program” and in-
3 serting “title XVIII, a State health care pro-
4 gram, or a health plan”.

5 (D) In the second sentence of subsection
6 (a)—

7 (i) by inserting after “title XIX” the
8 following: “or a health plan”, and

9 (ii) by inserting after “the State” the
10 following: “or the plan”.

11 (2) IDENTIFICATION OF COMMUNITY SERVICE
12 OPPORTUNITIES.—Section 1128B of such Act (42
13 U.S.C. 1320a–7b) is further amended by adding at
14 the end the following new subsection:

15 “(f) The Secretary may—

16 “(1) in consultation with State and local health
17 care officials, identify opportunities for the satisfac-
18 tion of community service obligations that a court
19 may impose upon the conviction of an offense under
20 this section, and

21 “(2) make information concerning such oppor-
22 tunities available to Federal and State law enforce-
23 ment officers and State and local health care offi-
24 cials.”.

1 (b) HEALTH PLAN DEFINED.—Section 1128 of the
 2 Social Security Act (42 U.S.C. 1320a–7) is amended by
 3 redesignating subsection (i) as subsection (j) and by in-
 4 serting after subsection (h) the following new subsection:

5 “(i) HEALTH PLAN DEFINED.—For purposes of sec-
 6 tions 1128A and 1128B, the term ‘health plan’ means a
 7 plan that provides health benefits, whether through di-
 8 rectly, through insurance, or otherwise, and includes a pol-
 9 icy of health insurance, a contract of a service benefit or-
 10 ganization, or a membership agreement with a health
 11 maintenance organization or other prepaid health plan,
 12 and also includes an employee welfare benefit plan or a
 13 multiple employer welfare plan (as such terms are defined
 14 in section 3 of the Employee Retirement Income Security
 15 Act of 1974).”.

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

18 **SEC. 403. HEALTH CARE FRAUD AND ABUSE GUIDANCE.**

19 (a) SOLICITATION AND PUBLICATION OF MODIFICA-
 20 TIONS TO EXISTING SAFE HARBORS AND NEW SAFE
 21 HARBORS.—

22 (1) IN GENERAL.—

23 (A) SOLICITATION OF PROPOSALS FOR
 24 SAFE HARBORS.—Not later than January 1,
 25 1997, and not less than annually thereafter, the

1 Secretary shall publish a notice in the Federal
2 Register soliciting proposals, which will be ac-
3 cepted during a 60-day period, for—

4 (i) modifications to existing safe har-
5 bors issued pursuant to section 14(a) of
6 the Medicare and Medicaid Patient and
7 Program Protection Act of 1987 (42
8 U.S.C. 1320a–7b note);

9 (ii) additional safe harbors specifying
10 payment practices that shall not be treated
11 as a criminal offense under section
12 1128B(b) of the Social Security Act the
13 (42 U.S.C. 1320a–7b(b)) and shall not
14 serve as the basis for an exclusion under
15 section 1128(b)(7) of such Act (42 U.S.C.
16 1320a–7(b)(7));

17 (iii) interpretive rulings to be issued
18 pursuant to subsection (b); and

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

21 (B) PUBLICATION OF PROPOSED MODI-
22 FICATIONS AND PROPOSED ADDITIONAL SAFE
23 HARBORS.—After considering the proposals de-
24 scribed in clauses (i) and (ii) of subparagraph
25 (A), the Secretary, in consultation with the At-

1 torney General, shall publish in the Federal
2 Register proposed modifications to existing safe
3 harbors and proposed additional safe harbors, if
4 appropriate, with a 60-day comment period.
5 After considering any public comments received
6 during this period, the Secretary shall issue
7 final rules modifying the existing safe harbors
8 and establishing new safe harbors, as appro-
9 priate.

10 (C) REPORT.—The Inspector General of
11 the Department of Health and Human Services
12 (hereafter in this section referred to as the “In-
13 specter General”) shall, in an annual report to
14 Congress or as part of the year-end semiannual
15 report required by section 5 of the Inspector
16 General Act of 1978 (5 U.S.C. App.), describe
17 the proposals received under clauses (i) and (ii)
18 of subparagraph (A) and explain which propos-
19 als were included in the publication described in
20 subparagraph (B), which proposals were not in-
21 cluded in that publication, and the reasons for
22 the rejection of the proposals that were not in-
23 cluded.

24 (2) CRITERIA FOR MODIFYING AND ESTABLISH-
25 ING SAFE HARBORS.—In modifying and establishing

1 safe harbors under paragraph (1)(B), the Secretary
2 may consider the extent to which providing a safe
3 harbor for the specified payment practice may result
4 in any of the following:

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

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

9 (C) An increase or decrease in patient free-
10 dom of choice among health care providers.

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

13 (E) An increase or decrease in the ability
14 of health care facilities to provide services in
15 medically underserved areas or to medically un-
16 derserved populations.

17 (F) An increase or decrease in the cost to
18 Government health care programs.

19 (G) An increase or decrease in the poten-
20 tial overutilization of health care services.

21 (H) The existence or nonexistence of any
22 potential financial benefit to a health care pro-
23 fessional or provider which may vary based on
24 their decisions of—

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

3 (ii) whether to arrange for a referral
4 of health care items or services to a par-
5 ticular practitioner or provider.

6 (I) Any other factors the Secretary deems
7 appropriate in the interest of preventing fraud
8 and abuse in Government health care programs.

9 (b) INTERPRETIVE RULINGS.—

10 (1) IN GENERAL.—

11 (A) REQUEST FOR INTERPRETIVE RUL-
12 ING.—Any person may present, at any time, a
13 request to the Inspector General for a state-
14 ment of the Inspector General’s current inter-
15 pretation of the meaning of a specific aspect of
16 the application of sections 1128A and 1128B of
17 the Social Security Act (hereafter in this sec-
18 tion referred to as an “interpretive ruling”).

19 (B) ISSUANCE AND EFFECT OF INTERPRE-
20 TIVE RULING.—

21 (i) IN GENERAL.—If appropriate, the
22 Inspector General shall in consultation
23 with the Attorney General, issue an inter-
24 pretive ruling in response to a request de-
25 scribed in subparagraph (A). Interpretive

1 rulings shall not have the force of law and
2 shall be treated as an interpretive rule
3 within the meaning of section 553(b) of
4 title 5, United States Code. All interpretive
5 rulings issued pursuant to this provision
6 shall be published in the Federal Register
7 or otherwise made available for public in-
8 spection.

9 (ii) REASONS FOR DENIAL.—If the In-
10 spector General does not issue an interpre-
11 tive ruling in response to a request de-
12 scribed in subparagraph (A), the Inspector
13 General shall notify the requesting party of
14 such decision and shall identify the reasons
15 for such decision.

16 (2) CRITERIA FOR INTERPRETIVE RULINGS.—

17 (A) IN GENERAL.—In determining whether
18 to issue an interpretive ruling under paragraph
19 (1)(B), the Inspector General may consider—

20 (i) whether and to what extent the re-
21 quest identifies an ambiguity within the
22 language of the statute, the existing safe
23 harbors, or previous interpretive rulings;
24 and

1 (ii) whether the subject of the re-
2 requested interpretive ruling can be ade-
3 quately addressed by interpretation of the
4 language of the statute, the existing safe
5 harbor rules, or previous interpretive rul-
6 ings, or whether the request would require
7 a substantive ruling not authorized under
8 this subsection.

9 (B) NO RULINGS ON FACTUAL ISSUES.—

10 The Inspector General shall not give an inter-
11 pretive ruling on any factual issue, including
12 the intent of the parties or the fair market
13 value of particular leased space or equipment.

14 (c) SPECIAL FRAUD ALERTS.—

15 (1) IN GENERAL.—

16 (A) REQUEST FOR SPECIAL FRAUD
17 ALERTS.—Any person may present, at any
18 time, a request to the Inspector General for a
19 notice which informs the public of practices
20 which the Inspector General considers to be
21 suspect or of particular concern under section
22 1128B(b) of the Social Security Act (42 U.S.C.
23 1320a–7b(b)) (hereafter in this subsection re-
24 ferred to as a “special fraud alert”).

1 (B) ISSUANCE AND PUBLICATION OF SPE-
2 CIAL FRAUD ALERTS.—Upon receipt of a re-
3 quest described in subparagraph (A), the In-
4 specter General shall investigate the subject
5 matter of the request to determine whether a
6 special fraud alert should be issued. If appro-
7 priate, the Inspector General shall in consulta-
8 tion with the Attorney General, issue a special
9 fraud alert in response to the request. All spe-
10 cial fraud alerts issued pursuant to this sub-
11 paragraph shall be published in the Federal
12 Register.

13 (2) CRITERIA FOR SPECIAL FRAUD ALERTS.—
14 In determining whether to issue a special fraud alert
15 upon a request described in paragraph (1), the In-
16 specter General may consider—

17 (A) whether and to what extent the prac-
18 tices that would be identified in the special
19 fraud alert may result in any of the con-
20 sequences described in subsection (a)(2); and

21 (B) the volume and frequency of the con-
22 duct that would be identified in the special
23 fraud alert.

1 **SEC. 404. REPORTING OF FRAUDULENT ACTIONS UNDER**
2 **MEDICARE.**

3 Not later than 1 year after the date of the enactment
4 of this Act, the Secretary shall establish a program
5 through which individuals entitled to benefits under the
6 medicare program may report to the Secretary on a con-
7 fidential basis (at the individual's request) instances of
8 suspected fraudulent actions arising under the program by
9 providers of items and services under the program.

10 **Subtitle B—Revisions to Current**
11 **Sanctions for Fraud and Abuse**

12 **SEC. 411. MANDATORY EXCLUSION FROM PARTICIPATION**
13 **IN MEDICARE AND STATE HEALTH CARE PRO-**
14 **GRAMS.**

15 (a) INDIVIDUAL CONVICTED OF FELONY RELATING
16 TO FRAUD.—

17 (1) IN GENERAL.—Section 1128(a) of the So-
18 cial Security Act (42 U.S.C. 1320a-7(a)) is amend-
19 ed by adding at the end the following new para-
20 graph:

21 “(3) FELONY CONVICTION RELATING TO
22 FRAUD.—Any individual or entity that has been con-
23 victed after the date of the enactment of the Senior
24 Citizens Bill of Rights Act of 1996, under Federal
25 or State law, in connection with the delivery of a
26 health care item or service or with respect to any act

1 or omission in a program (other than those specifi-
2 cally described in paragraph (1)) operated by or fi-
3 nanced in whole or in part by any Federal, State, or
4 local government agency, of a criminal offense con-
5 sisting of a felony relating to fraud, theft, embezzle-
6 ment, breach of fiduciary responsibility, or other fi-
7 nancial misconduct.”.

8 (2) CONFORMING AMENDMENT.—Section
9 1128(b)(1) of such Act (42 U.S.C. 1320a–7(b)(1))
10 is amended—

11 (A) in the heading, by striking “CONVIC-
12 TION” and inserting “MISDEMEANOR CONVIC-
13 TION”; and

14 (B) by striking “criminal offense” and in-
15 sserting “criminal offense consisting of a mis-
16 demeanor”.

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

19 (1) IN GENERAL.—Section 1128(a) of the So-
20 cial Security Act (42 U.S.C. 1320a–7(a)), as amend-
21 ed by subsection (a), is amended by adding at the
22 end the following new paragraph:

23 “(4) FELONY CONVICTION RELATING TO CON-
24 TROLLED SUBSTANCE.—Any individual or entity
25 that has been convicted after the date of the enact-

1 ment of the Senior Citizens Bill of Rights Act of
2 1996, under Federal or State law, of a criminal of-
3 fense consisting of a felony relating to the unlawful
4 manufacture, distribution, prescription, or dispens-
5 ing of a controlled substance.”.

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

9 (A) in the heading, by striking “CONVIC-
10 TION” and inserting “MISDEMEANOR CONVIC-
11 TION”; and

12 (B) by striking “criminal offense” and in-
13 serting “criminal offense consisting of a mis-
14 demeanor”.

15 **SEC. 412. ESTABLISHMENT OF MINIMUM PERIOD OF EX-**
16 **CLUSION FOR CERTAIN INDIVIDUALS AND**
17 **ENTITIES SUBJECT TO PERMISSIVE EXCLU-**
18 **SION FROM MEDICARE AND STATE HEALTH**
19 **CARE PROGRAMS.**

20 Section 1128(c)(3) of the Social Security Act (42
21 U.S.C. 1320a–7(c)(3)) is amended by adding at the end
22 the following new subparagraphs:

23 “(D) In the case of an exclusion of an individual or
24 entity under paragraph (1), (2), or (3) of subsection (b),
25 the period of the exclusion shall be 3 years, unless the

1 Secretary determines in accordance with published regula-
2 tions that a shorter period is appropriate because of miti-
3 gating circumstances or that a longer period is appro-
4 priate because of aggravating circumstances.

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

12 “(F) In the case of an exclusion of an individual or
13 entity under subsection (b)(6)(B), the period of the exclu-
14 sion shall be not less than 1 year.”.

15 **SEC. 413. PERMISSIVE EXCLUSION OF INDIVIDUALS WITH**
16 **OWNERSHIP OR CONTROL INTEREST IN**
17 **SANCTIONED ENTITIES.**

18 Section 1128(b) of the Social Security Act (42 U.S.C.
19 1320a–7(b)) is amended by adding at the end the follow-
20 ing new paragraph:

21 “(15) INDIVIDUALS CONTROLLING A SANC-
22 TIONED ENTITY.—Any individual who has a direct
23 or indirect ownership or control interest of 5 percent
24 or more, or an ownership or control interest (as de-
25 fined in section 1124(a)(3)) in, or who is an officer,

1 director, agent, or managing employee (as defined in
2 section 1126(b)) of, an entity—

3 “(A) that has been convicted of any of-
4 fense described in subsection (a) or in para-
5 graph (1), (2), or (3) of this subsection;

6 “(B) against which a civil monetary pen-
7 alty has been assessed under section 1128A; or

8 “(C) that has been excluded from partici-
9 pation under a program under title XVIII or
10 under a State health care program.”.

11 **SEC. 414. SANCTIONS AGAINST PRACTITIONERS AND PER-**
12 **SONS FOR FAILURE TO COMPLY WITH STATU-**
13 **TORY OBLIGATIONS.**

14 (a) MINIMUM PERIOD OF EXCLUSION FOR PRACTI-
15 TIONERS AND PERSONS FAILING TO MEET STATUTORY
16 OBLIGATIONS.—

17 (1) IN GENERAL.—The second sentence of sec-
18 tion 1156(b)(1) of the Social Security Act (42
19 U.S.C. 1320c-5(b)(1)) is amended by striking “may
20 prescribe)” and inserting “may prescribe, except
21 that such period may not be less than 1 year)”.

22 (2) CONFORMING AMENDMENT.—Section
23 1156(b)(2) of such Act (42 U.S.C. 1320c-5(b)(2)) is
24 amended by striking “shall remain” and inserting

1 “shall (subject to the minimum period specified in
2 the second sentence of paragraph (1)) remain”.

3 (b) REPEAL OF “UNWILLING OR UNABLE” CONDI-
4 TION FOR IMPOSITION OF SANCTION.—Section 1156(b)(1)
5 of the Social Security Act (42 U.S.C. 1320c–5(b)(1)) is
6 amended—

7 (1) in the second sentence, by striking “and de-
8 termines” and all that follows through “such obliga-
9 tions,”; and

10 (2) by striking the third sentence.

11 **SEC. 415. INTERMEDIATE SANCTIONS FOR MEDICARE**
12 **HEALTH MAINTENANCE ORGANIZATIONS.**

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

15 (1) IN GENERAL.—Section 1876(i)(1) of the
16 Social Security Act (42 U.S.C. 1395mm(i)(1)) is
17 amended by striking “the Secretary may terminate”
18 and all that follows and inserting the following: “in
19 accordance with procedures established under para-
20 graph (9), the Secretary may at any time terminate
21 any such contract or may impose the intermediate
22 sanctions described in paragraph (6)(B) or (6)(C)
23 (whichever is applicable) on the eligible organization
24 if the Secretary determines that the organization—

1 “(A) has failed substantially to carry out
2 the contract;

3 “(B) is carrying out the contract in a man-
4 ner inconsistent with the efficient and effective
5 administration of this section; or

6 “(C) no longer substantially meets the ap-
7 plicable conditions of subsections (b), (c), (e),
8 and (f).”.

9 (2) OTHER INTERMEDIATE SANCTIONS FOR
10 MISCELLANEOUS PROGRAM VIOLATIONS.—Section
11 1876(i)(6) of such Act (42 U.S.C. 1395mm(i)(6)) is
12 amended by adding at the end the following new
13 subparagraph:

14 “(C) In the case of an eligible organization for which
15 the Secretary makes a determination under paragraph (1)
16 the basis of which is not described in subparagraph (A),
17 the Secretary may apply the following intermediate sanc-
18 tions:

19 “(i) Civil money penalties of not more than
20 \$25,000 for each determination under paragraph (1)
21 if the deficiency that is the basis of the determina-
22 tion has directly adversely affected (or has the sub-
23 stantial likelihood of adversely affecting) an individ-
24 ual covered under the organization’s contract.

1 “(ii) Civil money penalties of not more than
2 \$10,000 for each week beginning after the initiation
3 of procedures by the Secretary under paragraph (9)
4 during which the deficiency that is the basis of a de-
5 termination under paragraph (1) exists.

6 “(iii) Suspension of enrollment of individuals
7 under this section after the date the Secretary noti-
8 fies the organization of a determination under para-
9 graph (1) and until the Secretary is satisfied that
10 the deficiency that is the basis for the determination
11 has been corrected and is not likely to recur.”.

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

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

22 “(A) the Secretary provides the organization
23 with the opportunity to develop and implement a
24 corrective action plan to correct the deficiencies that

1 were the basis of the Secretary's determination
2 under paragraph (1);

3 “(B) in deciding whether to impose sanctions,
4 the Secretary considers aggravating factors such as
5 whether an entity has a history of deficiencies or has
6 not taken action to correct deficiencies the Secretary
7 has brought to their attention;

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

11 “(D) the Secretary provides the organization
12 with reasonable notice and opportunity for hearing
13 (including the right to appeal an initial decision) be-
14 fore imposing any sanction or terminating the con-
15 tract.”.

16 (4) CONFORMING AMENDMENTS.—Section
17 1876(i)(6)(B) of such Act (42 U.S.C.
18 1395mm(i)(6)(B)) is amended by striking the sec-
19 ond sentence.

20 (b) AGREEMENTS WITH PEER REVIEW ORGANIZA-
21 TIONS.—

22 (1) REQUIREMENT FOR WRITTEN AGREE-
23 MENT.—Section 1876(i)(7)(A) of the Social Security
24 Act (42 U.S.C. 1395mm(i)(7)(A)) is amended by

1 striking “an agreement” and inserting “a written
2 agreement”.

3 (2) DEVELOPMENT OF MODEL AGREEMENT.—

4 Not later than July 1, 1996, the Secretary shall de-
5 velop a model of the agreement that an eligible orga-
6 nization with a risk-sharing contract under section
7 1876 of the Social Security Act must enter into with
8 an entity providing peer review services with respect
9 to services provided by the organization under sec-
10 tion 1876(i)(7)(A) of such Act.

11 (3) REPORT BY GAO.—

12 (A) STUDY.—The Comptroller General of
13 the United States shall conduct a study of the
14 costs incurred by eligible organizations with
15 risk-sharing contracts under section 1876(b) of
16 such Act of complying with the requirement of
17 entering into a written agreement with an en-
18 tity providing peer review services with respect
19 to services provided by the organization, to-
20 gether with an analysis of how information gen-
21 erated by such entities is used by the Secretary
22 to assess the quality of services provided by
23 such eligible organizations.

24 (B) REPORT TO CONGRESS.—Not later
25 than July 1, 1999, the Comptroller General

1 shall submit a report to the Committee on
2 Ways and Means and the Committee on Energy
3 and Commerce of the House of Representatives
4 and the Committee on Finance and the Special
5 Committee on Aging of the Senate on the study
6 conducted under subparagraph (A).

7 (c) EFFECTIVE DATE.—The amendments made by
8 this section shall apply with respect to contract years be-
9 ginning on or after January 1, 1997.

10 **SEC. 416. EFFECTIVE DATE.**

11 The amendments made by this part shall take effect
12 January 1, 1997.

13 **Subtitle C—Administrative and**
14 **Miscellaneous Provisions**

15 **SEC. 421. ESTABLISHMENT OF THE HEALTH CARE FRAUD**
16 **AND ABUSE DATA COLLECTION PROGRAM.**

17 (a) GENERAL PURPOSE.—Not later than January 1,
18 1997, the Secretary shall establish a national health care
19 fraud and abuse data collection program for the reporting
20 of final adverse actions (not including settlements in which
21 no findings of liability have been made) against health
22 care providers, suppliers, or practitioners as required by
23 subsection (b), with access as set forth in subsection (c).

24 (b) REPORTING OF INFORMATION.—

1 (1) IN GENERAL.—Each government agency
2 and health plan shall report any final adverse action
3 (not including settlements in which no findings of li-
4 ability have been made) taken against a health care
5 provider, supplier, or practitioner.

6 (2) INFORMATION TO BE REPORTED.—The in-
7 formation to be reported under paragraph (1) in-
8 cludes:

9 (A) The name of any health care provider,
10 supplier, or practitioner who is the subject of a
11 final adverse action.

12 (B) The name (if known) of any health
13 care entity with which a health care provider,
14 supplier, or practitioner is affiliated or associ-
15 ated.

16 (C) The nature of the final adverse action.

17 (D) A description of the acts or omissions
18 and injuries upon which the final adverse action
19 was based, and such other information as the
20 Secretary determines by regulation is required
21 for appropriate interpretation of information re-
22 ported under this section.

23 (3) CONFIDENTIALITY.—In determining what
24 information is required, the Secretary shall include
25 procedures to assure that the privacy of individuals

1 receiving health care services is appropriately pro-
2 tected.

3 (4) TIMING AND FORM OF REPORTING.—The
4 information required to be reported under this sub-
5 section shall be reported regularly (but not less often
6 than monthly) and in such form and manner as the
7 Secretary prescribes. Such information shall first be
8 required to be reported on a date specified by the
9 Secretary.

10 (5) TO WHOM REPORTED.—The information re-
11 quired to be reported under this subsection shall be
12 reported to the Secretary.

13 (c) DISCLOSURE AND CORRECTION OF INFORMA-
14 TION.—

15 (1) DISCLOSURE.—With respect to the informa-
16 tion about final adverse actions (not including settle-
17 ments in which no findings of liability have been
18 made) reported to the Secretary under this section
19 respecting a health care provider, supplier, or practi-
20 tioner, the Secretary shall, by regulation, provide
21 for—

22 (A) disclosure of the information, upon re-
23 quest, to the health care provider, supplier, or
24 licensed practitioner, and

1 (B) procedures in the case of disputed ac-
2 curacy of the information.

3 (2) CORRECTIONS.—Each Government agency
4 and health plan shall report corrections of informa-
5 tion already reported about any final adverse action
6 taken against a health care provider, supplier, or
7 practitioner, in such form and manner that the Sec-
8 retary prescribes by regulation.

9 (d) ACCESS TO REPORTED INFORMATION.—

10 (1) AVAILABILITY.—The information in this
11 database shall be available to Federal and State gov-
12 ernment agencies and health plans pursuant to pro-
13 cedures that the Secretary shall provide by regula-
14 tion.

15 (2) FEES FOR DISCLOSURE.—The Secretary
16 may establish or approve reasonable fees for the dis-
17 closure of information in this database. The amount
18 of such a fee may not exceed the costs of processing
19 the requests for disclosure and of providing such in-
20 formation. Such fees shall be available to the Sec-
21 retary or, in the Secretary's discretion to the agency
22 designated under this section to cover such costs.

23 (e) PROTECTION FROM LIABILITY FOR REPORT-
24 ING.—No person or entity, including the agency des-
25 ignated by the Secretary in subsection (b)(5) shall be held

1 liable in any civil action with respect to any report made
2 as required by this section, without knowledge of the fal-
3 sity of the information contained in the report.

4 (f) DEFINITIONS AND SPECIAL RULES.—For pur-
5 poses of this section:

6 (1) The term “final adverse action” includes:

7 (A) Civil judgments against a health care
8 provider in Federal or State court related to the
9 delivery of a health care item or service.

10 (B) Federal or State criminal convictions
11 related to the delivery of a health care item or
12 service.

13 (C) Actions by Federal or State agencies
14 responsible for the licensing and certification of
15 health care providers, suppliers, and licensed
16 health care practitioners, including—

17 (i) formal or official actions, such as
18 revocation or suspension of a license (and
19 the length of any such suspension), rep-
20 rimand, censure or probation,

21 (ii) any other loss of license of the
22 provider, supplier, or practitioner, by oper-
23 ation of law, or

1 (iii) any other negative action or find-
2 ing by such Federal or State agency that
3 is publicly available information.

4 (D) Exclusion from participation in Fed-
5 eral or State health care programs.

6 (E) Any other adjudicated actions or deci-
7 sions that the Secretary shall establish by regu-
8 lation.

9 (2) The terms “licensed health care practi-
10 tioner”, “licensed practitioner”, and “practitioner”
11 mean, with respect to a State, an individual who is
12 licensed or otherwise authorized by the State to pro-
13 vide health care services (or any individual who,
14 without authority holds himself or herself out to be
15 so licensed or authorized).

16 (3) The term “health care provider” means a
17 provider of services as defined in section 1861(u) of
18 the Social Security Act, and any entity, including a
19 health maintenance organization, group medical
20 practice, or any other entity listed by the Secretary
21 in regulation, that provides health care services.

22 (4) The term “supplier” means a supplier of
23 health care items and services described in section
24 1819 (a) and (b), and section 1861 of the Social Se-
25 curity Act.

1 (5) The term “Government agency” shall in-
2 clude:

3 (A) The Department of Justice.

4 (B) The Department of Health and
5 Human Services.

6 (C) Any other Federal agency that either
7 administers or provides payment for the deliv-
8 ery of health care services, including, but not
9 limited to the Department of Defense and the
10 Veterans’ Administration.

11 (D) State law enforcement agencies.

12 (E) State medicaid fraud and abuse units.

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

16 (6) The term “health plan” has the meaning
17 given to such term by section 1128(i) of the Social
18 Security Act.

19 (7) For purposes of paragraph (2), the exist-
20 ence of a conviction shall be determined under para-
21 graph (4) of section 1128(j) of the Social Security
22 Act.

23 (g) CONFORMING AMENDMENT.—Section 1921(d) of
24 the Social Security Act is amended by inserting “and sec-
25 tion 421 of the Senior Citizens Bill of Rights Act of 1996”

1 after “section 422 of the Health Care Quality Improve-
2 ment Act of 1986”.

3 **Subtitle D—Civil Monetary** 4 **Penalties**

5 **SEC. 431. CIVIL MONETARY PENALTIES.**

6 (a) GENERAL CIVIL MONETARY PENALTIES.—Sec-
7 tion 1128A of the Social Security Act (42 U.S.C. 1320a-
8 7a) is amended as follows:

9 (1) In subsection (a)(1), by inserting “or of any
10 health plan (as defined in section 1128(i)),” after
11 “subsection (i)(1)),”.

12 (2) In subsection (f)—

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

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

17 “(3) With respect to amounts recovered arising
18 out of a claim under a health plan, the portion of
19 such amounts as is determined to have been paid by
20 the plan shall be repaid to the plan, and the portion
21 of such amounts attributable to the amounts recov-
22 ered under this section by reason of the amendments
23 made by title IV of the Senior Citizens Bill of Rights
24 Act of 1996 (as estimated by the Secretary) shall be
25 deposited into the Health Care Fraud and Abuse

1 Control Account established under section 101(b) of
2 such Act.”.

3 (3) In subsection (i)—

4 (A) in paragraph (2), by inserting “or
5 under a health plan” before the period at the
6 end, and

7 (B) in paragraph (5), by inserting “or
8 under a health plan” after “or XX”.

9 (b) EXCLUDED INDIVIDUAL RETAINING OWNERSHIP
10 OR CONTROL INTEREST IN PARTICIPATING ENTITY.—

11 Section 1128A(a) of the Social Security Act (42 U.S.C.
12 1320a–7a(a)) is amended—

13 (1) by striking “or” at the end of paragraph
14 (1)(D);

15 (2) by striking “, or” at the end of paragraph
16 (2) and inserting a semicolon;

17 (3) by striking the semicolon at the end of
18 paragraph (3) and inserting “; or”; and

19 (4) by inserting after paragraph (3) the follow-
20 ing new paragraph:

21 “(4) in the case of a person who is not an orga-
22 nization, agency, or other entity, is excluded from
23 participating in a program under title XVIII or a
24 State health care program in accordance with this
25 subsection or under section 1128 and who, at the

1 time of a violation of this subsection, retains a direct
2 or indirect ownership or control interest of 5 percent
3 or more, or an ownership or control interest (as de-
4 fined in section 1124(a)(3)) in, or who is an officer,
5 director, agent, or managing employee (as defined in
6 section 1126(b)) of, an entity that is participating in
7 a program under title XVIII or a State health care
8 program;”.

9 (c) MODIFICATIONS OF AMOUNTS OF PENALTIES
10 AND ASSESSMENTS.—Section 1128A(a) of the Social Se-
11 curity Act (42 U.S.C. 1320a–7a(a)), as amended by sub-
12 section (b), is amended in the matter following paragraph
13 (4)—

14 (1) by striking “\$2,000” and inserting
15 “\$10,000”;

16 (2) by inserting “; in cases under paragraph
17 (4), \$10,000 for each day the prohibited relationship
18 occurs” after “false or misleading information was
19 given”; and

20 (3) by striking “twice the amount” and insert-
21 ing “3 times the amount”.

22 (d) CLAIM FOR ITEM OR SERVICE BASED ON INCOR-
23 RECT CODING OR MEDICALLY UNNECESSARY SERV-
24 ICES.—Section 1128A(a)(1) of the Social Security Act (42
25 U.S.C. 1320a–7a(a)(1)) is amended—

1 (1) in subparagraph (A) by striking “claimed,”
2 and inserting the following: “claimed, including any
3 person who repeatedly presents or causes to be pre-
4 sented a claim for an item or service that is based
5 on a code that the person knows or should know will
6 result in a greater payment to the person than the
7 code the person knows or should know is applicable
8 to the item or service actually provided,”;

9 (2) in subparagraph (C), by striking “or” at
10 the end;

11 (3) in subparagraph (D), by striking “; or” and
12 inserting “, or”; and

13 (4) by inserting after subparagraph (D) the fol-
14 lowing new subparagraph:

15 “(E) is for a medical or other item or serv-
16 ice that a person repeatedly knows or should
17 know is not medically necessary; or”.

18 (e) PERMITTING SECRETARY TO IMPOSE CIVIL MON-
19 ETARY PENALTY.—Section 1128A(b) of the Social Secu-
20 rity Act (42 U.S.C. 1320a–7a(a)) is amended by adding
21 the following new paragraph:

22 “(3) Any person (including any organization,
23 agency, or other entity, but excluding a beneficiary
24 as defined in subsection (i)(5)) who the Secretary
25 determines has violated section 1128B(b) of this

1 title shall be subject to a civil monetary penalty of
2 not more than \$10,000 for each such violation. In
3 addition, such person shall be subject to an assess-
4 ment of not more than twice the total amount of the
5 remuneration offered, paid, solicited, or received in
6 violation of section 1128B(b). The total amount of
7 remuneration subject to an assessment shall be cal-
8 culated without regard to whether some portion
9 thereof also may have been intended to serve a pur-
10 pose other than one proscribed by section
11 1128B(b).”.

12 (f) SANCTIONS AGAINST PRACTITIONERS AND PER-
13 SONS FOR FAILURE TO COMPLY WITH STATUTORY OBLI-
14 GATIONS.—Section 1156(b)(3) of the Social Security Act
15 (42 U.S.C. 1320c-5(b)(3)) is amended by striking “the
16 actual or estimated cost” and inserting the following: “up
17 to \$10,000 for each instance”.

18 (g) PROCEDURAL PROVISIONS.—Section 1876(i)(6)
19 of such Act (42 U.S.C. 1395mm(i)(6)) is further amended
20 by adding at the end the following new subparagraph:

21 “(D) The provisions of section 1128A (other than
22 subsections (a) and (b)) shall apply to a civil money pen-
23 alty under subparagraph (A) or (B) in the same manner
24 as they apply to a civil money penalty or proceeding under
25 section 1128A(a).”.

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

3 (i) PROHIBITION AGAINST OFFERING INDUCEMENTS
4 TO INDIVIDUALS ENROLLED UNDER PROGRAMS OR
5 PLANS.—

6 (1) OFFER OF REMUNERATION.—Section
7 1128A(a) of the Social Security Act (42 U.S.C.
8 1320a–7a(a)) is amended—

9 (A) by striking “or” at the end of para-
10 graph (1)(D);

11 (B) by striking “, or” at the end of para-
12 graph (2) and inserting a semicolon;

13 (C) by striking the semicolon at the end of
14 paragraph (3) and inserting “; or”; and

15 (D) by inserting after paragraph (3) the
16 following new paragraph:

17 “(4) offers to or transfers remuneration to any
18 individual eligible for benefits under title XVIII of
19 this Act, or under a State health care program (as
20 defined in section 1128(h)) that such person knows
21 or should know is likely to influence such individual
22 to order or receive from a particular provider, practi-
23 tioner, or supplier any item or service for which pay-
24 ment may be made, in whole or in part, under title
25 XVIII, or a State health care program;”.

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

4 “(6) The term ‘remuneration’ includes the waiv-
5 er of coinsurance and deductible amounts (or any
6 part thereof), and transfers of items or services for
7 free or for other than fair market value. The term
8 ‘remuneration’ does not include—

9 “(A) the waiver of coinsurance and deduct-
10 ible amounts by a person, if—

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

13 “(ii) the person does not routinely
14 waive coinsurance or deductible amounts;
15 and

16 “(iii) the person—

17 “(I) waives the coinsurance and
18 deductible amounts after determining
19 in good faith that the individual is in
20 financial need;

21 “(II) fails to collect coinsurance
22 or deductible amounts after making
23 reasonable collection efforts; or

24 “(III) provides for any permis-
25 sible waiver as specified in section

1 1128B(b)(3) or in regulations issued
2 by the Secretary;

3 “(B) differentials in coinsurance and de-
4 ductible amounts as part of a benefit plan de-
5 sign as long as the differentials have been dis-
6 closed in writing to all third party payors to
7 whom claims are presented and as long as the
8 differentials meet the standards as defined in
9 regulations promulgated by the Secretary; or

10 “(C) incentives given to individuals to pro-
11 mote the delivery of preventive care as deter-
12 mined by the Secretary in regulations.”.

13 **Subtitle E—Amendments to**
14 **Criminal Law**

15 **SEC. 441. HEALTH CARE FRAUD.**

16 (a) IN GENERAL.—

17 (1) FINES AND IMPRISONMENT FOR HEALTH
18 CARE FRAUD VIOLATIONS.—Chapter 63 of title 18,
19 United States Code, is amended by adding at the
20 end the following new section:

21 **“§ 1347. Health care fraud**

22 “(a) Whoever knowingly executes, or attempts to exe-
23 cute, a scheme or artifice—

1 “(1) to defraud any health plan or other per-
2 son, in connection with the delivery of or payment
3 for health care benefits, items, or services; or

4 “(2) to obtain, by means of false or fraudulent
5 pretenses, representations, or promises, any of the
6 money or property owned by, or under the custody
7 or control of, any health plan, or person in connec-
8 tion with the delivery of or payment for health care
9 benefits, items, or services;

10 shall be fined under this title or imprisoned not more than
11 10 years, or both. If the violation results in serious bodily
12 injury (as defined in section 1365(g)(3) of this title), such
13 person shall be imprisoned for any term of years.

14 “(b) For purposes of this section, the term ‘health
15 plan’ has the same meaning given such term in section
16 1128(i) of the Social Security Act.”.

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

“1347. Health care fraud.”.

21 (b) CRIMINAL FINES DEPOSITED IN THE HEALTH
22 CARE FRAUD AND ABUSE CONTROL ACCOUNT.—The Sec-
23 retary of the Treasury shall deposit into the Health Care
24 Fraud and Abuse Control Account established under sec-
25 tion 401(b) an amount equal to the criminal fines imposed

1 under section 1347 of title 18, United States Code (relat-
2 ing to health care fraud).

3 **SEC. 442. FORFEITURES FOR FEDERAL HEALTH CARE OF-**
4 **FENSES.**

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

8 “(6)(A) The court, in imposing sentence on a person
9 convicted of a Federal health care offense, shall order the
10 person to forfeit property, real or personal, that—

11 “(i) is used in the commission of the offense if
12 the offense results in a financial loss or gain of
13 \$50,000 or more; or

14 “(ii) constitutes or is derived from proceeds
15 traceable to the commission of the offense.

16 “(B) For purposes of this paragraph, the term ‘Fed-
17 eral health care offense’ means a violation of, or a criminal
18 conspiracy to violate—

19 “(i) section 1347 of this title;

20 “(ii) section 1128B of the Social Security Act;

21 “(iii) sections 287, 371, 664, 666, 1001, 1027,
22 1341, 1343, or 1954 of this title if the violation or
23 conspiracy relates to health care fraud; and

1 “(iv) section 501 or 511 of the Employee Re-
2 tirement Income Security Act of 1974, if the viola-
3 tion or conspiracy relates to health care fraud.”.

4 (b) **PROPERTY FORFEITED DEPOSITED IN HEALTH**
5 **CARE FRAUD AND ABUSE CONTROL ACCOUNT.**—The Sec-
6 retary of the Treasury shall deposit into the Health Care
7 Fraud and Abuse Control Account established under sec-
8 tion 401(b) an amount equal to amounts resulting from
9 forfeiture of property by reason of a Federal health care
10 offense pursuant to section 982(a)(6) of title 18, United
11 States Code.

12 **SEC. 443. INJUNCTIVE RELIEF RELATING TO FEDERAL**
13 **HEALTH CARE OFFENSES.**

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

16 (1) by striking “or” at the end of subparagraph
17 (A);

18 (2) by inserting “or” at the end of subpara-
19 graph (B); and

20 (3) by adding at the end the following:

21 “(C) committing or about to commit a
22 Federal health care offense (as defined in sec-
23 tion 982(a)(6)(B) of this title);”.

24 (b) **FREEZING OF ASSETS.**—Section 1345(a)(2) of
25 title 18, United States Code, is amended by inserting “or

1 a Federal health care offense (as defined in section
2 982(a)(6)(B))” after “title”.

3 **SEC. 444. GRAND JURY DISCLOSURE.**

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

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

8 (2) by inserting after subsection (b) the follow-
9 ing:

10 “(c) A person who is privy to grand jury information
11 concerning a Federal health care offense (as defined in
12 section 982(a)(6)(B))—

13 “(1) received in the course of duty as an attor-
14 ney for the Government; or

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

17 may disclose that information to an attorney for the Gov-
18 ernment to use in any investigation or civil proceeding re-
19 lating to health care fraud.”.

20 **SEC. 445. FALSE STATEMENTS.**

21 (a) IN GENERAL.—Chapter 47, of title 18, United
22 States Code, is amended by adding at the end the follow-
23 ing:

1 **“§ 1033. False statements relating to health care mat-**
2 **ters**

3 “Whoever, in any matter involving a health plan,
4 knowingly and willfully falsifies, conceals, or covers up by
5 any trick, scheme, or device a material fact, or makes any
6 false, fictitious, or fraudulent statements or representa-
7 tions, or makes or uses any false writing or document
8 knowing the same to contain any false, fictitious, or fraud-
9 ulent statement or entry, shall be fined under this title
10 or imprisoned not more than 5 years, or both.”.

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

“1033. False statements relating to health care matters.”.

14 **SEC. 446. VOLUNTARY DISCLOSURE PROGRAM.**

15 In consultation with the Attorney General of the
16 United States, the Secretary of Health and Human Serv-
17 ices shall publish proposed regulations not later than 9
18 months after the date of enactment of this Act, and final
19 regulations not later than 18 months after such date of
20 enactment, establishing a program of voluntary disclosure
21 that would facilitate the enforcement of sections 1128A
22 and 1128B of the Social Security Act (42 U.S.C. 1320a-
23 7a and 1320a-7b) and other relevant provisions of Fed-
24 eral law relating to health care fraud and abuse. Such pro-
25 gram should promote and provide incentives for disclo-

1 sures of potential violations of such sections and provi-
2 sions by providing that, under certain circumstances, the
3 voluntary disclosure of wrongdoing would result in the im-
4 position of penalties and punishments less substantial
5 than those that would be assessed for the same wrong-
6 doing if voluntary disclosure did not occur.

7 **SEC. 447. OBSTRUCTION OF CRIMINAL INVESTIGATIONS OF**
8 **FEDERAL HEALTH CARE OFFENSES.**

9 (a) IN GENERAL.—Chapter 73 of title 18, United
10 States Code, is amended by adding at the end the follow-
11 ing new section:

12 **“§ 1518. Obstruction of criminal investigations of**
13 **Federal health care offenses**

14 “(a) IN GENERAL.—Whoever willfully prevents, ob-
15 structs, misleads, delays or attempts to prevent, obstruct,
16 mislead, or delay the communication of information or
17 records relating to a Federal health care offense to a
18 criminal investigator shall be fined under this title or im-
19 prisoned not more than 5 years, or both.

20 “(b) FEDERAL HEALTH CARE OFFENSE.—As used
21 in this section the term ‘Federal health care offense’ has
22 the same meaning given such term in section 982(a)(6)(B)
23 of this title.

24 “(c) CRIMINAL INVESTIGATOR.—As used in this sec-
25 tion the term ‘criminal investigator’ means any individual

1 duly authorized by a department, agency, or armed force
2 of the United States to conduct or engage in investigations
3 for prosecutions for violations of health care offenses.”.

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

“1518. Obstruction of criminal investigations of Federal health care offenses.”.

7 **SEC. 448. THEFT OR EMBEZZLEMENT.**

8 (a) IN GENERAL.—Chapter 31 of title 18, United
9 States Code, is amended by adding at the end the follow-
10 ing new section:

11 **“§ 669. Theft or embezzlement in connection with**
12 **health care**

13 “(a) IN GENERAL.—Whoever willfully embezzles,
14 steals, or otherwise without authority willfully and unlaw-
15 fully converts to the use of any person other than the
16 rightful owner, or intentionally misapplies any of the mon-
17 eys, funds, securities, premiums, credits, property, or
18 other assets of a health care benefit program, shall be
19 fined under this title or imprisoned not more than 10
20 years, or both.

21 “(b) FEDERAL HEALTH CARE OFFENSE.—As used
22 in this section the term ‘Federal health care offense’ has
23 the same meaning given such term in section 982(a)(6)(B)
24 of this title.”.

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

“669. Theft or embezzlement in connection with health care.”.

4 **SEC. 449. LAUNDERING OF MONETARY INSTRUMENTS.**

5 Section 1956(c)(7) of title 18, United States Code,
6 is amended by adding at the end the following new sub-
7 paragraph:

8 “(F) Any act or activity constituting an of-
9 fense involving a Federal health care offense as
10 that term is defined in section 982(a)(6)(B) of
11 this title.”.

12 **Subtitle F—Payments for State**
13 **Health Care Fraud Control Units**

14 **SEC. 451. ESTABLISHMENT OF STATE FRAUD UNITS.**

15 (a) ESTABLISHMENT OF HEALTH CARE FRAUD AND
16 ABUSE CONTROL UNIT.—The Governor of each State
17 shall, consistent with State law, establish and maintain in
18 accordance with subsection (b) a State agency to act as
19 a Health Care Fraud and Abuse Control Unit for purposes
20 of this part.

21 (b) DEFINITION.—In this section, a “State Fraud
22 Unit” means a Health Care Fraud and Abuse Control
23 Unit designated under subsection (a) that the Secretary
24 certifies meets the requirements of this part.

1 **SEC. 452. REQUIREMENTS FOR STATE FRAUD UNITS.**

2 (a) IN GENERAL.—The State Fraud Unit must—

3 (1) be a single identifiable entity of the State
4 government;

5 (2) be separate and distinct from any State
6 agency with principal responsibility for the adminis-
7 tration of any Federally-funded or mandated health
8 care program;

9 (3) meet the other requirements of this section.

10 (b) SPECIFIC REQUIREMENTS DESCRIBED.—The
11 State Fraud Unit shall—

12 (1) be a Unit of the office of the State Attorney
13 General or of another department of State govern-
14 ment which possesses statewide authority to pros-
15 ecute individuals for criminal violations;

16 (2) if it is in a State the constitution of which
17 does not provide for the criminal prosecution of indi-
18 viduals by a statewide authority and has formal pro-
19 cedures, (A) assure its referral of suspected criminal
20 violations to the appropriate authority or authorities
21 in the State for prosecution, and (B) assure its as-
22 sistance of, and coordination with, such authority or
23 authorities in such prosecutions; or

24 (3) have a formal working relationship with the
25 office of the State Attorney General or the appro-
26 priate authority or authorities for prosecution and

1 have formal procedures (including procedures for its
2 referral of suspected criminal violations to such of-
3 fice) which provide effective coordination of activities
4 between the Fraud Unit and such office with respect
5 to the detection, investigation, and prosecution of
6 suspected criminal violations relating to any Feder-
7 ally-funded or mandated health care programs.

8 (c) STAFFING REQUIREMENTS.—The State Fraud
9 Unit shall—

10 (1) employ attorneys, auditors, investigators
11 and other necessary personnel; and

12 (2) be organized in such a manner and provide
13 sufficient resources as is necessary to promote the
14 effective and efficient conduct of State Fraud Unit
15 activities.

16 (d) COOPERATIVE AGREEMENTS; MEMORANDA OF
17 UNDERSTANDING.—The State Fraud Unit shall have co-
18 operative agreements with—

19 (1) Federally-funded or mandated health care
20 programs;

21 (2) similar Fraud Units in other States, as ex-
22 emplified through membership and participation in
23 the National Association of Medicaid Fraud Control
24 Units or its successor; and

25 (3) the Secretary.

1 (e) REPORTS.—The State Fraud Unit shall submit
2 to the Secretary an application and an annual report con-
3 taining such information as the Secretary determines to
4 be necessary to determine whether the State Fraud Unit
5 meets the requirements of this section.

6 (f) FUNDING SOURCE; PARTICIPATION IN ALL-
7 PAYER PROGRAM.—In addition to those sums expended
8 by a State under section 454(a) for purposes of determin-
9 ing the amount of the Secretary’s payments, a State
10 Fraud Unit may receive funding for its activities from
11 other sources, the identity of which shall be reported to
12 the Secretary in its application or annual report. The
13 State Fraud Unit shall participate in the all-payer fraud
14 and abuse control program established under section 101.

15 **SEC. 453. SCOPE AND PURPOSE.**

16 The State Fraud Unit shall carry out the following
17 activities:

18 (1) The State Fraud Unit shall conduct a state-
19 wide program for the investigation and prosecution
20 (or referring for prosecution) of violations of all ap-
21 plicable state laws regarding any and all aspects of
22 fraud in connection with any aspect of the adminis-
23 tration and provision of health care services and ac-
24 tivities of providers of such services under any Fed-
25 erally-funded or mandated health care programs;

1 (2) The State Fraud Unit shall have procedures
2 for reviewing complaints of the abuse or neglect of
3 patients of facilities (including patients in residential
4 facilities and home health care programs) that re-
5 ceive payments under any Federally-funded or man-
6 dated health care programs, and, where appropriate,
7 to investigate and prosecute such complaints under
8 the criminal laws of the State or for referring the
9 complaints to other State agencies for action.

10 (3) The State Fraud Unit shall provide for the
11 collection, or referral for collection to the appro-
12 priate agency, of overpayments that are made under
13 any Federally-funded or mandated health care pro-
14 gram and that are discovered by the State Fraud
15 Unit in carrying out its activities.

16 **SEC. 454. PAYMENTS TO STATES.**

17 (a) MATCHING PAYMENTS TO STATES.—Subject to
18 subsection (c), for each year for which a State has a State
19 Fraud Unit approved under section 602(b) in operation
20 the Secretary shall provide for a payment to the State for
21 each quarter in a fiscal year in an amount equal to the
22 applicable percentage of the sums expended during the
23 quarter by the State Fraud Unit.

24 (b) APPLICABLE PERCENTAGE DEFINED.—

1 (1) IN GENERAL.—In subsection (a), the “ap-
2 plicable percentage” with respect to a State for a
3 fiscal year is—

4 (A) 90 percent, for quarters occurring dur-
5 ing the first 3 years for which the State Fraud
6 Unit is in operation; or

7 (B) 75 percent, for any other quarters.

8 (2) TREATMENT OF STATES WITH MEDICAID
9 FRAUD CONTROL UNITS.—In the case of a State
10 with a State medicaid fraud control in operation
11 prior to or as of the date of the enactment of this
12 Act, in determining the number of years for which
13 the State Fraud Unit under this part has been in
14 operation, there shall be included the number of
15 years for which such State medicaid fraud control
16 unit was in operation.

17 (c) LIMIT ON PAYMENT.—Notwithstanding sub-
18 section (a), the total amount of payments made to a State
19 under this section for a fiscal year may not exceed the
20 amounts as authorized pursuant to section 1903(b)(3) of
21 the Social Security Act.

○