

104TH CONGRESS  
2D SESSION

# H. R. 3063

To amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, and to simplify the administration of health insurance.

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## IN THE HOUSE OF REPRESENTATIVES

MARCH 12, 1996

Mr. ARCHER (for himself and Mr. THOMAS) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committees on Economic and Educational Opportunities, Commerce, and the Judiciary, 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

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## A BILL

To amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, and to simplify the administration of health insurance.

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

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

2 (a) SHORT TITLE.—This Act may be cited as the  
 3 “Health Coverage Availability and Affordability Act of  
 4 1996”.

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

Sec. 1. Short title; table of contents.

TITLE I—IMPROVED AVAILABILITY AND PORTABILITY OF  
 HEALTH INSURANCE COVERAGE

Subtitle A—Coverage Under Group Health Plans

Sec. 101. Portability of coverage for previously covered individuals.

Sec. 102. Limitation on preexisting condition exclusions; no application to cer-  
 tain newborns, adopted children, and pregnancy.

Sec. 103. Prohibiting exclusions based on health status and providing for en-  
 rollment periods.

Sec. 104. Enforcement.

Subtitle B—Definitions; General Provisions

Sec. 191. Definitions; scope of coverage.

Sec. 192. State flexibility to provide greater protection.

Sec. 193. Effective date.

Sec. 194. Rule of construction.

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

Sec. 200. References in title.

Subtitle A—Fraud and Abuse Control Program

Sec. 201. Fraud and abuse control program.

Sec. 202. Medicare integrity program.

Sec. 203. Beneficiary incentive programs.

Sec. 204. Application of certain health anti-fraud and abuse sanctions to fraud  
 and abuse against Federal health care programs.

Sec. 205. Guidance regarding application of health care fraud and abuse sanc-  
 tions.

Subtitle B—Revisions to Current Sanctions for Fraud and Abuse

Sec. 211. Mandatory exclusion from participation in medicare and State health  
 care programs.

Sec. 212. Establishment of minimum period of exclusion for certain individuals  
 and entities subject to permissive exclusion from medicare and  
 State health care programs.

Sec. 213. Permissive exclusion of individuals with ownership or control interest  
 in sanctioned entities.

- Sec. 214. Sanctions against practitioners and persons for failure to comply with statutory obligations.
- Sec. 215. Intermediate sanctions for medicare health maintenance organizations.
- Sec. 216. Additional exception to anti-kickback penalties for discounting and managed care arrangements.
- Sec. 217. Criminal penalty for fraudulent disposition of assets in order to obtain medicaid benefits.
- Sec. 218. Effective date.

#### Subtitle C—Data Collection

- Sec. 221. Establishment of the health care fraud and abuse data collection program.

#### Subtitle D—Civil Monetary Penalties

- Sec. 231. Social security act civil monetary penalties.
- Sec. 232. Clarification of level of intent required for imposition of sanctions.
- Sec. 233. Penalty for false certification for home health services.

#### Subtitle E—Revisions to Criminal Law

- Sec. 241. Definition of Federal health care offense.
- Sec. 242. Health care fraud.
- Sec. 243. Theft or embezzlement.
- Sec. 244. False statements.
- Sec. 245. Obstruction of criminal investigations of health care offenses.
- Sec. 246. Laundering of monetary instruments.
- Sec. 247. Injunctive relief relating to health care offenses.
- Sec. 248. Authorized investigative demand procedures.
- Sec. 249. Forfeitures for Federal health care offenses.

#### Subtitle F—Administrative Simplification

- Sec. 251. Purpose.
- Sec. 252. Administrative simplification.

#### “PART C—ADMINISTRATIVE SIMPLIFICATION

- “Sec. 1171. Definitions.
- “Sec. 1172. General requirements for adoption of standards.
- “Sec. 1173. Standards for information transactions and data elements.
- “Sec. 1174. Timetables for adoption of standards.
- “Sec. 1175. Requirements.
- “Sec. 1176. General penalty for failure to comply with requirements and standards.
- “Sec. 1177. Wrongful disclosure of individually identifiable health information.
- “Sec. 1178. Effect on State law.
- “Sec. 1179. Health Information Advisory Committee.

#### TITLE III—TAX-RELATED HEALTH PROVISIONS

##### Subtitle A—Medical Savings Accounts

- Sec. 301. Medical savings accounts.

Subtitle B—Increase in Deduction for Health Insurance Costs of Self-Employed Individuals

Sec. 311. Increase in deduction for health insurance costs of self-employed individuals.

**1 TITLE I—IMPROVED AVAILABIL-**  
**2 ITY AND PORTABILITY OF**  
**3 HEALTH INSURANCE COV-**  
**4 ERAGE**

**5 Subtitle A—Coverage Under Group**  
**6 Health Plans**

**7 SEC. 101. PORTABILITY OF COVERAGE FOR PREVIOUSLY**  
**8 COVERED INDIVIDUALS.**

9 (a) CREDITING PERIODS OF PREVIOUS COVERAGE  
10 TOWARD PREEXISTING CONDITION RESTRICTIONS.—Sub-  
11 ject to the succeeding provisions of this section, a group  
12 health plan, and an insurer or health maintenance organi-  
13 zation offering health insurance coverage in connection  
14 with a group health plan, shall provide that any preexist-  
15 ing condition limitation period (as defined in subsection  
16 (b)(2)) is reduced by the length of the aggregate period  
17 of qualified prior coverage (if any, as defined in subsection  
18 (b)(3)) applicable to the participant or beneficiary as of  
19 the date of commencement of coverage under the plan.

20 (b) DEFINITIONS AND OTHER PROVISIONS RELAT-  
21 ING TO PREEXISTING CONDITIONS.—

22 (1) PREEXISTING CONDITION.—

1 (A) IN GENERAL.—For purposes of this  
2 subtitle, subject to subparagraph (B), the term  
3 “preexisting condition” means a condition, re-  
4 gardless of the cause of the condition, for which  
5 medical advice, diagnosis, care, or treatment  
6 was recommended or received within the 6-  
7 month period ending on the day before—

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

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

13 whichever is earlier.

14 (B) EXTENSION OF PERIOD IN THE CASE  
15 OF LATE ENROLLMENT.—In the case of a par-  
16 ticipant or beneficiary whose initial coverage  
17 commences after the date the participant or  
18 beneficiary first becomes eligible for coverage  
19 under the group health plan, the reference in  
20 subparagraph (A) to “6-month period” is  
21 deemed a reference to “12-month period”.

22 (2) PREEXISTING CONDITION LIMITATION PE-  
23 RIOD.—For purposes of this subtitle, the term “pre-  
24 existing condition limitation period” means, with re-  
25 spect to coverage of an individual under a group

1 health plan or under health insurance coverage, the  
2 period during which benefits with respect to treat-  
3 ment of a condition of such individual are not pro-  
4 vided based on the fact that the condition is a pre-  
5 existing condition.

6 (3) AGGREGATE PERIOD OF QUALIFIED PRIOR  
7 COVERAGE.—

8 (A) IN GENERAL.—For purposes of this  
9 section, the term “aggregate period of qualified  
10 prior coverage” means, with respect to com-  
11 mencement of coverage of an individual under  
12 a group health plan or health insurance cov-  
13 erage offered in connection with a group health  
14 plan, the aggregate of the qualified coverage pe-  
15 riods (as defined in subparagraph (B)) of such  
16 individual occurring before the date of such  
17 commencement. Such period shall be treated as  
18 zero if there is more than a 60-day break in  
19 coverage under a group health plan (or health  
20 insurance coverage offered in connection with  
21 such a plan) between the date the most recent  
22 qualified coverage period ends and the date of  
23 such commencement.

24 (B) QUALIFIED COVERAGE PERIOD.—

1 (i) IN GENERAL.—For purposes of  
2 this paragraph, subject to subsection (c),  
3 the term “qualified coverage period”  
4 means, with respect to an individual, any  
5 period of coverage of the individual under  
6 a group health plan, health insurance cov-  
7 erage, or under title XIX of the Social Se-  
8 curity Act.

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

14 (C) WAITING PERIOD NOT TREATED AS A  
15 BREAK IN COVERAGE.—For purposes of sub-  
16 paragraphs (A) and (B), any period that is in  
17 a waiting period for any coverage under a  
18 group health plan (or for health insurance cov-  
19 erage offered in connection with a group health  
20 plan) shall not be considered to be a break in  
21 coverage described in subparagraph (B)(ii).

22 (D) ESTABLISHMENT OF PERIOD.—A  
23 qualified coverage period with respect to an in-  
24 dividual shall be established through presen-  
25 tation of certifications described in subsection

1 (c) or in such other manner as may be specified  
2 in regulations to carry out this section.

3 (c) CERTIFICATIONS OF COVERAGE; CONFORMING  
4 COVERAGE.—

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

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

22 (3) ALTERNATIVE METHOD.—Such a plan, in-  
23 surer, or HMO may elect to make such determina-  
24 tion on a benefit-specific basis for all participants  
25 and beneficiaries and not to include as a qualified



1 coverage period with respect to a specific benefit  
2 coverage during a previous period unless such pre-  
3 vious coverage for that benefit was included at the  
4 end of the most recent period of coverage. In the  
5 case of such an election—

6 (A) the plan, insurer, or HMO shall promi-  
7 nently state in any disclosure statements con-  
8 cerning the plan or coverage and to each en-  
9 rollee at the time of enrollment under the plan  
10 (or at the time the health insurance coverage is  
11 offered for sale in the group health market)  
12 that the plan or coverage has made such elec-  
13 tion and shall include a description of the effect  
14 of this election; and

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

18 (i) shall promptly disclose to the re-  
19 questing plan, insurer, or HMO the plan  
20 statement (insofar as it relates to health  
21 benefits under the plan) or other detailed  
22 benefit information on the benefits avail-  
23 able under the previous plan or coverage,  
24 and

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

3 **SEC. 102. LIMITATION ON PREEXISTING CONDITION EXCLU-**  
4 **SIONS; NO APPLICATION TO CERTAIN**  
5 **NEWBORNS, ADOPTED CHILDREN, AND PREG-**  
6 **NANCY.**

7 (a) LIMITATION OF PERIOD.—

8 (1) IN GENERAL.—Subject to the succeeding  
9 provisions of this section, a group health plan, and  
10 an insurer or HMO offering health insurance cov-  
11 erage in connection with a group health plan, shall  
12 provide that any preexisting condition limitation pe-  
13 riod (as defined in section 101(b)(2)) does not ex-  
14 ceed 12 months, counting from the effective date of  
15 coverage.

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

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

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

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

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

14      becomes covered under a group health plan or other-  
15      wise becomes covered under health insurance cov-  
16      erage (or covered for medical assistance under title  
17      XIX of the Social Security Act).

18           (2) LOSS IF BREAK IN COVERAGE.—Paragraph  
19      (1) shall no longer apply to an individual if the indi-  
20      vidual does not have any coverage under a group  
21      health plan, health insurance coverage, or under title  
22      XIX of the Social Security Act for a continuous pe-  
23      riod of 60 days, not counting in such period any  
24      days that are in a waiting period for any coverage  
25      under a group health plan.

1           (3) PLACED FOR ADOPTION DEFINED.—In this  
2       subsection and section 103(d), the term “place-  
3       ment”, or being “placed”, for adoption, in connec-  
4       tion with any placement for adoption of a child with  
5       any person, means the assumption and retention by  
6       such person of a legal obligation for total or partial  
7       support of such child in anticipation of adoption of  
8       such child. The child’s placement with such person  
9       terminates upon the termination of such legal obliga-  
10      tion.

11       (c) EXCLUSION NOT APPLICABLE TO PREGNANCY.—  
12      For purposes of this section, pregnancy shall not be treat-  
13      ed as a preexisting condition.

14       (d) ELIGIBILITY PERIOD IMPOSED BY HEALTH  
15      MAINTENANCE ORGANIZATIONS AS ALTERNATIVE TO  
16      PREEXISTING CONDITION LIMITATION.—A health mainte-  
17      nance organization which offers health insurance coverage  
18      in connection with a group health plan and which does  
19      not use the preexisting condition limitations allowed under  
20      this section and section 101 with respect to any particular  
21      coverage option may impose an eligibility period for such  
22      coverage option, but only if such period does not exceed—  
23           (1) 90 days, in the case of a participant or ben-  
24      eficiary whose initial coverage commences at the

1 time such participant or beneficiary first becomes el-  
 2 igible for coverage under the plan, or

3 (2) 180 days, in the case of a participant or  
 4 beneficiary whose initial coverage commences after  
 5 the date on which such participant or beneficiary  
 6 first becomes eligible for coverage.

7 For purposes of this subsection, the term “eligibility pe-  
 8 riod” means a period which, under the terms of the health  
 9 insurance coverage offered by the health maintenance or-  
 10 ganization, must expire before the health insurance cov-  
 11 erage becomes effective. Any such eligibility period shall  
 12 be treated for purposes of this subtitle as a waiting period  
 13 under the plan and shall run concurrently with any other  
 14 applicable waiting period under the plan.

15 **SEC. 103. PROHIBITING EXCLUSIONS BASED ON HEALTH**  
 16 **STATUS AND PROVIDING FOR ENROLLMENT**  
 17 **PERIODS.**

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

20 (1) IN GENERAL.—A group health plan, and an  
 21 insurer or HMO offering health insurance coverage  
 22 in connection with a group health plan, may not ex-  
 23 clude an employee or his or her beneficiary from  
 24 being (or continuing to be) a participant or bene-  
 25 ficiary under the terms of such plan or coverage

1 based on health status (as defined in section  
2 191(c)(6)).

3 (2) CONSTRUCTION.—Nothing in this sub-  
4 section shall be construed as preventing the estab-  
5 lishment of preexisting condition limitations and re-  
6 strictions to the extent consistent with the provisions  
7 of this subtitle.

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

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

20 (2) The employee stated in writing at such time  
21 that coverage under a group health plan or health  
22 insurance coverage was the reason for declining en-  
23 rollment.

24 (3) The employee or dependent lost coverage  
25 under a group health plan or health insurance cov-

1       erage (as a result of loss of eligibility for the cov-  
2       erage, termination of employment, or reduction in  
3       the number of hours of employment).

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

7       (c) DEPENDENT BENEFICIARIES.—

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

14           (A) is a newborn,

15           (B) is an adopted child or child placed for  
16      adoption (within the meaning of section  
17      102(b)(3)), at the time of adoption or place-  
18      ment, or

19           (C) is a spouse, at the time of marriage,  
20      if the participant has met any waiting period appli-  
21      cable to that participant.

22      (2) TIMELY ENROLLMENT.—

23           (A) IN GENERAL.—Enrollment of a partici-  
24      pant's beneficiary described in paragraph (1)  
25      shall be considered to be timely if a request for

1 enrollment is made within 30 days of the date  
 2 family coverage is first made available or, in the  
 3 case described in—

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

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

9 (iii) paragraph (1)(C), within 30 days  
 10 of the date of the marriage with such a  
 11 beneficiary who is the spouse of the partic-  
 12 ipant,

13 if family coverage is available as of such date.

14 (B) COVERAGE.—If available coverage in-  
 15 cludes family coverage and enrollment is made  
 16 under such coverage on a timely basis under  
 17 subparagraph (A), the coverage shall become ef-  
 18 fective not later than the first day of the first  
 19 month beginning 15 days after the date the  
 20 completed request for enrollment is received.

21 **SEC. 104. ENFORCEMENT.**

22 (a) ENFORCEMENT THROUGH COBRAZ PROVISIONS  
 23 IN INTERNAL REVENUE CODE.—

24 (1) APPLICATION OF COBRA SANCTIONS.—Sub-  
 25 section (a) of section 4980B of the Internal Revenue



1 Code of 1986 is amended by striking “the require-  
2 ments of” and all that follows and inserting “the re-  
3 quirements of—

4 “(1) subsection (f) with respect to any qualified  
5 beneficiary, or

6 “(2) subject to subsection (h)—

7 “(A) section 101 or 102 of the Health  
8 Coverage Availability and Affordability Act of  
9 1996 with respect to any individual covered  
10 under the group health plan, or

11 “(B) section 103 of such Act with respect  
12 to any individual.”.

13 (2) NOTICE REQUIREMENT.—Section  
14 4980B(f)(6)(A) of such Code is amended by insert-  
15 ing before the period the following: “and subtitle A  
16 of title I of the Health Coverage Availability and Af-  
17 fordability Act of 1996”.

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

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

1           “(1) DEFERRAL TO STATE REGULATION.—No  
2       tax shall be imposed by this section on any failure  
3       to meet the requirements of such section by any en-  
4       tity which offers health insurance coverage and  
5       which is an insurer or health maintenance organiza-  
6       tion (as defined in section 191(c) of the Health Cov-  
7       erage Availability and Affordability Act of 1996)  
8       regulated by a State if the Secretary of Health and  
9       Human Services has made the determination de-  
10      scribed in section 104(c)(2) of such Act with respect  
11      to such State, section, and entity.

12           “(2) LIMITATION FOR INSURED PLANS.—In the  
13      case of a group health plan of a small employer (as  
14      defined in section 191 of the Health Coverage Avail-  
15      ability and Affordability Act of 1996) that provides  
16      health care benefits solely through a contract with  
17      an insurer or health maintenance organization (as  
18      defined in such section), no tax shall be imposed by  
19      this section upon the employer on a failure to meet  
20      such requirements if the failure is solely because of  
21      the product offered by the insurer or organization  
22      under such contract.

23           “(3) LIMITATION ON IMPOSITION OF TAX.—In  
24      no case shall a tax be imposed by this section for a

1 failure to meet such a requirement if a sanction has  
2 been imposed—

3 “(A) by the Secretary of Labor under part  
4 5 of subtitle A of title I of the Employee Retirement  
5 Income Security Act of 1974 with respect  
6 to such failure, or

7 “(B) by the Secretary of Health and  
8 Human Services under section 109 of the  
9 Health Coverage Availability and Affordability  
10 Act of 1996 with respect to such failure.”.

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

13 (1) IN GENERAL.—Subject to the succeeding  
14 provisions of this subsection, sections 101 through  
15 103 of this subtitle shall be deemed to be provisions  
16 of title I of the Employee Retirement Income Security  
17 Act of 1974 for purposes of applying such title.

18 (2) FEDERAL ENFORCEMENT ONLY IF NO EN-  
19 FORCEMENT THROUGH STATE.—The Secretary of  
20 Labor shall enforce each section referred to in para-  
21 graph (1) with respect to any entity which is an in-  
22 surer or health maintenance organization regulated  
23 by a State only if the Secretary of Labor determines  
24 that—

1 (A) such State has not provided for en-  
2 forcement of State laws which govern the same  
3 matters as are governed by such section and  
4 which require compliance by such entity with at  
5 least the same requirements as those provided  
6 under such section, and

7 (B) such entity has failed to comply with  
8 such requirements of such section as are appli-  
9 cable to such entity.

10 (3) LIMITATIONS ON LIABILITY.—

11 (A) NO APPLICATION WHERE FAILURE  
12 NOT DISCOVERED EXERCISING REASONABLE  
13 DILIGENCE.—No liability shall be imposed  
14 under this subsection on the basis of any failure  
15 during any period for which it is established to  
16 the satisfaction of the Secretary of Labor that  
17 none of the persons against whom the liability  
18 would be imposed knew, or exercising reason-  
19 able diligence would have known, that such fail-  
20 ure existed.

21 (B) NO APPLICATION WHERE FAILURE  
22 CORRECTED WITHIN 30 DAYS.—No liability  
23 shall be imposed under this subsection on the  
24 basis of any failure if such failure was due to  
25 reasonable cause and not to willful neglect, and

1 such failure is corrected during the 30-day pe-  
2 riod beginning on the first day any of the per-  
3 sons against whom the liability would be im-  
4 posed knew, or exercising reasonable diligence  
5 would have known, that such failure existed.

6 (4) AVOIDING DUPLICATION OF CERTAIN PEN-  
7 ALTIES.—In no case shall a civil money penalty be  
8 imposed under the authority provided under para-  
9 graph (1) for a violation of this subtitle for which  
10 an excise tax has been imposed under section 4980B  
11 of the Internal Revenue Code of 1986 or a civil  
12 money penalty imposed under subsection (c).

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

15 (1) IMPOSITION.—

16 (A) IN GENERAL.—Subject to the succeed-  
17 ing provisions of this subsection, any group  
18 health plan, insurer, or organization that fails  
19 to meet a requirement of this subtitle is subject  
20 to a civil money penalty under this section.

21 (B) LIABILITY FOR PENALTY.—Rules simi-  
22 lar to the rules described in section 4980B(e) of  
23 the Internal Revenue Code of 1986 for liability  
24 for a tax imposed under section 4980B(a) of

1 such Code shall apply to liability for a penalty  
2 imposed under subparagraph (A).

3 (C) AMOUNT OF PENALTY.—

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

9 (ii) CONSIDERATIONS IN IMPOSI-  
10 TION.—In determining the amount of any  
11 penalty to be assessed under this para-  
12 graph, the Secretary of Health and Human  
13 Services shall take into account the pre-  
14 vious record of compliance of the person  
15 being assessed with the applicable require-  
16 ments of this subtitle, the gravity of the  
17 violation, and the overall limitations for  
18 unintentional failures provided under sec-  
19 tion 4980B(c)(4) of the Internal Revenue  
20 Code of 1986.

21 (iii) LIMITATIONS.—

22 (I) PENALTY NOT TO APPLY  
23 WHERE FAILURE NOT DISCOVERED  
24 EXERCISING REASONABLE DILI-  
25 GENCE.—No civil money penalty shall

1 be imposed under this paragraph on  
2 any failure during any period for  
3 which it is established to the satisfac-  
4 tion of the Secretary that none of the  
5 persons against whom the penalty  
6 would be imposed knew, or exercising  
7 reasonable diligence would have  
8 known, that such failure existed.

9 (II) PENALTY NOT TO APPLY TO  
10 FAILURES CORRECTED WITHIN 30  
11 DAYS.—No civil money penalty shall  
12 be imposed under this paragraph on  
13 any failure if such failure was due to  
14 reasonable cause and not to willful ne-  
15 glect, and such failure is corrected  
16 during the 30-day period beginning on  
17 the first day any of the persons  
18 against whom the penalty would be  
19 imposed knew, or exercising reason-  
20 able diligence would have known, that  
21 such failure existed.

22 (D) ADMINISTRATIVE REVIEW.—

23 (i) OPPORTUNITY FOR HEARING.—  
24 The person assessed shall be afforded an  
25 opportunity for hearing by the Secretary

1           upon request made within 30 days after  
2           the date of the issuance of a notice of as-  
3           sessment. In such hearing the decision  
4           shall be made on the record pursuant to  
5           section 554 of title 5, United States Code.  
6           If no hearing is requested, the assessment  
7           shall constitute a final and unappealable  
8           order.

9                     (ii) HEARING PROCEDURE.—If a  
10           hearing is requested, the initial agency de-  
11           cision shall be made by an administrative  
12           law judge, and such decision shall become  
13           the final order unless the Secretary modi-  
14           fies or vacates the decision. Notice of in-  
15           tent to modify or vacate the decision of the  
16           administrative law judge shall be issued to  
17           the parties within 30 days after the date of  
18           the decision of the judge. A final order  
19           which takes effect under this paragraph  
20           shall be subject to review only as provided  
21           under subparagraph (D).

22           (E) JUDICIAL REVIEW.—

23                     (i) FILING OF ACTION FOR REVIEW.—  
24           Any person against whom an order impos-  
25           ing a civil money penalty has been entered



1 after an agency hearing under this para-  
2 graph may obtain review by the United  
3 States district court for any district in  
4 which such person is located or the United  
5 States District Court for the District of  
6 Columbia by filing a notice of appeal in  
7 such court within 30 days from the date of  
8 such order, and simultaneously sending a  
9 copy of such notice by registered mail to  
10 the Secretary.

11 (ii) CERTIFICATION OF ADMINISTRATIVE  
12 RECORD.—The Secretary shall  
13 promptly certify and file in such court the  
14 record upon which the penalty was im-  
15 posed.

16 (iii) STANDARD FOR REVIEW.—The  
17 findings of the Secretary shall be set aside  
18 only if found to be unsupported by sub-  
19 stantial evidence as provided by section  
20 706(2)(E) of title 5, United States Code.

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

1 (F) FAILURE TO PAY ASSESSMENT; MAIN-  
2 TENANCE OF ACTION.—

3 (i) FAILURE TO PAY ASSESSMENT.—If  
4 any person fails to pay an assessment after  
5 it has become a final and unappealable  
6 order, or after the court has entered final  
7 judgment in favor of the Secretary, the  
8 Secretary shall refer the matter to the At-  
9 torney General who shall recover the  
10 amount assessed by action in the appro-  
11 priate United States district court.

12 (ii) NONREVIEWABILITY.—In such ac-  
13 tion the validity and appropriateness of the  
14 final order imposing the penalty shall not  
15 be subject to review.

16 (G) PAYMENT OF PENALTIES.—Except as  
17 otherwise provided, penalties collected under  
18 this paragraph shall be paid to the Secretary  
19 (or other officer) imposing the penalty and shall  
20 be available without appropriation and until ex-  
21 pended for the purpose of enforcing the provi-  
22 sions with respect to which the penalty was im-  
23 posed.

24 (2) FEDERAL ENFORCEMENT ONLY IF NO EN-  
25 FORCEMENT THROUGH STATE.—Paragraph (1) shall

1 not apply to enforcement of the requirements of sec-  
2 tion 101, 102, or 103 with respect to any entity  
3 which offers health insurance coverage and which is  
4 an insurer or HMO regulated by a State if the Sec-  
5 retary of Health and Human Services has deter-  
6 mined that—

7 (A) such State has not provided for en-  
8 forcement of State laws which govern the same  
9 matters as are governed by such section and  
10 which require compliance by such entity with at  
11 least the same requirements as those provided  
12 under such section, and

13 (B) such entity has failed to comply with  
14 such requirements of such section as are appli-  
15 cable to such entity.

16 (3) NONDUPLICATION OF SANCTIONS.—In no  
17 case shall a civil money penalty be imposed under  
18 this subsection for a violation of this subtitle for  
19 which an excise tax has been imposed under section  
20 4980B of the Internal Revenue Code of 1986 or for  
21 which a civil money penalty has been imposed under  
22 the authority provided under subsection (b).

23 (d) COORDINATION IN ADMINISTRATION.—The Sec-  
24 retaries of the Treasury, Labor, and Health and Human  
25 Services shall issue regulations that are nonduplicative to

1 carry out this subtitle. Such regulations shall be issued  
2 in a manner that assures coordination and nonduplication  
3 in their activities under this subtitle.

## 4     **Subtitle B—Definitions; General** 5                   **Provisions**

### 6     **SEC. 191. DEFINITIONS; SCOPE OF COVERAGE.**

7             (a) GROUP HEALTH PLAN.—

8                   (1) DEFINITION.—Subject to the succeeding  
9             provisions of this subsection and subsection (d)(1),  
10            the term “group health plan” means an employee  
11            welfare benefit plan to the extent that the plan pro-  
12            vides medical care (as defined in subsection (b)(1)) to  
13            employees or their dependents (as defined under the  
14            terms of the plan) directly or through insurance, re-  
15            imbursement, or otherwise, and includes a group  
16            health plan (within the meaning of section  
17            5000B(b)(1) of the Internal Revenue Code of 1986).

18                   (2) LIMITATION OF REQUIREMENTS TO PLANS  
19            WITH 2 OR MORE EMPLOYEE PARTICIPANTS.—The  
20            requirements of subtitle A and part 1 of subtitle B  
21            shall apply in the case of a group health plan for  
22            any plan year, or for health insurance coverage of-  
23            fered in connection with a group health plan for a  
24            year, only if the group health plan has two or more

1 participants as current employees on the first day of  
2 the plan year.

3 (3) EXCLUSION OF PLANS WITH LIMITED COV-  
4 ERAGE.—An employee welfare benefit plan shall be  
5 treated as a group health plan under this title only  
6 with respect to medical care which is provided under  
7 the plan and which does not consist of coverage ex-  
8 cluded from the definition of health insurance cov-  
9 erage under subsection (c)(4)(B).

10 (3) TREATMENT OF CHURCH PLANS.—

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

14 (B) OPTIONAL DISREGARD IN DETERMIN-  
15 ING PERIOD OF COVERAGE.—For purposes of  
16 applying section 101(b)(3)(B)(i), a group health  
17 plan may elect to disregard periods of coverage  
18 of an individual under a church plan that, pur-  
19 suant to subparagraph (A), is not subject to the  
20 requirements of this title.

21 (4) TREATMENT OF GOVERNMENTAL PLANS.—

22 (A) ELECTION TO BE EXCLUDED.—If the  
23 plan sponsor of a governmental plan which is a  
24 group health plan to which the provisions of  
25 this subtitle otherwise apply makes an election

under this paragraph for any specified period (in such form and manner as the Secretary of Health and Human Services may by regulations prescribe), then the requirements of this title insofar as they apply to group health plans shall not apply to such governmental plans for such period.

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

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

(b) INCORPORATION OF CERTAIN DEFINITIONS IN EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—Except as provided in this section, the terms “beneficiary”, “church plan”, “employee”, “employee welfare benefit plan”, “employer”, “governmental plan”, “multi-

1 employer plan”, “multiple employer welfare arrange-  
2 ment”, “participant”, “plan sponsor”, and “State” have  
3 the meanings given such terms in section 3 of the Em-  
4 ployee Retirement Income Security Act of 1974.

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

6 (1) APPLICABLE STATE AUTHORITY.—The term  
7 “applicable State authority” means, with respect to  
8 an insurer or health maintenance organization in a  
9 State, the State insurance commissioner or official  
10 or officials designated by the State to enforce the re-  
11 quirements of this title for the State involved with  
12 respect to such insurer or organization.

13 (2) BONA FIDE ASSOCIATION.—The term “bona  
14 fide association” means an association which—

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

17 (B) has been formed and maintained in  
18 good faith for purposes other than obtaining in-  
19 surance,

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

22 (D) makes health insurance coverage of-  
23 fered through the association available to all  
24 members regardless of health status,

1           (E) does not make health insurance cov-  
2           erage offered through the association available  
3           to any individual who is not a member (or de-  
4           pendent of a member) of the association at the  
5           time the coverage is initially issued,

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

10          (G) provides for renewal and continuation  
11          of health insurance coverage in a manner con-  
12          sistent with the requirements of section 132 as  
13          they relate to the renewal and continuation in  
14          force of coverage in a group market.

15          (3) COBRA CONTINUATION PROVISION.—The  
16          term “COBRA continuation provision” means any of  
17          the following:

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

22                (B) Part 6 of subtitle B of title I of the  
23                Employee Retirement Income Security Act of  
24                1974 (29 U.S.C. 1161 et seq.), other than sec-  
25                tion 609.



1 (C) Title XXII of the Public Health Serv-  
2 ice Act.

3 (4) HEALTH INSURANCE COVERAGE.—

4 (A) IN GENERAL.—Except as provided in  
5 subparagraph (B), the term “health insurance  
6 coverage” means benefits consisting of medical  
7 care (provided directly, through insurance or re-  
8 imbursement, or otherwise) under any hospital  
9 or medical service policy or certificate, hospital  
10 or medical service plan contract, or health  
11 maintenance organization group contract of-  
12 fered by an insurer or a health maintenance or-  
13 ganization.

14 (B) EXCEPTION.—Such term does not in-  
15 clude coverage under any separate policy, cer-  
16 tificate, or contract only for one or more of any  
17 of the following:

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

24 (ii) Medicare supplemental health in-  
25 surance (within the meaning of section

1 1882(g)(1) of the Social Security Act (42  
2 U.S.C. 1395ss(g)(1))) and similar supple-  
3 mental coverage provided under a group  
4 health plan.

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

7 (iv) Liability insurance, including gen-  
8 eral liability insurance and automobile li-  
9 ability insurance.

10 (v) Workers' compensation or similar  
11 insurance.

12 (vi) Automobile medical-payment in-  
13 surance.

14 (vii) Coverage consisting of benefit  
15 payments made on a periodic basis for a  
16 specified disease or illness or period of hos-  
17 pitalization, without regard to the costs in-  
18 curred or services rendered during the pe-  
19 riod to which the payments relate.

20 (viii) Short-term limited duration in-  
21 surance.

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

1           (5) HEALTH MAINTENANCE ORGANIZATION;  
2       HMO.—The terms “health maintenance organiza-  
3       tion” and “HMO” mean—

4           (A) a Federally qualified health mainte-  
5       nance organization (as defined in section  
6       1301(a) of the Public Health Service Act (42  
7       U.S.C. 300e(a))),

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

10          (C) a similar organization regulated under  
11       State law for solvency in the same manner and  
12       to the same extent as such a health mainte-  
13       nance organization,

14       if (other than for purposes of part 2 of subtitle B)  
15       it is subject to State law which regulates insurance  
16       (within the meaning of section 514(b)(2) of the Em-  
17       ployee Retirement Income Security Act of 1974).

18          (6) HEALTH STATUS.—The term “health sta-  
19       tus” includes, with respect to an individual, medical  
20       condition, claims experience, receipt of health care,  
21       medical history, evidence of insurability, or disabil-  
22       ity.

23          (7) INDIVIDUAL HEALTH INSURANCE COV-  
24       ERAGE.—The term “individual health insurance cov-  
25       erage” means health insurance coverage offered to

1 individuals if the coverage is not offered in connec-  
2 tion with a group health plan (other than such a  
3 plan that has fewer than two participants as current  
4 employees on the first day of the plan year).

5 (8) INSURER.—The term “insurer” means an  
6 insurance company, insurance service, or insurance  
7 organization which is licensed to engage in the busi-  
8 ness of insurance in a State and (except for pur-  
9 poses of part 2 of subtitle B) which is regulated by  
10 a State (within the meaning of section 514(b)(2)(A)  
11 of the Employee Retirement Income Security Act of  
12 1974).

13 (9) MEDICAL CARE.—The term “medical care”  
14 means—

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

21 (B) amounts paid for, or services in the  
22 form of, transportation primarily for and essen-  
23 tial to medical care referred to in subparagraph  
24 (A), and

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

4 (10) NETWORK PLAN.—The term “network  
5 plan” means, with respect to health insurance cov-  
6 erage, an arrangement of an insurer or a health  
7 maintenance organization under which the financing  
8 and delivery of medical care are provided, in whole  
9 or in part, through a defined set of providers under  
10 contract with the insurer or health maintenance or-  
11 ganization.

12 (11) WAITING PERIOD.—The term “waiting pe-  
13 riod” means, with respect to a group health plan  
14 and an individual who is a potential participant or  
15 beneficiary in the plan, the minimum period that  
16 must pass with respect to the individual before the  
17 individual is eligible to be covered for benefits under  
18 the plan.

19 (d) TREATMENT OF PARTNERSHIPS.—

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

1 in the partnership or to their dependents (as defined  
2 under the terms of the plan, fund, or program), di-  
3 rectly or through insurance, reimbursement, or oth-  
4 erwise, shall be treated (subject to paragraph (1)) as  
5 an employee welfare benefit plan which is a group  
6 health plan.

7 (2) TREATMENT OF PARTNERSHIP AND PART-  
8 NERS AND EMPLOYER AND PARTICIPANTS.—In the  
9 case of a group health plan—

10 (A) the term “employer” includes the part-  
11 nership in relation to any partner; and

12 (B) the term “participant” includes—

13 (i) in connection with a group health  
14 plan maintained by a partnership, an indi-  
15 vidual who is a partner in relation to the  
16 partnership, or

17 (ii) in connection with a group health  
18 plan maintained by a self-employed individ-  
19 ual (under which one or more employees  
20 are participants), the self-employed individ-  
21 ual,

22 if such individual is or may become eligible to  
23 receive a benefit under the plan or such individ-  
24 ual’s beneficiaries may be eligible to receive any  
25 such benefit.

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

3 (1) INDIVIDUAL MARKET.—The term “individ-  
4 ual market” means the market for health insurance  
5 coverage offered to individuals and not to employers  
6 or in connection with a group health plan and does  
7 not include the market for such coverage issued only  
8 by an insurer or HMO that makes such coverage  
9 available only on the basis of affiliation with an as-  
10 sociation or other group.

11 (2) LARGE GROUP MARKET.—The term “large  
12 group market” means the market for health insur-  
13 ance coverage offered to employers (other than small  
14 employers) on behalf of their employees (and their  
15 dependents) and does not include health insurance  
16 coverage available solely in connection with a bona  
17 fide association (as defined in subsection (c)(2)).

18 (3) SMALL EMPLOYER.—The term “small em-  
19 ployer” means, in connection with a group health  
20 plan with respect to a calendar year, an employer  
21 who employs at least 2 but fewer than 51 employees  
22 on a typical business day in the year. For purposes  
23 of this paragraph, two or more trades or businesses,  
24 whether or not incorporated, shall be deemed a sin-  
25 gle employer if such trades or businesses are within

1 the same control group (within the meaning of sec-  
 2 tion 3(40)(B)(ii)).

3 (4) SMALL GROUP MARKET.—The term “small  
 4 group market” means the health insurance market  
 5 under which individuals obtain health insurance cov-  
 6 erage (directly or through any arrangement) on be-  
 7 half of themselves (and their dependents) on the  
 8 basis of employment or other relationship with re-  
 9 spect to a small employer and does not include  
 10 health insurance coverage available solely in connec-  
 11 tion with a bona fide association (as defined in sub-  
 12 section (c)(2)).

13 **SEC. 192. STATE FLEXIBILITY TO PROVIDE GREATER PRO-**  
 14 **TECTION.**

15 (a) STATE FLEXIBILITY TO PROVIDE GREATER PRO-  
 16 TECTION.—Subject to subsection (b), nothing in this title  
 17 shall be construed to preempt State laws that—

18 (1) require insurers or HMOs to impose a limi-  
 19 tation or exclusion of benefits relating to the treat-  
 20 ment of a preexisting condition for a period that is  
 21 shorter than the applicable period provided for under  
 22 this title; or

23 (2) allow individuals, participants, and bene-  
 24 ficiaries to be considered to be in a period of pre-  
 25 vious qualifying coverage if such individual, partici-



1       pant, or beneficiary experiences a lapse in coverage  
2       that is greater than the 60-day periods provided for  
3       under sections 101(b)(3)(A), 101(b)(3)(B)(ii), and  
4       102(b)(2).

5       (b) NO OVERRIDE OF ERISA PREEMPTION.—Noth-  
6       ing in this Act shall be construed to affect or modify the  
7       provisions of section 514 of the Employee Retirement In-  
8       come Security Act of 1974 (29 U.S.C. 1144).

9       **SEC. 193. EFFECTIVE DATE.**

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

13               (1) group health plans, and health insurance  
14       coverage offered in connection with group health  
15       plans, for plan years beginning on or after January  
16       1, 1998, and

17               (2) individual health insurance coverage issued,  
18       renewed, in effect, or operated on or after July 1,  
19       1998.

20       (b) CONSIDERATION OF PREVIOUS COVERAGE.—The  
21       Secretaries of Health and Human Services, Treasury, and  
22       Labor shall jointly establish rules regarding the treatment  
23       (in determining qualified coverage periods under sections  
24       102(b) and 141(b)) of coverage before the applicable effec-  
25       tive date specified in subsection (a).

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

5 **SEC. 194. RULE OF CONSTRUCTION.**

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

11 **TITLE II—PREVENTING HEALTH**  
12 **CARE FRAUD AND ABUSE; AD-**  
13 **MINISTRATIVE SIMPLIFICA-**  
14 **TION**

15 **SEC. 200. REFERENCES IN TITLE.**

16 Except as otherwise specifically provided, whenever in  
17 this title an amendment is expressed in terms of an  
18 amendment to or repeal of a section or other provision,  
19 the reference shall be considered to be made to that sec-  
20 tion or other provision of the Social Security Act.

**Subtitle A—Fraud and Abuse  
Control Program**

**SEC. 201. FRAUD AND ABUSE CONTROL PROGRAM.**

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

“FRAUD AND ABUSE CONTROL PROGRAM

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

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

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

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

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

1           “(D) to provide for the modification and  
2           establishment of safe harbors and to issue advi-  
3           sory opinions and special fraud alerts pursuant  
4           to section 1128D, and

5           “(E) to provide for the reporting and dis-  
6           closure of certain final adverse actions against  
7           health care providers, suppliers, or practitioners  
8           pursuant to the data collection system estab-  
9           lished under section 1128E.

10          “(2) COORDINATION WITH HEALTH PLANS.—In  
11          carrying out the program established under para-  
12          graph (1), the Secretary and the Attorney General  
13          shall consult with, and arrange for the sharing of  
14          data with representatives of health plans.

15          “(3) GUIDELINES.—

16                 “(A) IN GENERAL.—The Secretary and the  
17                 Attorney General shall issue guidelines to carry  
18                 out the program under paragraph (1). The pro-  
19                 visions of sections 553, 556, and 557 of title 5,  
20                 United States Code, shall not apply in the issu-  
21                 ance of such guidelines.

22                 “(B) INFORMATION GUIDELINES.—

23                         “(i) IN GENERAL.—Such guidelines  
24                         shall include guidelines relating to the fur-  
25                         nishing of information by health plans,

1 providers, and others to enable the Sec-  
2 retary and the Attorney General to carry  
3 out the program (including coordination  
4 with health plans under paragraph (2)).

5 “(ii) CONFIDENTIALITY.—Such guide-  
6 lines shall include procedures to assure  
7 that such information is provided and uti-  
8 lized in a manner that appropriately pro-  
9 tects the confidentiality of the information  
10 and the privacy of individuals receiving  
11 health care services and items.

12 “(iii) QUALIFIED IMMUNITY FOR PRO-  
13 VIDING INFORMATION.—The provisions of  
14 section 1157(a) (relating to limitation on  
15 liability) shall apply to a person providing  
16 information to the Secretary or the Attor-  
17 ney General in conjunction with their per-  
18 formance of duties under this section.

19 “(4) ENSURING ACCESS TO DOCUMENTATION.—  
20 The Inspector General of the Department of Health  
21 and Human Services is authorized to exercise such  
22 authority described in paragraphs (3) through (9) of  
23 section 6 of the Inspector General Act of 1978 (5  
24 U.S.C. App.) as necessary with respect to the activi-

1       ties under the fraud and abuse control program es-  
2       tablished under this subsection.

3           “(5) 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 (5 U.S.C. App.).

8           “(b) ADDITIONAL USE OF FUNDS BY INSPECTOR  
9       GENERAL.—

10          “(1) REIMBURSEMENTS FOR INVESTIGA-  
11       TIONS.—The Inspector General of the Department  
12       of Health and Human Services is authorized to re-  
13       ceive and retain for current use reimbursement for  
14       the costs of conducting investigations and audits and  
15       for monitoring compliance plans when such costs are  
16       ordered by a court, voluntarily agreed to by the  
17       payor, or otherwise.

18          “(2) CREDITING.—Funds received by the In-  
19       specter General under paragraph (1) as reimburse-  
20       ment for costs of conducting investigations shall be  
21       deposited to the credit of the appropriation from  
22       which initially paid, or to appropriations for similar  
23       purposes currently available at the time of deposit,  
24       and shall remain available for obligation for 1 year  
25       from the date of the deposit of such funds.

1       “(c) HEALTH PLAN DEFINED.—For purposes of this  
 2 section, the term ‘health plan’ means a plan or program  
 3 that provides health benefits, whether directly, through in-  
 4 surance, or otherwise, and includes—

5               “(1) a policy of health insurance;

6               “(2) a contract of a service benefit organiza-  
 7 tion; and

8               “(3) a membership agreement with a health  
 9 maintenance organization or other prepaid health  
 10 plan.”.

11       (b) ESTABLISHMENT OF HEALTH CARE FRAUD AND  
 12 ABUSE CONTROL ACCOUNT IN FEDERAL HOSPITAL IN-  
 13 SURANCE TRUST FUND.—Section 1817 (42 U.S.C. 1395i)  
 14 is amended by adding at the end the following new sub-  
 15 section:

16       “(k) HEALTH CARE FRAUD AND ABUSE CONTROL  
 17 ACCOUNT.—

18               “(1) ESTABLISHMENT.—There is hereby estab-  
 19 lished in the Trust Fund an expenditure account to  
 20 be known as the ‘Health Care Fraud and Abuse  
 21 Control Account’ (in this subsection referred to as  
 22 the ‘Account’).

23               “(2) APPROPRIATED AMOUNTS TO TRUST  
 24 FUND.—

1           “(A) IN GENERAL.—There are hereby ap-  
2           propriated to the Trust Fund—

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

5                   “(ii) such amounts as may be depos-  
6                   ited in the Trust Fund as provided in sec-  
7                   tions 242(b) and 249(c) of the Health Cov-  
8                   erage Availability and Affordability Act of  
9                   1996, and title XI; and

10                  “(iii) such amounts as are transferred  
11                  to the Trust Fund under subparagraph  
12                  (C).

13           “(B) AUTHORIZATION TO ACCEPT GIFTS.—  
14           The Trust Fund is authorized to accept on be-  
15           half of the United States money gifts and be-  
16           quests made unconditionally to the Trust Fund,  
17           for the benefit of the Account or any activity fi-  
18           nanced through the Account.

19           “(C) TRANSFER OF AMOUNTS.—The Man-  
20           aging Trustee shall transfer to the Trust Fund,  
21           under rules similar to the rules in section 9601  
22           of the Internal Revenue Code of 1986, an  
23           amount equal to the sum of the following:

24                   “(i) Criminal fines recovered in cases  
25                   involving a Federal health care offense (as



1 defined in section 982(a)(6)(B) of title 18,  
2 United States Code).

3 “(ii) Civil monetary penalties and as-  
4 sessments imposed in health care cases, in-  
5 cluding amounts recovered under titles XI,  
6 XVIII, and XXI, and chapter 38 of title  
7 31, United States Code (except as other-  
8 wise provided by law).

9 “(iii) Amounts resulting from the for-  
10 feiture of property by reason of a Federal  
11 health care offense.

12 “(iv) Penalties and damages obtained  
13 and otherwise creditable to miscellaneous  
14 receipts of the general fund of the Treas-  
15 ury obtained under sections 3729 through  
16 3733 of title 31, United States Code  
17 (known as the False Claims Act), in cases  
18 involving claims related to the provision of  
19 health care items and services (other than  
20 funds awarded to a relator, for restitution  
21 or otherwise authorized by law).

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

24 “(A) DEPARTMENTS OF HEALTH AND  
25 HUMAN SERVICES AND JUSTICE.—

1           “(i) IN GENERAL.—There are hereby  
2           appropriated to the Account from the  
3           Trust Fund such sums as the Secretary  
4           and the Attorney General certify are nec-  
5           essary to carry out the purposes described  
6           in subparagraph (C), to be available with-  
7           out further appropriation, in an amount  
8           not to exceed—

9                   “(I) for fiscal year 1997,  
10                   \$104,000,000, and

11                   “(II) for each of the fiscal years  
12                   1998 through 2003, the limit for the  
13                   preceding fiscal year, increased by 15  
14                   percent; and

15                   “(III) for each fiscal year after  
16                   fiscal year 2003, the limit for fiscal  
17                   year 2003.

18           “(ii) MEDICARE AND MEDICAID AC-  
19           TIVITIES.—For each fiscal year, of the  
20           amount appropriated in clause (i), the fol-  
21           lowing amounts shall be available only for  
22           the purposes of the activities of the Office  
23           of the Inspector General of the Depart-  
24           ment of Health and Human Services with

1           respect to the medicare and medicaid pro-  
2           grams—

3                   “(I) for fiscal year 1997, not less  
4                   than \$60,000,000 and not more than  
5                   \$70,000,000;

6                   “(II) for fiscal year 1998, not  
7                   less than \$80,000,000 and not more  
8                   than \$90,000,000;

9                   “(III) for fiscal year 1999, not  
10                  less than \$90,000,000 and not more  
11                  than \$100,000,000;

12                  “(IV) for fiscal year 2000, not  
13                  less than \$110,000,000 and not more  
14                  than \$120,000,000;

15                  “(V) for fiscal year 2001, not  
16                  less than \$120,000,000 and not more  
17                  than \$130,000,000;

18                  “(VI) for fiscal year 2002, not  
19                  less than \$140,000,000 and not more  
20                  than \$150,000,000; and

21                  “(VII) for each fiscal year after  
22                  fiscal year 2002, not less than  
23                  \$150,000,000 and not more than  
24                  \$160,000,000.

1           “(B) FEDERAL BUREAU OF INVESTIGA-  
2           TION.—There are hereby appropriated from the  
3           general fund of the United States Treasury and  
4           hereby appropriated to the Account for transfer  
5           to the Federal Bureau of Investigation to carry  
6           out the purposes described in subparagraph  
7           (C), to be available without further appropria-  
8           tion—

9                   “(i) for fiscal year 1997, \$47,000,000;

10                   “(ii) for fiscal year 1998,  
11                   \$56,000,000;

12                   “(iii) for fiscal year 1999,  
13                   \$66,000,000;

14                   “(iv) for fiscal year 2000,  
15                   \$76,000,000;

16                   “(v) for fiscal year 2001,  
17                   \$88,000,000;

18                   “(vi) for fiscal year 2002,  
19                   \$101,000,000; and

20                   “(vii) for each fiscal year after fiscal  
21                   year 2002, \$114,000,000.

22           “(C) USE OF FUNDS.—The purposes de-  
23           scribed in this subparagraph are to cover the  
24           costs (including equipment, salaries and bene-  
25           fits, and travel and training) of the administra-

tion and operation of the health care fraud and abuse control program established under section 1128C(a), including the costs of—

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

“(ii) investigations;

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

“(iv) inspections and other evaluations; and

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

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

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

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

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

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

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

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

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

“(vi) For fiscal year 2002, such amount shall be not less than

1                   \$690,000,000    and    not    more    than  
2                   \$700,000,000.

3                   “(vii) For each fiscal year after fiscal  
4                   year 2002, such amount shall be not less  
5                   than \$710,000,000 and not more than  
6                   \$720,000,000.

7                   “(5) ANNUAL REPORT.—The Secretary and the  
8                   Attorney General shall submit jointly an annual re-  
9                   port to Congress on the amount of revenue which is  
10                  generated and disbursed, and the justification for  
11                  such disbursements, by the Account in each fiscal  
12                  year.”.

13 **SEC. 202. MEDICARE INTEGRITY PROGRAM.**

14                  (a) ESTABLISHMENT OF MEDICARE INTEGRITY PRO-  
15                  GRAM.—Title XVIII is amended by adding at the end the  
16                  following new section:

17                         “MEDICARE INTEGRITY PROGRAM

18                         “SEC. 1893. (a) ESTABLISHMENT OF PROGRAM.—  
19                         There is hereby established the Medicare Integrity Pro-  
20                         gram (in this section referred to as the ‘Program’) under  
21                         which the Secretary shall promote the integrity of the  
22                         medicare program by entering into contracts in accord-  
23                         ance with this section with eligible private entities to carry  
24                         out the activities described in subsection (b).

25                         “(b) ACTIVITIES DESCRIBED.—The activities de-  
26                         scribed in this subsection are as follows:

1           “(1) Review of activities of providers of services  
2           or other individuals and entities furnishing items  
3           and services for which payment may be made under  
4           this title (including skilled nursing facilities and  
5           home health agencies), including medical and utiliza-  
6           tion review and fraud review (employing similar  
7           standards, processes, and technologies used by pri-  
8           vate health plans, including equipment and software  
9           technologies which surpass the capability of the  
10          equipment and technologies used in the review of  
11          claims under this title as of the date of the enact-  
12          ment of this section).

13           “(2) Audit of cost reports.

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

18           “(4) Education of providers of services, bene-  
19           ficiaries, and other persons with respect to payment  
20           integrity and benefit quality assurance issues.

21           “(5) Developing (and periodically updating) a  
22           list of items of durable medical equipment in accord-  
23           ance with section 1834(a)(15) which are subject to  
24           prior authorization under such section.



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

4               “(1) the entity has demonstrated capability to  
5 carry out such activities;

6               “(2) in carrying out such activities, the entity  
7 agrees to cooperate with the Inspector General of  
8 the Department of Health and Human Services, the  
9 Attorney General of the United States, and other  
10 law enforcement agencies, as appropriate, in the in-  
11 vestigation and deterrence of fraud and abuse in re-  
12 lation to this title and in other cases arising out of  
13 such activities;

14               “(3) the entity demonstrates to the Secretary  
15 that the entity’s financial holdings, interests, or rela-  
16 tionships will not interfere with its ability to perform  
17 the functions to be required by the contract in an ef-  
18 fective and impartial manner; and

19               “(4) the entity meets such other requirements  
20 as the Secretary may impose.

21 In the case of the activity described in subsection (b)(5),  
22 an entity shall be deemed to be eligible to enter into a  
23 contract under the Program to carry out the activity if  
24 the entity is a carrier with a contract in effect under sec-  
25 tion 1842.

1       “(d) PROCESS FOR ENTERING INTO CONTRACTS.—

2       The Secretary shall enter into contracts under the Pro-  
3       gram in accordance with such procedures as the Secretary  
4       shall by regulation establish, except that such procedures  
5       shall include the following:

6               “(1) The Secretary shall determine the appro-  
7       prium number of separate contracts which are nec-  
8       essary to carry out the Program and the appropriate  
9       times at which the Secretary shall enter into such  
10      contracts.

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

15             “(B) Competitive procedures must be used  
16      when entering into new contracts under this section,  
17      or at any other time considered appropriate by the  
18      Secretary, except that the Secretary may contract  
19      with entities that are carrying out the activities de-  
20      scribed in this section pursuant to agreements under  
21      section 1816 or contracts under section 1842 in ef-  
22      fect on the date of the enactment of this section.

23             “(3) A contract under this section may be re-  
24      newed without regard to any provision of law requir-  
25      ing competition if the contractor has met or ex-

1       ceeded the performance requirements established in  
2       the current contract.

3       “(e) LIMITATION ON CONTRACTOR LIABILITY.—The  
4 Secretary shall by regulation provide for the limitation of  
5 a contractor’s liability for actions taken to carry out a con-  
6 tract under the Program, and such regulation shall, to the  
7 extent the Secretary finds appropriate, employ the same  
8 or comparable standards and other substantive and proce-  
9 dural provisions as are contained in section 1157.”.

10       (b) ELIMINATION OF FI AND CARRIER RESPONSIBIL-  
11 ITY FOR CARRYING OUT ACTIVITIES SUBJECT TO PRO-  
12 GRAM.—

13           (1)       RESPONSIBILITIES       OF       FISCAL  
14 INTERMEDIARIES UNDER PART A.—Section 1816  
15 (42 U.S.C. 1395h) is amended by adding at the end  
16 the following new subsection:

17       “(l) No agency or organization may carry out (or re-  
18 ceive payment for carrying out) any activity pursuant to  
19 an agreement under this section to the extent that the ac-  
20 tivity is carried out pursuant to a contract under the Med-  
21 icare Integrity Program under section 1893.”.

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

1 “(6) No carrier may carry out (or receive payment  
2 for carrying out) any activity pursuant to a contract under  
3 this subsection to the extent that the activity is carried  
4 out pursuant to a contract under the Medicare Integrity  
5 Program under section 1893. The previous sentence shall  
6 not apply with respect to the activity described in section  
7 1893(b)(5) (relating to prior authorization of certain  
8 items of durable medical equipment under section  
9 1834(a)(15)).”.

10 **SEC. 203. BENEFICIARY INCENTIVE PROGRAMS.**

11 (a) CLARIFICATION OF REQUIREMENT TO PROVIDE  
12 EXPLANATION OF MEDICARE BENEFITS.—The Secretary  
13 of Health and Human Services (in this section referred  
14 to as the “Secretary”) shall provide an explanation of ben-  
15 efits under the medicare program under title XVIII of the  
16 Social Security Act with respect to each item or service  
17 for which payment may be made under the program which  
18 is furnished to an individual, without regard to whether  
19 or not a deductible or coinsurance may be imposed against  
20 the individual with respect to the item or service.

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

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

1 under which the Secretary shall encourage individ-  
2 uals to report to the Secretary information on indi-  
3 viduals and entities who are engaging or who have  
4 engaged in acts or omissions which constitute  
5 grounds for the imposition of a sanction under sec-  
6 tion 1128, section 1128A, or section 1128B of the  
7 Social Security Act, or who have otherwise engaged  
8 in fraud and abuse against the medicare program  
9 for which there is a sanction provided under law.  
10 The program shall discourage provision of, and not  
11 consider, information which is frivolous or otherwise  
12 not relevant or material to the imposition of such a  
13 sanction.

14 (2) PAYMENT OF PORTION OF AMOUNTS COL-  
15 LECTED.—If an individual reports information to  
16 the Secretary under the program established under  
17 paragraph (1) which serves as the basis for the col-  
18 lection by the Secretary or the Attorney General of  
19 any amount of at least \$100 (other than any  
20 amount paid as a penalty under section 1128B of  
21 the Social Security Act), the Secretary may pay a  
22 portion of the amount collected to the individual  
23 (under procedures similar to those applicable under  
24 section 7623 of the Internal Revenue Code of 1986

1 to payments to individuals providing information on  
2 violations of such Code).

3 (c) PROGRAM TO COLLECT INFORMATION ON PRO-  
4 GRAM EFFICIENCY.—

5 (1) ESTABLISHMENT OF PROGRAM.—Not later  
6 than 3 months after the date of the enactment of  
7 this Act, the Secretary shall establish a program  
8 under which the Secretary shall encourage individ-  
9 uals to submit to the Secretary suggestions on meth-  
10 ods to improve the efficiency of the medicare pro-  
11 gram.

12 (2) PAYMENT OF PORTION OF PROGRAM SAV-  
13 INGS.—If an individual submits a suggestion to the  
14 Secretary under the program established under  
15 paragraph (1) which is adopted by the Secretary and  
16 which results in savings to the program, the Sec-  
17 retary may make a payment to the individual of  
18 such amount as the Secretary considers appropriate.

19 **SEC. 204. APPLICATION OF CERTAIN HEALTH ANTI-FRAUD**  
20 **AND ABUSE SANCTIONS TO FRAUD AND**  
21 **ABUSE AGAINST FEDERAL HEALTH CARE**  
22 **PROGRAMS.**

23 (a) IN GENERAL.—Section 1128B (42 U.S.C.  
24 1320a-7b) is amended as follows:

1           (1) In the heading, by striking “MEDICARE OR  
2       STATE HEALTH CARE PROGRAMS” and inserting  
3       “FEDERAL HEALTH CARE PROGRAMS”.

4           (2) In subsection (a)(1), by striking “a program  
5       under title XVIII or a State health care program (as  
6       defined in section 1128(h))” and inserting “a Fed-  
7       eral health care program”.

8           (3) In subsection (a)(5), by striking “a program  
9       under title XVIII or a State health care program”  
10      and inserting “a Federal health care program”.

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

12               (A) by striking “a State plan approved  
13              under title XIX” and inserting “a Federal  
14              health care program”, and

15               (B) by striking “the State may at its op-  
16              tion (notwithstanding any other provision of  
17              that title or of such plan)” and inserting “the  
18              administrator of such program may at its op-  
19              tion (notwithstanding any other provision of  
20              such program)”.

21          (5) In subsection (b), by striking “title XVIII  
22       or a State health care program” each place it ap-  
23       pears and inserting “a Federal health care pro-  
24       gram”.

1           (6) In subsection (c), by inserting “(as defined  
2       in section 1128(h))” after “a State health care pro-  
3       gram”.

4           (7) By adding at the end the following new sub-  
5       section:

6       “(f) For purposes of this section, the term ‘Federal  
7       health care program’ means—

8           “(1) any plan or program that provides health  
9       benefits, whether directly, through insurance, or oth-  
10      erwise, which is funded directly, in whole or in part,  
11      by the United States Government (other than the  
12      health insurance program under chapter 89 of title  
13      5, United States Code); or

14          “(2) any State health care program, as defined  
15      in section 1128(h).”.

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

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

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



1 “GUIDANCE REGARDING APPLICATION OF HEALTH CARE  
2 FRAUD AND ABUSE SANCTIONS

3 “SEC. 1128D. (a) SOLICITATION AND PUBLICATION  
4 OF MODIFICATIONS TO EXISTING SAFE HARBORS AND  
5 NEW SAFE HARBORS.—

6 “(1) IN GENERAL.—

7 “(A) SOLICITATION OF PROPOSALS FOR  
8 SAFE HARBORS.—Not later than January 1,  
9 1997, and not less than annually thereafter, the  
10 Secretary shall publish a notice in the Federal  
11 Register soliciting proposals, which will be ac-  
12 cepted during a 60-day period, for—

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

18 “(ii) additional safe harbors specifying  
19 payment practices that shall not be treated  
20 as a criminal offense under section  
21 1128B(b) and shall not serve as the basis  
22 for an exclusion under section 1128(b)(7);

23 “(iii) advisory opinions to be issued  
24 pursuant to subsection (b); and

1 “(iv) special fraud alerts to be issued  
2 pursuant to subsection (c).

3 “(B) PUBLICATION OF PROPOSED MODI-  
4 FICATIONS AND PROPOSED ADDITIONAL SAFE  
5 HARBORS.—After considering the proposals de-  
6 scribed in clauses (i) and (ii) of subparagraph  
7 (A), the Secretary, in consultation with the At-  
8 torney General, shall publish in the Federal  
9 Register proposed modifications to existing safe  
10 harbors and proposed additional safe harbors, if  
11 appropriate, with a 60-day comment period.  
12 After considering any public comments received  
13 during this period, the Secretary shall issue  
14 final rules modifying the existing safe harbors  
15 and establishing new safe harbors, as appro-  
16 priate.

17 “(C) REPORT.—The Inspector General of  
18 the Department of Health and Human Services  
19 (in this section referred to as the ‘Inspector  
20 General’) shall, in an annual report to Congress  
21 or as part of the year-end semiannual report re-  
22 quired by section 5 of the Inspector General  
23 Act of 1978 (5 U.S.C. App.), describe the pro-  
24 posals received under clauses (i) and (ii) of sub-  
25 paragraph (A) and explain which proposals

1           were included in the publication described in  
2           subparagraph (B), which proposals were not in-  
3           cluded in that publication, and the reasons for  
4           the rejection of the proposals that were not in-  
5           cluded.

6           “(2) CRITERIA FOR MODIFYING AND ESTAB-  
7           LISHING SAFE HARBORS.—In modifying and estab-  
8           lishing safe harbors under paragraph (1)(B), the  
9           Secretary may consider the extent to which provid-  
10          ing a safe harbor for the specified payment practice  
11          may result in any of the following:

12                 “(A) An increase or decrease in access to  
13                 health care services.

14                 “(B) An increase or decrease in the quality  
15                 of health care services.

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

18                 “(D) An increase or decrease in competi-  
19                 tion among health care providers.

20                 “(E) An increase or decrease in the ability  
21                 of health care facilities to provide services in  
22                 medically underserved areas or to medically un-  
23                 derserved populations.

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

4           “(G) An increase or decrease in the poten-  
5           tial overutilization of health care services.

6           “(H) The existence or nonexistence of any  
7           potential financial benefit to a health care pro-  
8           fessional or provider which may vary based on  
9           their decisions of—

10           “(i) whether to order a health care  
11           item or service; or

12           “(ii) whether to arrange for a referral  
13           of health care items or services to a par-  
14           ticular practitioner or provider.

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

19           “(b) ADVISORY OPINIONS.—

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

23           “(2) MATTERS SUBJECT TO ADVISORY OPIN-  
24           IONS.—The Secretary shall issue advisory opinions  
25           as to the following matters:

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

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

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

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

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

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

1           “(A) Whether the fair market value shall  
2           be, or was paid or received for any goods, serv-  
3           ices or property.

4           “(B) Whether an individual is a bona fide  
5           employee within the requirements of section  
6           3121(d)(2) of the Internal Revenue Code of  
7           1986.

8           “(4) EFFECT OF ADVISORY OPINIONS.—

9           “(A) BINDING AS TO SECRETARY AND  
10          PARTIES INVOLVED.—Each advisory opinion is-  
11          sued by the Secretary shall be binding as to the  
12          Secretary and the party or parties requesting  
13          the opinion.

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

19          “(5) REGULATIONS.—

20          “(A) IN GENERAL.—Not later than 180  
21          days after the date of the enactment of this sec-  
22          tion, the Secretary shall issue regulations to  
23          carry out this section. Such regulations shall  
24          provide for—

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

3 “(ii) the procedure to be followed by  
4 the Secretary in responding to a request  
5 for an advisory opinion;

6 “(iii) the interval in which the Sec-  
7 retary shall respond;

8 “(iv) the reasonable fee to be charged  
9 to the party requesting an advisory opin-  
10 ion; and

11 “(v) the manner in which advisory  
12 opinions will be made available to the pub-  
13 lic.

14 “(B) SPECIFIC CONTENTS.—Under the  
15 regulations promulgated pursuant to subpara-  
16 graph (A)—

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

21 “(ii) the fee charged to the party re-  
22 questing an advisory opinion shall be equal  
23 to the costs incurred by the Secretary in  
24 responding to the request.

25 “(c) SPECIAL FRAUD ALERTS.—

1 “(1) IN GENERAL.—

2 “(A) REQUEST FOR SPECIAL FRAUD  
3 ALERTS.—Any person may present, at any  
4 time, a request to the Inspector General for a  
5 notice which informs the public of practices  
6 which the Inspector General considers to be  
7 suspect or of particular concern under the med-  
8 icare program or a State health care program,  
9 as defined in section 1128(h) (in this subsection  
10 referred to as a ‘special fraud alert’).

11 “(B) ISSUANCE AND PUBLICATION OF SPE-  
12 CIAL FRAUD ALERTS.—Upon receipt of a re-  
13 quest described in subparagraph (A), the In-  
14 spector General shall investigate the subject  
15 matter of the request to determine whether a  
16 special fraud alert should be issued. If appro-  
17 priate, the Inspector General shall issue a spe-  
18 cial fraud alert in response to the request. All  
19 special fraud alerts issued pursuant to this sub-  
20 paragraph shall be published in the Federal  
21 Register.

22 “(2) CRITERIA FOR SPECIAL FRAUD ALERTS.—  
23 In determining whether to issue a special fraud alert  
24 upon a request described in paragraph (1), the In-  
25 spector General may consider—



1           “(A) whether and to what extent the prac-  
 2           tices that would be identified in the special  
 3           fraud alert may result in any of the con-  
 4           sequences described in subsection (a)(2); and

5           “(B) the volume and frequency of the con-  
 6           duct that would be identified in the special  
 7           fraud alert.”.

8           **Subtitle B—Revisions to Current**  
 9           **Sanctions for Fraud and Abuse**

10       **SEC. 211. MANDATORY EXCLUSION FROM PARTICIPATION**

11                       **IN MEDICARE AND STATE HEALTH CARE PRO-**  
 12                       **GRAMS.**

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

15               (1) IN GENERAL.—Section 1128(a) (42 U.S.C.  
 16       1320a–7(a)) is amended by adding at the end the  
 17       following new paragraph:

18               “(3) FELONY CONVICTION RELATING TO  
 19       HEALTH CARE FRAUD.—Any individual or entity  
 20       that has been convicted after the date of the enact-  
 21       ment of the Health Coverage Availability and Af-  
 22       fordability Act of 1996, under Federal or State law,  
 23       in connection with the delivery of a health care item  
 24       or service or with respect to any act or omission in  
 25       a health care program (other than those specifically

1 described in paragraph (1)) operated by or financed  
2 in whole or in part by any Federal, State, or local  
3 government agency, of a criminal offense consisting  
4 of a felony relating to fraud, theft, embezzlement,  
5 breach of fiduciary responsibility, or other financial  
6 misconduct.”.

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

10 “(1) CONVICTION RELATING TO FRAUD.—Any  
11 individual or entity that has been convicted after the  
12 date of the enactment of the Health Coverage Avail-  
13 ability and Affordability Act of 1996, under Federal  
14 or State law—

15 “(A) of a criminal offense consisting of a  
16 misdemeanor relating to fraud, theft, embezzle-  
17 ment, breach of fiduciary responsibility, or  
18 other financial misconduct—

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

21 “(ii) with respect to any act or omis-  
22 sion in a health care program (other than  
23 those specifically described in subsection  
24 (a)(1)) operated by or financed in whole or

1 in part by any Federal, State, or local gov-  
2 ernment agency; or

3 “(B) of a criminal offense relating to  
4 fraud, theft, embezzlement, breach of fiduciary  
5 responsibility, or other financial misconduct  
6 with respect to any act or omission in a pro-  
7 gram (other than a health care program) oper-  
8 ated by or financed in whole or in part by any  
9 Federal, State, or local government agency.”.

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

12 (1) IN GENERAL.—Section 1128(a) (42 U.S.C.  
13 1320a–7(a)), as amended by subsection (a), is  
14 amended by adding at the end the following new  
15 paragraph:

16 “(4) FELONY CONVICTION RELATING TO CON-  
17 TROLLED SUBSTANCE.—Any individual or entity  
18 that has been convicted after the date of the enact-  
19 ment of the Health Coverage Availability and Af-  
20 fordability Act of 1996, under Federal or State law,  
21 of a criminal offense consisting of a felony relating  
22 to the unlawful manufacture, distribution, prescrip-  
23 tion, or dispensing of a controlled substance.”.

24 (2) CONFORMING AMENDMENT.—Section  
25 1128(b)(3) (42 U.S.C. 1320a–7(b)(3)) is amended—

1 (A) in the heading, by striking “CONVIC-  
 2 TION” and inserting “MISDEMEANOR CONVIC-  
 3 TION”; and

4 (B) by striking “criminal offense” and in-  
 5 serting “criminal offense consisting of a mis-  
 6 demeanor”.

7 **SEC. 212. ESTABLISHMENT OF MINIMUM PERIOD OF EX-**  
 8 **CLUSION FOR CERTAIN INDIVIDUALS AND**  
 9 **ENTITIES SUBJECT TO PERMISSIVE EXCLU-**  
 10 **SION FROM MEDICARE AND STATE HEALTH**  
 11 **CARE PROGRAMS.**

12 Section 1128(c)(3) (42 U.S.C. 1320a–7(c)(3)) is  
 13 amended by adding at the end the following new subpara-  
 14 graphs:

15 “(D) In the case of an exclusion of an individual or  
 16 entity under paragraph (1), (2), or (3) of subsection (b),  
 17 the period of the exclusion shall be 3 years, unless the  
 18 Secretary determines in accordance with published regula-  
 19 tions that a shorter period is appropriate because of miti-  
 20 gating circumstances or that a longer period is appro-  
 21 priate because of aggravating circumstances.

22 “(E) In the case of an exclusion of an individual or  
 23 entity under subsection (b)(4) or (b)(5), the period of the  
 24 exclusion shall not be less than the period during which  
 25 the individual’s or entity’s license to provide health care

1 is revoked, suspended, or surrendered, or the individual  
 2 or the entity is excluded or suspended from a Federal or  
 3 State health care program.

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

7 **SEC. 213. PERMISSIVE EXCLUSION OF INDIVIDUALS WITH**  
 8 **OWNERSHIP OR CONTROL INTEREST IN**  
 9 **SANCTIONED ENTITIES.**

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

12 “(15) INDIVIDUALS CONTROLLING A SANC-  
 13 TIONED ENTITY.—(A) Any individual—

14 “(i) who has a direct or indirect ownership  
 15 or control interest in a sanctioned entity and  
 16 who knows or should know (as defined in sec-  
 17 tion 1128A(i)(6)) of the action constituting the  
 18 basis for the conviction or exclusion described  
 19 in subparagraph (B); or

20 “(ii) who is an officer or managing em-  
 21 ployee (as defined in section 1126(b)) of such  
 22 an entity.

23 “(B) For purposes of subparagraph (A), the  
 24 term ‘sanctioned entity’ means an entity—

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

4 “(ii) that has been excluded from partici-  
 5 pation under a program under title XVIII or  
 6 under a State health care program.”.

7 **SEC. 214. SANCTIONS AGAINST PRACTITIONERS AND PER-**  
 8 **SONS FOR FAILURE TO COMPLY WITH STATU-**  
 9 **TORY OBLIGATIONS.**

10 (a) MINIMUM PERIOD OF EXCLUSION FOR PRACTI-  
 11 TIONERS AND PERSONS FAILING TO MEET STATUTORY  
 12 OBLIGATIONS.—

13 (1) IN GENERAL.—The second sentence of sec-  
 14 tion 1156(b)(1) (42 U.S.C. 1320c–5(b)(1)) is  
 15 amended by striking “may prescribe)” and inserting  
 16 “may prescribe, except that such period may not be  
 17 less than 1 year)”.

18 (2) CONFORMING AMENDMENT.—Section  
 19 1156(b)(2) (42 U.S.C. 1320c–5(b)(2)) is amended  
 20 by striking “shall remain” and inserting “shall (sub-  
 21 ject to the minimum period specified in the second  
 22 sentence of paragraph (1)) remain”.

23 (b) REPEAL OF “UNWILLING OR UNABLE” CONDI-  
 24 TION FOR IMPOSITION OF SANCTION.—Section 1156(b)(1)  
 25 (42 U.S.C. 1320c–5(b)(1)) is amended—

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

4           (2) by striking the third sentence.

5       **SEC. 215. INTERMEDIATE SANCTIONS FOR MEDICARE**  
 6                               **HEALTH MAINTENANCE ORGANIZATIONS.**

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

9           (1) IN GENERAL.—Section 1876(i)(1) (42  
 10       U.S.C. 1395mm(i)(1)) is amended by striking “the  
 11       Secretary may terminate” and all that follows and  
 12       inserting “in accordance with procedures established  
 13       under paragraph (9), the Secretary may at any time  
 14       terminate any such contract or may impose the in-  
 15       termediate sanctions described in paragraph (6)(B)  
 16       or (6)(C) (whichever is applicable) on the eligible or-  
 17       ganization if the Secretary determines that the orga-  
 18       nization—

19                       “(A) has failed substantially to carry out  
 20       the contract;

21                       “(B) is carrying out the contract in a man-  
 22       ner substantially inconsistent with the efficient  
 23       and effective administration of this section; or

1                   “(C) no longer substantially meets the ap-  
 2                   plicable conditions of subsections (b), (c), (e),  
 3                   and (f).”.

4                   (2) OTHER INTERMEDIATE SANCTIONS FOR  
 5 MISCELLANEOUS PROGRAM VIOLATIONS.—Section  
 6 1876(i)(6) (42 U.S.C. 1395mm(i)(6)) is amended by  
 7 adding at the end the following new subparagraph:  
 8                   “(C) In the case of an eligible organization for which  
 9 the Secretary makes a determination under paragraph (1)  
 10 the basis of which is not described in subparagraph (A),  
 11 the Secretary may apply the following intermediate sanc-  
 12 tions:

13                   “(i) Civil money penalties of not more than  
 14 \$25,000 for each determination under paragraph (1)  
 15 if the deficiency that is the basis of the determina-  
 16 tion has directly adversely affected (or has the sub-  
 17 stantial likelihood of adversely affecting) an individ-  
 18 ual covered under the organization’s contract.

19                   “(ii) Civil money penalties of not more than  
 20 \$10,000 for each week beginning after the initiation  
 21 of procedures by the Secretary under paragraph (9)  
 22 during which the deficiency that is the basis of a de-  
 23 termination under paragraph (1) exists.

24                   “(iii) Suspension of enrollment of individuals  
 25 under this section after the date the Secretary noti-



1       fies the organization of a determination under para-  
2       graph (1) and until the Secretary is satisfied that  
3       the deficiency that is the basis for the determination  
4       has been corrected and is not likely to recur.”.

5               (3) PROCEDURES FOR IMPOSING SANCTIONS.—

6       Section 1876(i) (42 U.S.C. 1395mm(i)) is amended  
7       by adding at the end the following new paragraph:  
8       “(9) The Secretary may terminate a contract with an  
9       eligible organization under this section or may impose the  
10      intermediate sanctions described in paragraph (6) on the  
11      organization in accordance with formal investigation and  
12      compliance procedures established by the Secretary under  
13      which—

14              “(A) the Secretary first provides the organiza-  
15      tion with the reasonable opportunity to develop and  
16      implement a corrective action plan to correct the de-  
17      ficiencies that were the basis of the Secretary’s de-  
18      termination under paragraph (1) and the organiza-  
19      tion fails to develop or implement such a plan;

20              “(B) in deciding whether to impose sanctions,  
21      the Secretary considers aggravating factors such as  
22      whether an organization has a history of deficiencies  
23      or has not taken action to correct deficiencies the  
24      Secretary has brought to the organization’s atten-  
25      tion;

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

4 “(D) the Secretary provides the organization  
 5 with reasonable notice and opportunity for hearing  
 6 (including the right to appeal an initial decision) be-  
 7 fore imposing any sanction or terminating the con-  
 8 tract.”.

9 (4) CONFORMING AMENDMENTS.—Section  
 10 1876(i)(6)(B) (42 U.S.C. 1395mm(i)(6)(B)) is  
 11 amended by striking the second sentence.

12 (b) AGREEMENTS WITH PEER REVIEW ORGANIZA-  
 13 TIONS.—Section 1876(i)(7)(A) (42 U.S.C.  
 14 1395mm(i)(7)(A)) is amended by striking “an agreement”  
 15 and inserting “a written agreement”.

16 (c) EFFECTIVE DATE.—The amendments made by  
 17 this section shall apply with respect to contract years be-  
 18 ginning on or after January 1, 1996.

19 **SEC. 216. ADDITIONAL EXCEPTION TO ANTI-KICKBACK PEN-**  
 20 **ALTIES FOR DISCOUNTING AND MANAGED**  
 21 **CARE ARRANGEMENTS.**

22 (a) IN GENERAL.—Section 1128B(b)(3) (42 U.S.C.  
 23 1320a–7b(b)(3)) is amended—

24 (1) by striking “and” at the end of subpara-  
 25 graph (D);

1           (2) by striking the period at the end of sub-  
2 paragraph (E) and inserting “; and”; and

3           (3) by adding at the end the following new sub-  
4 paragraph:

5           “(F) any remuneration between an organization  
6 and an individual or entity providing items or serv-  
7 ices, or a combination thereof, pursuant to a written  
8 agreement between the organization and the individ-  
9 ual or entity if the organization is an eligible organi-  
10 zation under section 1876 or if the written agree-  
11 ment places the individual or entity at substantial fi-  
12 nancial risk for the cost or utilization of the items  
13 or services, or a combination thereof, which the indi-  
14 vidual or entity is obligated to provide, whether  
15 through a withhold, capitation, incentive pool, per  
16 diem payment, or any other similar risk arrange-  
17 ment which places the individual or entity at sub-  
18 stantial financial risk.”.

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

1 **SEC. 217. CRIMINAL PENALTY FOR FRAUDULENT DISPOSI-**  
2 **TION OF ASSETS IN ORDER TO OBTAIN MED-**  
3 **ICAID BENEFITS.**

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

6 (1) by striking “or” at the end of paragraph  
7 (4);

8 (2) by adding “or” at the end of paragraph (5);  
9 and

10 (3) by inserting after paragraph (5) the follow-  
11 ing new paragraph:

12 “(6) knowingly and willfully disposes of assets  
13 (including by any transfer in trust) in order for an  
14 individual to become eligible for medical assistance  
15 under a State plan under title XIX, if disposing of  
16 the assets results in the imposition of a period of in-  
17 eligibility for such assistance under section  
18 1917(c),”.

19 **SEC. 218. EFFECTIVE DATE.**

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

## Subtitle C—Data Collection

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

(a) IN GENERAL.—Title XI (42 U.S.C. 1301 et seq.), as amended by sections 211 and 215, is amended by inserting after section 1128D the following new section:

“HEALTH CARE FRAUD AND ABUSE DATA COLLECTION  
PROGRAM

9           “SEC. 1128E. (a) GENERAL PURPOSE.—Not later  
10 than January 1, 1997, the Secretary shall establish a na-  
11 tional health care fraud and abuse data collection program  
12 for the reporting of final adverse actions (not including  
13 settlements in which no findings of liability have been  
14 made) against health care providers, suppliers, or practi-  
15 tioners as required by subsection (b), with access as set  
16 forth in subsection (c).

“(b) REPORTING OF INFORMATION.—

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

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

1           “(A) The name and TIN (as defined in  
2           section 7701(a)(41) of the Internal Revenue  
3           Code of 1986) of any health care provider, sup-  
4           plier, or practitioner who is the subject of a  
5           final adverse action.

6           “(B) The name (if known) of any health  
7           care entity with which a health care provider,  
8           supplier, or practitioner is affiliated or associ-  
9           ated.

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

12          “(D) A description of the acts or omissions  
13          and injuries upon which the final adverse action  
14          was based, and such other information as the  
15          Secretary determines by regulation is required  
16          for appropriate interpretation of information re-  
17          ported under this section.

18          “(3) CONFIDENTIALITY.—In determining what  
19          information is required, the Secretary shall include  
20          procedures to assure that the privacy of individuals  
21          receiving health care services is appropriately pro-  
22          tected.

23          “(4) TIMING AND FORM OF REPORTING.—The  
24          information required to be reported under this sub-  
25          section shall be reported regularly (but not less often

1 than monthly) and in such form and manner as the  
2 Secretary prescribes. Such information shall first be  
3 required to be reported on a date specified by the  
4 Secretary.

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

8 “(c) DISCLOSURE AND CORRECTION OF INFORMA-  
9 TION.—

10 “(1) DISCLOSURE.—With respect to the infor-  
11 mation about final adverse actions (not including  
12 settlements in which no findings of liability have  
13 been made) reported to the Secretary under this sec-  
14 tion respecting a health care provider, supplier, or  
15 practitioner, the Secretary shall, by regulation, pro-  
16 vide for—

17 “(A) disclosure of the information, upon  
18 request, to the health care provider, supplier, or  
19 licensed practitioner, and

20 “(B) procedures in the case of disputed ac-  
21 curacy of the information.

22 “(2) CORRECTIONS.—Each Government agency  
23 and health plan shall report corrections of informa-  
24 tion already reported about any final adverse action  
25 taken against a health care provider, supplier, or

1 practitioner, in such form and manner that the Sec-  
2 retary prescribes by regulation.

3 “(d) ACCESS TO REPORTED INFORMATION.—

4 “(1) AVAILABILITY.—The information in this  
5 database shall be available to Federal and State gov-  
6 ernment agencies and health plans pursuant to pro-  
7 cedures that the Secretary shall provide by regula-  
8 tion.

9 “(2) FEES FOR DISCLOSURE.—The Secretary  
10 may establish or approve reasonable fees for the dis-  
11 closure of information in this database (other than  
12 with respect to requests by Federal agencies). The  
13 amount of such a fee shall be sufficient to recover  
14 the full costs of operating the database. Such fees  
15 shall be available to the Secretary or, in the Sec-  
16 retary’s discretion to the agency designated under  
17 this section to cover such costs.

18 “(e) PROTECTION FROM LIABILITY FOR REPORT-  
19 ING.—No person or entity, including the agency des-  
20 ignated by the Secretary in subsection (b)(5) shall be held  
21 liable in any civil action with respect to any report made  
22 as required by this section, without knowledge of the fal-  
23 sity of the information contained in the report.

24 “(f) DEFINITIONS AND SPECIAL RULES.—For pur-  
25 poses of this section:



1 “(1) FINAL ADVERSE ACTION.—

2 “(A) IN GENERAL.—The term ‘final ad-  
3 verse action’ includes:

4 “(i) Civil judgments against a health  
5 care provider, supplier, or practitioner in  
6 Federal or State court related to the deliv-  
7 ery of a health care item or service.

8 “(ii) Federal or State criminal convic-  
9 tions related to the delivery of a health  
10 care item or service.

11 “(iii) Actions by Federal or State  
12 agencies responsible for the licensing and  
13 certification of health care providers, sup-  
14 pliers, and licensed health care practition-  
15 ers, including—

16 “(I) formal or official actions,  
17 such as revocation or suspension of a  
18 license (and the length of any such  
19 suspension), reprimand, censure or  
20 probation,

21 “(II) any other loss of license or  
22 the right to apply for, or renew, a li-  
23 cense of the provider, supplier, or  
24 practitioner, whether by operation of

1 law, voluntary surrender, non-renew-  
2 ability, or otherwise, or

3 “(III) any other negative action  
4 or finding by such Federal or State  
5 agency that is publicly available infor-  
6 mation.

7 “(iv) Exclusion from participation in  
8 Federal or State health care programs.

9 “(v) Any other adjudicated actions or  
10 decisions that the Secretary shall establish  
11 by regulation.

12 “(B) EXCEPTION.—The term does not in-  
13 clude any action with respect to a malpractice  
14 claim.

15 “(2) PRACTITIONER.—The terms ‘licensed  
16 health care practitioner’, ‘licensed practitioner’, and  
17 ‘practitioner’ mean, with respect to a State, an indi-  
18 vidual who is licensed or otherwise authorized by the  
19 State to provide health care services (or any individ-  
20 ual who, without authority holds himself or herself  
21 out to be so licensed or authorized).

22 “(3) GOVERNMENT AGENCY.—The term ‘Gov-  
23 ernment agency’ shall include:

24 “(A) The Department of Justice.

1           “(B) The Department of Health and  
2           Human Services.

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

8           “(D) State law enforcement agencies.

9           “(E) State medicaid fraud control units.

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

13          “(4) HEALTH PLAN.—The term ‘health plan’  
14          has the meaning given such term by section  
15          1128C(c).

16          “(5) DETERMINATION OF CONVICTION.—For  
17          purposes of paragraph (1), the existence of a convic-  
18          tion shall be determined under paragraph (4) of sec-  
19          tion 1128(i).”.

20          (b) IMPROVED PREVENTION IN ISSUANCE OF MEDI-  
21          CARE PROVIDER NUMBERS.—Section 1842(r) (42 U.S.C.  
22          1395u(r)) is amended by adding at the end the following  
23          new sentence: “Under such system, the Secretary may im-  
24          pose appropriate fees on such physicians to cover the costs

1 of investigation and recertification activities with respect  
 2 to the issuance of the identifiers.”.

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

### 5   **SEC. 231. SOCIAL SECURITY ACT CIVIL MONETARY PEN-** 6                   **ALTIES.**

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

9                   (1) In the third sentence of subsection (a), by  
 10 striking “programs under title XVIII” and inserting  
 11 “Federal health care programs (as defined in section  
 12 1128B(f)(1))”.

13                   (2) In subsection (f)—

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

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

18                           “(3) With respect to amounts recovered arising  
 19 out of a claim under a Federal health care program  
 20 (as defined in section 1128B(f)), the portion of such  
 21 amounts as is determined to have been paid by the  
 22 program shall be repaid to the program, and the  
 23 portion of such amounts attributable to the amounts  
 24 recovered under this section by reason of the amend-  
 25 ments made by the Health Coverage Availability and

1       Affordability Act of 1996 (as estimated by the Sec-  
2       retary) shall be deposited into the Federal Hospital  
3       Insurance Trust Fund pursuant to section  
4       1817(k)(2)(C).”.

5               (3) In subsection (i)—

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

10                      (B) in paragraph (4), by striking “a health  
11                      insurance or medical services program under  
12                      title XVIII or XIX of this Act” and inserting  
13                      “a Federal health care program (as so de-  
14                      fined)”, and

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

18               (4) By adding at the end the following new sub-  
19       section:

20               “(m)(1) For purposes of this section, with respect to  
21       a Federal health care program not contained in this Act,  
22       references to the Secretary in this section shall be deemed  
23       to be references to the Secretary or Administrator of the  
24       department or agency with jurisdiction over such program  
25       and references to the Inspector General of the Department

1 of Health and Human Services in this section shall be  
2 deemed to be references to the Inspector General of the  
3 applicable department or agency.

4 “(2)(A) The Secretary and Administrator of the de-  
5 partments and agencies referred to in paragraph (1) may  
6 include in any action pursuant to this section, claims with-  
7 in the jurisdiction of other Federal departments or agen-  
8 cies as long as the following conditions are satisfied:

9 “(i) The case involves primarily claims submit-  
10 ted to the Federal health care programs of the de-  
11 partment or agency initiating the action.

12 “(ii) The Secretary or Administrator of the de-  
13 partment or agency initiating the action gives notice  
14 and an opportunity to participate in the investiga-  
15 tion to the Inspector General of the department or  
16 agency with primary jurisdiction over the Federal  
17 health care programs to which the claims were sub-  
18 mitted.

19 “(B) If the conditions specified in subparagraph (A)  
20 are fulfilled, the Inspector General of the department or  
21 agency initiating the action is authorized to exercise all  
22 powers granted under the Inspector General Act of 1978  
23 with respect to the claims submitted to the other depart-  
24 ments or agencies to the same manner and extent as pro-

1 vided in that Act with respect to claims submitted to such  
2 departments or agencies.”.

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

6 (1) by striking “or” at the end of paragraph  
7 (1)(D);

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

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

12 (4) by inserting after paragraph (3) the follow-  
13 ing new paragraph:

14 “(4) in the case of a person who is not an orga-  
15 nization, agency, or other entity, is excluded from  
16 participating in a program under title XVIII or a  
17 State health care program in accordance with this  
18 subsection or under section 1128 and who, at the  
19 time of a violation of this subsection—

20 “(i) retains a direct or indirect ownership  
21 or control interest in an entity that is partici-  
22 pating in a program under title XVIII or a  
23 State health care program, and who knows or  
24 should know of the action constituting the basis  
25 for the exclusion; or

1                   “(ii) is an officer or managing employee  
2                   (as defined in section 1126(b)) of such an en-  
3                   tity;”.

4           (c) MODIFICATIONS OF AMOUNTS OF PENALTIES  
5 AND ASSESSMENTS.—Section 1128A(a) (42 U.S.C.  
6 1320a–7a(a)), as amended by subsection (b), is amended  
7 in the matter following paragraph (4)—

8                   (1) by striking “\$2,000” and inserting  
9                   “\$10,000”;

10                  (2) by inserting “; in cases under paragraph  
11                  (4), \$10,000 for each day the prohibited relationship  
12                  occurs” after “false or misleading information was  
13                  given”; and

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

16           (d) CLAIM FOR ITEM OR SERVICE BASED ON INCOR-  
17 RECT CODING OR MEDICALLY UNNECESSARY SERV-  
18 ICES.—Section 1128A(a)(1) (42 U.S.C. 1320a–7a(a)(1))  
19 is amended—

20                   (1) in subparagraph (A) by striking “claimed,”  
21                   and inserting “claimed, including any person who  
22                   engages in a pattern or practice of presenting or  
23                   causing to be presented a claim for an item or serv-  
24                   ice that is based on a code that the person knows  
25                   or should know will result in a greater payment to



1 the person than the code the person knows or should  
 2 know is applicable to the item or service actually  
 3 provided,”;

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

6 (3) in subparagraph (D), by striking “; or” and  
 7 inserting “, or”; and

8 (4) by inserting after subparagraph (D) the fol-  
 9 lowing new subparagraph:

10 “(E) is for a medical or other item or serv-  
 11 ice that a person knows or should know is not  
 12 medically necessary; or”.

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

18 (f) PROCEDURAL PROVISIONS.—Section 1876(i)(6)  
 19 (42 U.S.C. 1395mm(i)(6)), as amended by section  
 20 215(a)(2), is amended by adding at the end the following  
 21 new subparagraph:

22 “(D) The provisions of section 1128A (other than  
 23 subsections (a) and (b)) shall apply to a civil money pen-  
 24 alty under subparagraph (B)(i) or (C)(i) in the same man-

ner as such provisions apply to a civil money penalty or proceeding under section 1128A(a).”.

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

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

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

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

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

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

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

1           (2)     REMUNERATION     DEFINED.—Section  
2     1128A(i) (42 U.S.C. 1320a–7a(i)) is amended by  
3     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 beneficiaries, third party  
7 payers, and providers, to whom claims are pre-  
8 sented and as long as the differentials meet the  
9 standards as defined in regulations promulgated  
10 by the Secretary not later than 180 days after  
11 the date of the enactment of the Health Cov-  
12 erage Availability and Affordability Act of  
13 1996; or

14 “(C) incentives given to individuals to pro-  
15 mote the delivery of preventive care as deter-  
16 mined by the Secretary in regulations so pro-  
17 mulgated.”.

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

20 **SEC. 232. CLARIFICATION OF LEVEL OF INTENT REQUIRED**  
21 **FOR IMPOSITION OF SANCTIONS.**

22 (a) CLARIFICATION OF LEVEL OF KNOWLEDGE RE-  
23 QUIRED FOR IMPOSITION OF CIVIL MONETARY PEN-  
24 ALTIES.—

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

3           (A) in paragraphs (1) and (2), by inserting  
4 “knowingly” before “presents” each place it ap-  
5 pears; and

6           (B) in paragraph (3), by striking “gives”  
7 and inserting “knowingly gives or causes to be  
8 given”.

9           (2) DEFINITION OF STANDARD.—Section  
10 1128A(i) (42 U.S.C. 1320a–7a(i)) is amended by  
11 adding at the end the following new paragraph:

12           “(6) The term ‘should know’ means that a per-  
13 son, with respect to information—

14           “(A) acts in deliberate ignorance of the  
15 truth or falsity of the information; or

16           “(B) acts in reckless disregard of the truth  
17 or falsity of the information,

18 and no proof of specific intent to defraud is re-  
19 quired.”.

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

1 **SEC. 233. PENALTY FOR FALSE CERTIFICATION FOR HOME**  
2 **HEALTH SERVICES.**

3 (a) IN GENERAL.—Section 1128A(b) (42 U.S.C.  
4 1320a–7a(b)) is amended by adding at the end the follow-  
5 ing new paragraph:

6 “(3)(A) Any physician who executes a document de-  
7 scribed in subparagraph (B) with respect to an individual  
8 knowing that all of the requirements referred to in such  
9 subparagraph are not met with respect to the individual  
10 shall be subject to a civil monetary penalty of not more  
11 than the greater of—

12 “(i) \$5,000, or

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

16 “(B) A document described in this subparagraph is  
17 any document that certifies, for purposes of title XVIII,  
18 that an individual meets the requirements of section  
19 1814(a)(2)(C) or 1835(a)(2)(A) in the case of home  
20 health services furnished to the individual.”.

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

1     **Subtitle E—Revisions to Criminal**  
2                     **Law**

3     **SEC. 241. DEFINITION OF FEDERAL HEALTH CARE OF-**  
4                     **FENSE.**

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

8     **“§ 24. Definition of Federal health care offense**

9         “(a) As used in this title, the term ‘Federal health  
10 care offense’ means a violation of, or a criminal conspiracy  
11 to violate—

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

13             “(2) section 287, 371, 664, 666, 1001, 1027,  
14 1341, 1343, or 1954 of this title, if the violation or  
15 conspiracy relates to a health care benefit program.

16         “(b) As used in this title, the term ‘health care bene-  
17 fit program’ has the meaning given such term in section  
18 1347(b) of this title.”.

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

“24. Definition relating to Federal health care offense defined.”.

23     **SEC. 242. HEALTH CARE FRAUD.**

24         (a) OFFENSE.—

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

4   **“§ 1347. Health care fraud**

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

7           “(1) to defraud any health care benefit pro-  
8       gram; or

9           “(2) to obtain, by means of false or fraudulent  
10      pretenses, representations, or promises, any of the  
11      money or property owned by, or under the custody  
12      or control of, any health care benefit program,  
13      in connection with the delivery of or payment for health  
14      care benefits, items, or services, shall be fined under this  
15      title or imprisoned not more than 10 years, or both. If  
16      the violation results in serious bodily injury (as defined  
17      in section 1365 of this title), such person shall be fined  
18      under this title or imprisoned not more than 20 years, or  
19      both; and if the violation results in death, such person  
20      shall be fined under this title, or imprisoned for any term  
21      of years or for life, or both.

22      “(b) As used in this section, the term ‘health care  
23      benefit program’ means any public or private plan or con-  
24      tract, affecting commerce, under which any medical bene-  
25      fit, item, or service is provided to any individual, and in-



cludes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract.”.

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

“1347. Health care fraud.”.

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

**SEC. 243. THEFT OR EMBEZZLEMENT.**

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

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

“(a) Whoever embezzles, steals, or otherwise without authority willfully and unlawfully converts to the use of any person other than the rightful owner, or intentionally misapplies any of the moneys, funds, securities, premiums, credits, property, or other assets of a health care benefit

1 program, shall be fined under this title or imprisoned not  
 2 more than 10 years, or both; but if the value of such prop-  
 3 erty does not exceed the sum of \$100 the defendant shall  
 4 be fined under this title or imprisoned not more than one  
 5 year, or both.

6 “(b) As used in this section, the term ‘health care  
 7 benefit program’ has the meaning given such term in sec-  
 8 tion 1347(b) of this title.”.

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

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

12 **SEC. 244. FALSE STATEMENTS.**

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

16 **“§ 1035. False statements relating to health care mat-  
 17 ters**

18 “(a) Whoever, in any matter involving a health care  
 19 benefit program, knowingly—

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

22 “(2) makes any false, fictitious, or fraudulent  
 23 statements or representations, or makes or uses any  
 24 false writing or document knowing the same to con-

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

“(b) As used in this section, the term ‘health care benefit program’ has the meaning given such term in section 1347(b) of this title.”.

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

“1035. False statements relating to health care matters.”.

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

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

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

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

1       “(b) As used in this section the term ‘criminal inves-  
 2     tigator’ means any individual duly authorized by a depart-  
 3     ment, agency, or armed force of the United States to con-  
 4     duct or engage in investigations for prosecutions for viola-  
 5     tions of health care offenses.”.

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

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

10   **SEC. 246. LAUNDERING OF MONETARY INSTRUMENTS.**

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

13               “(F) Any act or activity constituting an of-  
 14               fense involving a Federal health care offense.”.

15   **SEC. 247. INJUNCTIVE RELIEF RELATING TO HEALTH CARE**  
 16               **OFFENSES.**

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

19               (1) by striking “or” at the end of subparagraph  
 20               (A);

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

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

24               “(C) committing or about to commit a  
 25               Federal health care offense.”.

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

4 **SEC. 248. AUTHORIZED INVESTIGATIVE DEMAND PROCE-**  
5 **DURES.**

6 (a) IN GENERAL.—Chapter 233 of title 18, United  
7 States Code, is amended by adding after section 3485 the  
8 following:

9 **“§ 3486. Authorized investigative demand procedures**

10 “(a) AUTHORIZATION.—In any investigation relating  
11 to any act or activity involving a Federal health care of-  
12 fense, the Attorney General or the Attorney General’s des-  
13 ignee may issue in writing and cause to be served a sub-  
14 poena requiring the production of any records (including  
15 any books, papers, documents, electronic media, or other  
16 objects or tangible things), which may be relevant to an  
17 authorized law enforcement inquiry, that a person or legal  
18 entity may possess or have care, custody, or control. A  
19 subpoena shall describe the objects required to be pro-  
20 duced and prescribe a return date within a reasonable pe-  
21 riod of time within which the objects can be assembled  
22 and made available.

23 “(b) SERVICE.—A subpoena issued under this section  
24 may be served by any person designated in the subpoena  
25 to serve it. Service upon a natural person may be made

1 by personal delivery of the subpoena to him. Service may  
2 be made upon a domestic or foreign corporation or upon  
3 a partnership or other unincorporated association which  
4 is subject to suit under a common name, by delivering the  
5 subpoena to an officer, to a managing or general agent,  
6 or to any other agent authorized by appointment or by  
7 law to receive service of process. The affidavit of the per-  
8 son serving the subpoena entered on a true copy thereof  
9 by the person serving it shall be proof of service.

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

24       “(d) IMMUNITY FROM CIVIL LIABILITY.—Notwith-  
25 standing any Federal, State, or local law, any person, in-

1 cluding officers, agents, and employees, receiving a sum-  
2 mons under this section, who complies in good faith with  
3 the summons and thus produces the materials sought,  
4 shall not be liable in any court of any State or the United  
5 States to any customer or other person for such produc-  
6 tion or for nondisclosure of that production to the cus-  
7 tomer.

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

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

23       “(3) Upon the granting of such order, the court, in  
24 determining the extent to which any disclosure of all or

1 any part of any record is necessary, shall impose appro-  
 2 priate safeguards against unauthorized disclosure.”.

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

“3486. Authorized investigative demand procedures.”.

7 (c) CONFORMING AMENDMENT.—Section  
 8 1510(b)(3)(B) of title 18, United States Code, is amended  
 9 by inserting “or a Department of Justice subpoena (issued  
 10 under section 3486 of title 18),” after “subpoena”.

11 **SEC. 249. FORFEITURES FOR FEDERAL HEALTH CARE OF-**  
 12 **FENSES.**

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

16 “(6) The court, in imposing sentence on a person con-  
 17 victed of a Federal health care offense, shall order the per-  
 18 son to forfeit property, real or personal, that constitutes  
 19 or is derived, directly or indirectly, from gross proceeds  
 20 traceable to the commission of the offense.”.

21 (b) CONFORMING AMENDMENT.—Section  
 22 982(b)(1)(A) of title 18, United States Code, is amended  
 23 by inserting “or (a)(6)” after “(a)(1)”.

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



1           (1) IN GENERAL.—After the payment of the  
2           costs of asset forfeiture has been made, and notwith-  
3           standing any other provision of law, the Secretary of  
4           the Treasury shall deposit into the Federal Hospital  
5           Insurance Trust Fund pursuant to section  
6           1817(k)(2)(C) of the Social Security Act, as added  
7           by section 301(b), an amount equal to the net  
8           amount realized from the forfeiture of property by  
9           reason of a Federal health care offense pursuant to  
10          section 982(a)(6) of title 18, United States Code.

11          (2) COSTS OF ASSET FORFEITURE.—For pur-  
12          poses of paragraph (1), the term “payment of the  
13          costs of asset forfeiture” means—

14                (A) the payment, at the discretion of the  
15                Attorney General, of any expenses necessary to  
16                seize, detain, inventory, safeguard, maintain,  
17                advertise, sell, or dispose of property under sei-  
18                zure, detention, or forfeited, or of any other  
19                necessary expenses incident to the seizure, de-  
20                tention, forfeiture, or disposal of such property,  
21                including payment for—

22                       (i) contract services,

23                       (ii) the employment of outside con-  
24                       tractors to operate and manage properties  
25                       or provide other specialized services nec-

1            necessary to dispose of such properties in an  
2            effort to maximize the return from such  
3            properties; and

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

8            (B) at the discretion of the Attorney Gen-  
9            eral, the payment of awards for information or  
10           assistance leading to a civil or criminal forfeit-  
11           ure involving any Federal agency participating  
12           in the Health Care Fraud and Abuse Control  
13           Account;

14           (C) the compromise and payment of valid  
15           liens and mortgages against property that has  
16           been forfeited, subject to the discretion of the  
17           Attorney General to determine the validity of  
18           any such lien or mortgage and the amount of  
19           payment to be made, and the employment of at-  
20           torneys and other personnel skilled in State real  
21           estate law as necessary;

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

1 (E) the payment of State and local prop-  
 2 erty taxes on forfeited real property that ac-  
 3 crued between the date of the violation giving  
 4 rise to the forfeiture and the date of the forfeit-  
 5 ure order.

## 6 **Subtitle F—Administrative** 7 **Simplification**

### 8 **SEC. 251. PURPOSE.**

9 It is the purpose of this subtitle to improve the medi-  
 10 care program under title XVIII of the Social Security Act,  
 11 the medicaid program under title XIX of such Act, and  
 12 the efficiency and effectiveness of the health care system,  
 13 by encouraging the development of a health information  
 14 system through the establishment of standards and re-  
 15 quirements for the electronic transmission of certain  
 16 health information.

### 17 **SEC. 252. ADMINISTRATIVE SIMPLIFICATION.**

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

#### 20 **“PART C—ADMINISTRATIVE SIMPLIFICATION**

#### 21 **“SEC. 1171. DEFINITIONS.**

22 “For purposes of this part:

23 “(1) CLEARINGHOUSE.—The term ‘clearing-  
 24 house’ means a public or private entity that—

1           “(A) processes or facilitates the processing  
2           of nonstandard data elements of health infor-  
3           mation into standard data elements; or

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

6           “(2) CODE SET.—The term ‘code set’ means  
7           any set of codes used for encoding data elements,  
8           such as tables of terms, medical concepts, medical  
9           diagnostic codes, or medical procedure codes.

10          “(3) COORDINATION OF BENEFITS.—The term  
11          ‘coordination of benefits’ means determining and co-  
12          ordinating the financial obligations of health plans  
13          when health care benefits are payable under 2 or  
14          more health plans.

15          “(4) HEALTH CARE PROVIDER.—The term  
16          ‘health care provider’ includes a provider of services  
17          (as defined in section 1861(u)), a provider of medi-  
18          cal or other health services (as defined in section  
19          1861(s)), and any other person furnishing health  
20          care services or supplies.

21          “(5) HEALTH INFORMATION.—The term ‘health  
22          information’ means any information, whether oral or  
23          recorded in any form or medium that—

24                 “(A) is created or received by a health care  
25                 provider, health plan, public health authority,

1 employer, life insurer, school or university, or  
2 clearinghouse; and

3 “(B) relates to the past, present, or future  
4 physical or mental health or condition of an in-  
5 dividual, the provision of health care to an indi-  
6 vidual, or the past, present, or future payment  
7 for the provision of health care to an individual.

8 “(6) HEALTH PLAN.—The term ‘health plan’  
9 means a plan which provides, or pays the cost of,  
10 health benefits. Such term includes the following, or  
11 any combination thereof:

12 “(A) Part A or part B of the medicare  
13 program under title XVIII.

14 “(B) The medicaid program under title  
15 XIX.

16 “(C) A medicare supplemental policy (as  
17 defined in section 1882(g)(1)).

18 “(D) Coverage issued as a supplement to  
19 liability insurance.

20 “(E) General liability insurance.

21 “(F) Worker’s compensation or similar in-  
22 surance.

23 “(G) Automobile or automobile medical-  
24 payment insurance.

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

7           “(I) A hospital or fixed indemnity income-  
8           protection policy.

9           “(J) An employee welfare benefit plan, as  
10          defined in section 3(1) of the Employee Retirement  
11          Income Security Act of 1974 (29 U.S.C.  
12          1002(1)), but only to the extent the plan is es-  
13          tablished or maintained for the purpose of pro-  
14          viding health benefits and has 50 or more par-  
15          ticipants (as defined in section 3(7) of such  
16          Act).

17          “(K) An employee welfare benefit plan or  
18          any other arrangement which is established or  
19          maintained for the purpose of offering or pro-  
20          viding health benefits to the employees of 2 or  
21          more employers.

22          “(L) The health care program for active  
23          military personnel under title 10, United States  
24          Code.

1           “(M) The veterans health care program  
2           under chapter 17 of title 38, United States  
3           Code.

4           “(N) The Civilian Health and Medical Pro-  
5           gram of the Uniformed Services (CHAMPUS),  
6           as defined in section 1073(4) of title 10, United  
7           States Code.

8           “(O) The Indian health service program  
9           under the Indian Health Care Improvement Act  
10          (25 U.S.C. 1601 et seq.).

11          “(P) The Federal Employees Health Bene-  
12          fit Plan under chapter 89 of title 5, United  
13          States Code.

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

16          “(7) INDIVIDUALLY IDENTIFIABLE HEALTH IN-  
17          FORMATION.—The term ‘individually identifiable  
18          health information’ means any information, includ-  
19          ing demographic information collected from an indi-  
20          vidual, that—

21                 “(A) is created or received by a health care  
22                 provider, health plan, employer, or clearing-  
23                 house; and

24                 “(B) relates to the past, present, or future  
25                 physical or mental health or condition of an in-

1           dividual, the provision of health care to an indi-  
2           vidual, or the past, present, or future payment  
3           for the provision of health care to an individual,  
4           and—

5                     “(i) identifies an individual; or

6                     “(ii) with respect to which there is a  
7                     reasonable basis to believe that the infor-  
8                     mation can be used to identify an individ-  
9                     ual.

10           “(8) STANDARD.—The term ‘standard’, when  
11           used with reference to a data element of health in-  
12           formation or a transaction referred to in section  
13           1173(a)(1), means any such data element or trans-  
14           action that meets each of the standards and imple-  
15           mentation specifications adopted or established by  
16           the Secretary with respect to the data element or  
17           transaction under sections 1172 and 1173.

18           “(9) STANDARD SETTING ORGANIZATION.—The  
19           term ‘standard setting organization’ means a stand-  
20           ard setting organization accredited by the American  
21           National Standards Institute, including the National  
22           Council for Prescription Drug Programs, that devel-  
23           ops standards for information transactions, data ele-  
24           ments, or any other standard that is necessary to,  
25           or will facilitate, the implementation of this part.



1   **“SEC. 1172. GENERAL REQUIREMENTS FOR ADOPTION OF**  
2                   **STANDARDS.**

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

6                   “(1) A health plan.

7                   “(2) A clearinghouse.

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

11          “(b) REDUCTION OF COSTS.—Any standard or modi-  
12 fication of a standard adopted under this part shall be  
13 consistent with the objective of reducing the administra-  
14 tive costs of providing and paying for health care.

15          “(c) ROLE OF STANDARD SETTING ORGANIZA-  
16 TIONS.—

17                   “(1) IN GENERAL.—Except as provided in para-  
18 graph (2), any standard or modification of a stand-  
19 ard adopted under this part shall be developed or  
20 modified by a standard setting organization.

21                   “(2) SPECIAL RULE.—The Secretary may adopt  
22 a standard or modification of a standard that is dif-  
23 ferent from any standard developed or modified by  
24 a standard setting organization, if—

25                                   “(A) the different standard or modification  
26 will substantially reduce administrative costs to

1 health care providers and health plans com-  
2 pared to the alternatives; and

3 “(B) the standard or modification is pro-  
4 mulgated in accordance with the rulemaking  
5 procedures of subchapter III of chapter 5 of  
6 title 5, United States Code.

7 “(d) IMPLEMENTATION SPECIFICATIONS.—The Sec-  
8 retary shall establish specifications for implementing each  
9 of the standards and modifications adopted under this  
10 part.

11 “(e) PROTECTION OF TRADE SECRETS.—Except as  
12 otherwise required by law, a standard or modification of  
13 a standard adopted under this part shall not require dis-  
14 closure of trade secrets or confidential commercial infor-  
15 mation by a person required to comply with this part.

16 “(f) ASSISTANCE TO THE SECRETARY.—In complying  
17 with the requirements of this part, the Secretary shall rely  
18 on the recommendations of the Health Information Advi-  
19 sory Committee established under section 1179 and shall  
20 consult with appropriate Federal and State agencies and  
21 private organizations. The Secretary shall publish in the  
22 Federal Register the recommendations of the Health In-  
23 formation Advisory Committee regarding the adoption of  
24 a standard or modification of a standard under this part.

1 **“SEC. 1173. STANDARDS FOR INFORMATION TRANSACTIONS**  
2 **AND DATA ELEMENTS.**

3 “(a) STANDARDS TO ENABLE ELECTRONIC EX-  
4 CHANGE.—

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

9 “(A) appropriate for the financial and ad-  
10 ministrative transactions described in para-  
11 graph (2); and

12 “(B) related to other financial and admin-  
13 istrative transactions determined appropriate by  
14 the Secretary consistent with the goals of im-  
15 proving the operation of the health care system  
16 and reducing administrative costs.

17 “(2) TRANSACTIONS.—The transactions re-  
18 ferred to in paragraph (1)(A) are the following:

19 “(A) Claims (including coordination of  
20 benefits) or equivalent encounter information.

21 “(B) Claims attachments.

22 “(C) Enrollment and disenrollment.

23 “(D) Eligibility.

24 “(E) Health care payment and remittance  
25 advice.

26 “(F) Premium payments.

1 “(G) First report of injury.

2 “(H) Claims status.

3 “(I) Referral certification and authoriza-  
4 tion.

5 “(3) ACCOMMODATION OF SPECIFIC PROVID-  
6 ERS.—The standards adopted by the Secretary  
7 under paragraph (1) shall accommodate the needs of  
8 different types of health care providers.

9 “(b) UNIQUE HEALTH IDENTIFIERS.—

10 “(1) IN GENERAL.—The Secretary shall adopt  
11 standards providing for a standard unique health  
12 identifier for each individual, employer, health plan,  
13 and health care provider for use in the health care  
14 system. In carrying out the preceding sentence for  
15 each health plan and health care provider, the Sec-  
16 retary shall take into account multiple uses for iden-  
17 tifiers and multiple locations and specialty classifica-  
18 tions for health care providers.

19 “(2) USE OF IDENTIFIERS.—The standards  
20 adopted under paragraphs (1) shall specify the pur-  
21 poses for which a unique health identifier may be  
22 used.

23 “(c) CODE SETS.—

24 “(1) IN GENERAL.—The Secretary shall adopt  
25 standards that—

1           “(A) select code sets for appropriate data  
2           elements for the transactions referred to in sub-  
3           section (a)(1) from among the code sets that  
4           have been developed by private and public enti-  
5           ties; or

6           “(B) establish code sets for such data ele-  
7           ments if no code sets for the data elements  
8           have been developed.

9           “(2) DISTRIBUTION.—The Secretary shall es-  
10          tablish efficient and low-cost procedures for distribu-  
11          tion (including electronic distribution) of code sets  
12          and modifications made to such code sets under sec-  
13          tion 1174(b).

14          “(d) SECURITY STANDARDS FOR HEALTH INFORMA-  
15          TION.—

16               “(1) SECURITY STANDARDS.—The Secretary  
17          shall adopt security standards that—

18                       “(A) take into account—

19                               “(i) the technical capabilities of record  
20                               systems used to maintain health informa-  
21                               tion;

22                               “(ii) the costs of security measures;

23                               “(iii) the need for training persons  
24                               who have access to health information;

1 “(iv) the value of audit trails in com-  
2 puterized record systems; and

3 “(v) the needs and capabilities of  
4 small health care providers and rural  
5 health care providers (as such providers  
6 are defined by the Secretary); and

7 “(B) ensure that a clearinghouse, if it is  
8 part of a larger organization, has policies and  
9 security procedures which isolate the activities  
10 of the clearinghouse with respect to processing  
11 information in a manner that prevents unau-  
12 thorized access to such information by such  
13 larger organization.

14 “(2) SAFEGUARDS.—Each person described in  
15 section 1172(a) who maintains or transmits health  
16 information shall maintain reasonable and appro-  
17 priate administrative, technical, and physical safe-  
18 guards—

19 “(A) to ensure the integrity and confiden-  
20 tiality of the information;

21 “(B) to protect against any reasonably an-  
22 ticipated—

23 “(i) threats or hazards to the security  
24 or integrity of the information; and

1                   “(ii) unauthorized uses or disclosures  
2                   of the information; and

3                   “(C) otherwise to ensure compliance with  
4                   this part by the officers and employees of such  
5                   person.

6           “(e) PRIVACY STANDARDS FOR HEALTH INFORMA-  
7   TION.—The Secretary shall adopt standards with respect  
8   to the privacy of individually identifiable health informa-  
9   tion. Such standards shall include standards concerning  
10   at least the following:

11               “(1) The rights of an individual who is a sub-  
12               ject of such information.

13               “(2) The procedures to be established for the  
14               exercise of such rights.

15               “(3) The uses and disclosures of such informa-  
16               tion that are authorized or required.

17           “(f) ELECTRONIC SIGNATURE.—

18               “(1) IN GENERAL.—The Secretary, in coordina-  
19               tion with the Secretary of Commerce, shall adopt  
20               standards specifying procedures for the electronic  
21               transmission and authentication of signatures, com-  
22               pliance with which shall be deemed to satisfy Fed-  
23               eral and State statutory requirements for written  
24               signatures with respect to the transactions referred  
25               to in subsection (a)(1).

1           “(2) PAYMENTS FOR SERVICES AND PRE-  
2           MIUMS.—Nothing in this part shall be construed to  
3           prohibit payment for health care services or health  
4           plan premiums by debit, credit, payment card or  
5           numbers, or other electronic means.

6           “(g) COORDINATION OF BENEFITS.—The Secretary  
7           shall adopt standards—

8                   “(1) for determining the financial liability of  
9           health plans when health care benefits are payable  
10          under two or more health plans; and

11                   “(2) for transferring among health plans appro-  
12          priate standard data elements needed for the coordi-  
13          nation of benefits, the sequential processing of  
14          claims, and other data elements for individuals who  
15          have more than one health plan.

16   **“SEC. 1174. TIMETABLES FOR ADOPTION OF STANDARDS.**

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

22           “(b) ADDITIONS AND MODIFICATIONS TO STAND-  
23          ARDS.—

24                   “(1) IN GENERAL.—Except as provided in para-  
25          graph (2), the Secretary shall review the standards



1       adopted under section 1173, and shall adopt addi-  
2       tional or modified standards, as determined appro-  
3       priate, but not more frequently than once every 6  
4       months. Any addition or modification to a standard  
5       shall be completed in a manner which minimizes the  
6       disruption and cost of compliance.

7               “(2) SPECIAL RULES.—

8               “(A) FIRST 12-MONTH PERIOD.—Except  
9       with respect to additions and modifications to  
10      code sets under subparagraph (B), the Sec-  
11      retary may not adopt any modification to a  
12      standard adopted under this part during the  
13      12-month period beginning on the date the  
14      standard is initially adopted, unless the Sec-  
15      retary determines that the modification is nec-  
16      essary in order to permit compliance with the  
17      standard.

18              “(B) ADDITIONS AND MODIFICATIONS TO  
19      CODE SETS.—

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

24              “(ii) ADDITIONAL RULES.—If a code  
25      set is modified under this subsection, the

1 modified code set shall include instructions  
2 on how data elements of health informa-  
3 tion that were encoded prior to the modi-  
4 fication may be converted or translated so  
5 as to preserve the informational value of  
6 the data elements that existed before the  
7 modification. Any modification to a code  
8 set under this subsection shall be imple-  
9 mented in a manner that minimizes the  
10 disruption and cost of complying with such  
11 modification.

12 **“SEC. 1175. REQUIREMENTS.**

13 “(a) CONDUCT OF TRANSACTIONS BY PLANS.—

14 “(1) IN GENERAL.—If a person desires to con-  
15 duct a transaction referred to in section 1173(a)(1)  
16 with a health plan as a standard transaction—

17 “(A) the health plan may not refuse to  
18 conduct such transaction as a standard trans-  
19 action;

20 “(B) the health plan may not delay such  
21 transaction, or otherwise adversely affect, or at-  
22 tempt to adversely affect, the person or the  
23 transaction on the ground that the transaction  
24 is a standard transaction; and

1           “(C) the information transmitted and re-  
2           ceived in connection with the transaction shall  
3           be in the form of standard data elements of  
4           health information.

5           “(2) SATISFACTION OF REQUIREMENTS.—A  
6           health plan may satisfy the requirements under  
7           paragraph (1) by—

8           “(A) directly transmitting and receiving  
9           standard data elements of health information;  
10          or

11          “(B) submitting nonstandard data ele-  
12          ments to a clearinghouse for processing into  
13          standard data elements and transmission by the  
14          clearinghouse, and receiving standard data ele-  
15          ments through the clearinghouse.

16          “(3) TIMETABLE FOR COMPLIANCE.—Para-  
17          graph (1) shall not be construed to require a health  
18          plan to comply with any standard, implementation  
19          specification, or modification to a standard or speci-  
20          fication adopted or established by the Secretary  
21          under sections 1172 and 1173 at any time prior to  
22          the date on which the plan is required to comply  
23          with the standard or specification under subsection  
24          (b).

25          “(b) COMPLIANCE WITH STANDARDS.—

1           “(1) INITIAL COMPLIANCE.—

2                   “(A) IN GENERAL.—Not later than 24  
3           months after the date on which an initial stand-  
4           ard or implementation specification is adopted  
5           or established under sections 1172 and 1173,  
6           each person to whom the standard or imple-  
7           mentation specification applies shall comply  
8           with the standard or specification.

9                   “(B) SPECIAL RULE FOR SMALL HEALTH  
10           PLANS.—In the case of a small health plan,  
11           paragraph (1) shall be applied by substituting  
12           “36 months” for “24 months”. For purposes of  
13           this subsection, the Secretary shall determine  
14           the plans that qualify as small health plans.

15                   “(2) COMPLIANCE WITH MODIFIED STAND-  
16           ARDS.—If the Secretary adopts a modification to a  
17           standard or implementation specification under this  
18           part, each person to whom the standard or imple-  
19           mentation specification applies shall comply with the  
20           modified standard or implementation specification at  
21           such time as the Secretary determines appropriate,  
22           taking into account the time needed to comply due  
23           to the nature and extent of the modification. The  
24           time determined appropriate under the preceding  
25           sentence may not be earlier than the last day of the

1 180-day period beginning on the date such modifica-  
 2 tion is adopted. The Secretary may extend the time  
 3 for compliance for small health plans, if the Sec-  
 4 retary determines that such extension is appropriate.

5 **“SEC. 1176. GENERAL PENALTY FOR FAILURE TO COMPLY**  
 6 **WITH REQUIREMENTS AND STANDARDS.**

7 “(a) GENERAL PENALTY.—

8 “(1) IN GENERAL.—Except as provided in sub-  
 9 section (b), the Secretary shall impose on any person  
 10 who violates a provision of this part a penalty of not  
 11 more than \$100 for each such violation, except that  
 12 the total amount imposed on the person for all viola-  
 13 tions of an identical requirement or prohibition dur-  
 14 ing a calendar year may not exceed \$25,000.

15 “(2) PROCEDURES.—The provisions of section  
 16 1128A (other than subsections (a) and (b) and the  
 17 second sentence of subsection (f)) shall apply to the  
 18 imposition of a civil money penalty under this sub-  
 19 section in the same manner as such provisions apply  
 20 to the imposition of a penalty under such section  
 21 1128A.

22 “(b) LIMITATIONS.—

23 “(1) OFFENSES OTHERWISE PUNISHABLE.—A  
 24 penalty may not be imposed under subsection (a)

1 with respect to an act if the act constitutes an of-  
2 fense punishable under section 1177.

3 “(2) NONCOMPLIANCE NOT DISCOVERED.—A  
4 penalty may not be imposed under subsection (a)  
5 with respect to a provision of this part if it is estab-  
6 lished to the satisfaction of the Secretary that the  
7 person liable for the penalty did not know, and by  
8 exercising reasonable diligence would not have  
9 known, that such person violated the provision.

10 “(3) FAILURES DUE TO REASONABLE CAUSE.—

11 “(A) IN GENERAL.—Except as provided in  
12 subparagraph (B), a penalty may not be im-  
13 posed under subsection (a) if—

14 “(i) the failure to comply was due to  
15 reasonable cause and not to willful neglect;  
16 and

17 “(ii) the failure to comply is corrected  
18 during the 30-day period beginning on the  
19 1st date the person liable for the penalty  
20 knew, or by exercising reasonable diligence  
21 would have known, that the failure to com-  
22 ply occurred.

23 “(B) EXTENSION OF PERIOD.—

24 “(i) NO PENALTY.—The period re-  
25 ferred to in subparagraph (A)(ii) may be

1 extended as determined appropriate by the  
2 Secretary based on the nature and extent  
3 of the failure to comply.

4 “(ii) ASSISTANCE.—If the Secretary  
5 determines that a person failed to comply  
6 because the person was unable to comply,  
7 the Secretary may provide technical assist-  
8 ance to the person during the period de-  
9 scribed in subparagraph (A)(ii). Such as-  
10 sistance shall be provided in any manner  
11 determined appropriate by the Secretary.

12 “(4) REDUCTION.—In the case of a failure to  
13 comply which is due to reasonable cause and not to  
14 willful neglect, any penalty under subsection (a) that  
15 is not entirely waived under paragraph (3) may be  
16 waived to the extent that the payment of such pen-  
17 alty would be excessive relative to the compliance  
18 failure involved.

19 **“SEC. 1177. WRONGFUL DISCLOSURE OF INDIVIDUALLY**  
20 **IDENTIFIABLE HEALTH INFORMATION.**

21 “(a) OFFENSE.—A person who knowingly—

22 “(1) uses or causes to be used a unique health  
23 identifier in violation of a provision of this part;

1           “(2) obtains individually identifiable health in-  
2           formation relating to an individual in violation of a  
3           provision of this part; or

4           “(3) discloses individually identifiable health in-  
5           formation to another person in violation of a provi-  
6           sion of this part,

7 shall be punished as provided in subsection (b).

8           “(b) PENALTIES.—A person described in subsection  
9 (a) shall—

10           “(1) be fined not more than \$50,000, impris-  
11           oned not more than 1 year, or both;

12           “(2) if the offense is committed under false pre-  
13           tenses, be fined not more than \$100,000, imprisoned  
14           not more than 5 years, or both; and

15           “(3) if the offense is committed with intent to  
16           sell, transfer, or use individually identifiable health  
17           information for commercial advantage, personal  
18           gain, or malicious harm, fined not more than  
19           \$250,000, imprisoned not more than 10 years, or  
20           both.

21 **“SEC. 1178. EFFECT ON STATE LAW.**

22           “(a) GENERAL EFFECT.—

23           “(1) GENERAL RULE.—Except as provided in  
24           paragraph (2), a provision or requirement under this  
25           part, or a standard or implementation specification



1        adopted or established under sections 1172 and  
2        1173, shall supersede any contrary provision of  
3        State law, including a provision of State law that re-  
4        quires medical or health plan records (including bill-  
5        ing information) to be maintained or transmitted in  
6        written rather than electronic form.

7            “(2) EXCEPTIONS.—A provision or requirement  
8        under this part, or a standard or implementation  
9        specification adopted or established under sections  
10       1172 and 1173, shall not supersede a contrary pro-  
11       vision of State law, if the provision of State law—

12            “(A) imposes requirements, standards, or  
13        implementation specifications that are more  
14        stringent than the requirements, standards, or  
15        implementation specifications under this part  
16        with respect to the privacy of individually iden-  
17        tifiable health information; or

18            “(B) is a provision the Secretary deter-  
19        mines—

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

22            “(ii) addresses controlled substances.

23        “(b) PUBLIC HEALTH REPORTING.—Nothing in this  
24        part shall be construed to invalidate or limit the authority,  
25        power, or procedures established under any law providing

1 for the reporting of disease or injury, child abuse, birth,  
2 or death, public health surveillance, or public health inves-  
3 tigation or intervention.

4 **“SEC. 1179. HEALTH INFORMATION ADVISORY COMMITTEE.**

5 “(a) ESTABLISHMENT.—There is established a com-  
6 mittee to be known as the Health Information Advisory  
7 Committee (in this section referred to as the ‘committee’).

8 “(b) DUTIES.—The committee shall—

9 “(1) provide assistance to the Secretary in com-  
10 plying with the requirements imposed on the Sec-  
11 retary under this part;

12 “(2) study the issues related to the adoption of  
13 uniform data standards for patient medical record  
14 information and the electronic exchange of such in-  
15 formation;

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

20 “(4) generally be responsible for advising the  
21 Secretary and the Congress on the status of the im-  
22 plementation of this part.

23 “(c) MEMBERSHIP.—

24 “(1) IN GENERAL.—The committee shall con-  
25 sist of 15 members of whom—

1           “(A) 3 shall be appointed by the President;

2           “(B) 6 shall be appointed by the Speaker  
3           of the House of Representatives after consulta-  
4           tion with the minority leader of the House of  
5           Representatives; and

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

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

13          “(2) EXPERTISE.—The membership of the com-  
14          mittee shall consist of individuals who are of recog-  
15          nized standing and distinction in the areas of infor-  
16          mation systems, information networking and inte-  
17          gration, consumer health, health care financial man-  
18          agement, or privacy, and who possess the dem-  
19          onstrated capacity to discharge the duties imposed  
20          on the committee.

21          “(3) TERMS.—Each member of the committee  
22          shall be appointed for a term of 5 years, except that  
23          the members first appointed shall serve staggered  
24          terms such that the terms of not more than 3 mem-  
25          bers expire at one time.

1           “(4) INITIAL MEETING.—Not later than 30  
2       days after the date on which a majority of the mem-  
3       bers have been appointed, the committee shall hold  
4       its first meeting.

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

9           “(1) the extent to which persons required to  
10      comply with this part are cooperating in implement-  
11      ing the standards adopted under this part;

12          “(2) the extent to which such entities are meet-  
13      ing the privacy and security standards adopted  
14      under this part and the types of penalties assessed  
15      for noncompliance with such standards;

16          “(3) whether the Federal and State Govern-  
17      ments are receiving information of sufficient quality  
18      to meet their responsibilities under this part;

19          “(4) any problems that exist with respect to im-  
20      plementation of this part; and

21          “(5) the extent to which timetables under this  
22      part are being met.”.

23       (b) CONFORMING AMENDMENTS.—

1           (1) REQUIREMENT FOR MEDICARE PROVID-  
2       ERS.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1))  
3       is amended—

4           (A) by striking “and” at the end of sub-  
5       paragraph (P);

6           (B) by striking the period at the end of  
7       subparagraph (Q) and inserting “; and”; and

8           (C) by inserting immediately after sub-  
9       paragraph (Q) the following new subparagraph:

10          “(R) to contract only with a clearinghouse  
11       (as defined in section 1171) that meets each  
12       standard and implementation specification  
13       adopted or established under sections 1172 and  
14       1173 on or after the date on which the clear-  
15       inghouse is required to comply with the stand-  
16       ard or specification.”.

17       (2) CLERICAL AMENDMENTS.—

18           (A) Title XI (42 U.S.C. 1301 et seq.) is  
19       amended by striking the title heading and in-  
20       serting the following:

21       “TITLE XI—GENERAL PROVISIONS, PEER RE-  
22       VIEW, AND ADMINISTRATIVE SIMPLIFICA-  
23       TION”.

24           (B) Parts A and B of title XI (42 U.S.C.  
25       1301 et seq.) are amended by striking “this

1 title” each place such term appears and insert-  
 2 ing “parts A and B of this title”.

3 **TITLE III—TAX-RELATED**  
 4 **HEALTH PROVISIONS**  
 5 **Subtitle A—Medical Savings**  
 6 **Accounts**

7 **SEC. 301. MEDICAL SAVINGS ACCOUNTS.**

8 (a) IN GENERAL.—Part VII of subchapter B of chap-  
 9 ter 1 of the Internal Revenue Code of 1986 (relating to  
 10 additional itemized deductions for individuals) is amended  
 11 by redesignating section 220 as section 221 and by insert-  
 12 ing after section 219 the following new section:

13 **“SEC. 220. MEDICAL SAVINGS ACCOUNTS.**

14 “(a) DEDUCTION ALLOWED.—In the case of an indi-  
 15 vidual who is an eligible individual for any month during  
 16 the taxable year, there shall be allowed as a deduction for  
 17 the taxable year an amount equal to the aggregate amount  
 18 paid in cash during such taxable year by such individual  
 19 to a medical savings account of such individual.

20 “(b) LIMITATIONS.—

21 “(1) IN GENERAL.—Except as otherwise pro-  
 22 vided in this subsection, the amount allowable as a  
 23 deduction under subsection (a) to an individual for  
 24 the taxable year shall not exceed—

1                   “(A) except as provided in subparagraph  
2                   (B), the lesser of—

3                               “(i) \$2,000, or

4                               “(ii) the annual deductible limit for  
5                   any individual covered under the high de-  
6                   ductible health plan, or

7                   “(B) in the case of a high deductible  
8                   health plan covering the taxpayer and any other  
9                   eligible individual who is the spouse or any de-  
10                  pendent (as defined in section 152) of the tax-  
11                  payer, the lesser of—

12                               “(i) \$4,000, or

13                               “(ii) the annual limit under the plan  
14                  on the aggregate amount of deductibles re-  
15                  quired to be paid by all individuals.

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

19                  “(2) SPECIAL RULE FOR MARRIED INDIVID-  
20                  UALS.—

21                               “(A) IN GENERAL.—This subsection shall  
22                  be applied separately for each married individ-  
23                  ual.

24                               “(B) SPECIAL RULE.—If individuals who  
25                  are married to each other are covered under the

1 same high deductible health plan, then the  
2 amounts applicable under paragraph (1)(B)  
3 shall be divided equally between them unless  
4 they agree on a different division.

5 “(3) COORDINATION WITH EXCLUSION FOR EM-  
6 PLOYER CONTRIBUTIONS.—No deduction shall be al-  
7 lowed under this section for any amount paid for  
8 any taxable year to a medical savings account of an  
9 individual if—

10 “(A) any amount is paid to any medical  
11 savings account of such individual which is ex-  
12 cludable from gross income under section  
13 106(b) for such year, or

14 “(B) in a case described in paragraph (2),  
15 any amount is paid to any medical savings ac-  
16 count of either spouse which is so excludable for  
17 such year.

18 “(4) PRORATION OF LIMITATION.—

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

23 “(i) such individual is not an eligible  
24 individual for all months of the taxable  
25 year,



1                   “(ii) the deductible under the high de-  
2                   ductible health plan covering such individ-  
3                   ual is not the same throughout such tax-  
4                   able year, or

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

8                   “(B) MONTHLY LIMITATION.—The month-  
9                   ly limitation for any month shall be an amount  
10                  equal to  $\frac{1}{12}$  of the limitation which would (but  
11                  for this paragraph and paragraph (3)) be deter-  
12                  mined under paragraph (1) if the facts and cir-  
13                  cumstances as of the first day of such month  
14                  that such individual is covered under a high de-  
15                  ductible health plan were true for the entire  
16                  taxable year.

17                  “(5) DENIAL OF DEDUCTION TO DEPEND-  
18                  ENTS.—No deduction shall be allowed under this  
19                  section to any individual with respect to whom a de-  
20                  duction under section 151 is allowable to another  
21                  taxpayer for a taxable year beginning in the cal-  
22                  endar year in which such individual’s taxable year  
23                  begins.

24                  “(c) DEFINITIONS.—For purposes of this section—

25                  “(1) ELIGIBLE INDIVIDUAL.—

1           “(A) IN GENERAL.—The term ‘eligible in-  
2           dividual’ means, with respect to any month, any  
3           individual—

4                   “(i) who is covered under a high de-  
5                   ductible health plan as of the 1st day of  
6                   such month, and

7                   “(ii) who is not, while covered under  
8                   a high deductible health plan, covered  
9                   under any health plan—

10                   “(I) which is not a high deduct-  
11                   ible health plan, and

12                   “(II) which provides coverage for  
13                   any benefit which is covered under the  
14                   high deductible health plan.

15           “(B)       CERTAIN       COVERAGE       DIS-  
16           REGARDED.—Subparagraph (A)(ii) shall be ap-  
17           plied without regard to—

18                   “(i) coverage for any benefit provided  
19                   by permitted insurance, and

20                   “(ii) coverage (whether through insur-  
21                   ance or otherwise) for accidents, disability,  
22                   dental care, vision care, or long-term care.

23           “(2) HIGH DEDUCTIBLE HEALTH PLAN.—The  
24           term ‘high deductible health plan’ means a health  
25           plan which—

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

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

8           Such term does not include a health plan if substan-  
9           tially all of its coverage is coverage described in  
10          paragraph (1)(B). A plan shall not fail to be treated  
11          as a high deductible health plan by reason of failing  
12          to have a deductible for preventive care if the ab-  
13          sence of a deductible for such care is required by  
14          State law.

15          “(3) PERMITTED INSURANCE.—The term ‘per-  
16          mitted insurance’ means—

17               “(A) Medicare supplemental insurance,

18               “(B) insurance if substantially all of the  
19               coverage provided under such insurance relates  
20               to—

21                       “(i) liabilities incurred under workers’  
22                       compensation laws,

23                       “(ii) tort liabilities,

24                       “(iii) liabilities relating to ownership  
25                       or use of property, or

1                   “(iv) such other similar liabilities as  
2                   the Secretary may specify by regulations,

3                   “(C) insurance for a specified disease or  
4                   illness, and

5                   “(D) insurance paying a fixed amount per  
6                   day (or other period) of hospitalization.

7           “(d) MEDICAL SAVINGS ACCOUNT.—For purposes of  
8 this section—

9                   “(1) MEDICAL SAVINGS ACCOUNT.—The term  
10           ‘medical savings account’ means a trust created or  
11           organized in the United States exclusively for the  
12           purpose of paying the qualified medical expenses of  
13           the account holder, but only if the written governing  
14           instrument creating the trust meets the following re-  
15           quirements:

16                   “(A) Except in the case of a rollover con-  
17                   tribution described in subsection (f)(5), no con-  
18                   tribution will be accepted—

19                           “(i) unless it is in cash, or

20                           “(ii) to the extent such contribution,  
21                   when added to previous contributions to  
22                   the trust for the calendar year, exceeds  
23                   \$4,000.

24                   “(B) The trustee is a bank (as defined in  
25                   section 408(n)), an insurance company (as de-

1           fined in section 816), or another person who  
2           demonstrates to the satisfaction of the Sec-  
3           retary that the manner in which such person  
4           will administer the trust will be consistent with  
5           the requirements of this section.

6           “(C) No part of the trust assets will be in-  
7           vested in life insurance contracts.

8           “(D) The assets of the trust will not be  
9           commingled with other property except in a  
10          common trust fund or common investment  
11          fund.

12          “(E) The interest of an individual in the  
13          balance in his account is nonforfeitable.

14          “(2) QUALIFIED MEDICAL EXPENSES.—

15               “(A) IN GENERAL.—The term ‘qualified  
16               medical expenses’ means, with respect to an ac-  
17               count holder, amounts paid by such holder for  
18               medical care (as defined in section 213(d)) for  
19               such individual, the spouse of such individual,  
20               and any dependent (as defined in section 152)  
21               of such individual, but only to the extent such  
22               amounts are not compensated for by insurance  
23               or otherwise.

24               “(B) HEALTH INSURANCE MAY NOT BE  
25               PURCHASED FROM ACCOUNT.—

1 “(i) IN GENERAL.—Subparagraph (A)  
2 shall not apply to any payment for insur-  
3 ance.

4 “(ii) EXCEPTIONS.—Clause (i) shall  
5 not apply to any expense for coverage  
6 under—

7 “(I) a health plan during any pe-  
8 riod of continuation coverage required  
9 under any Federal law, or

10 “(II) a health plan during a pe-  
11 riod in which the individual is receiv-  
12 ing unemployment compensation  
13 under any Federal or State law.

14 “(3) ACCOUNT HOLDER.—The term ‘account  
15 holder’ means the individual on whose behalf the  
16 medical savings account was established.

17 “(4) CERTAIN RULES TO APPLY.—Rules similar  
18 to the following rules shall apply for purposes of this  
19 section:

20 “(A) Section 219(d)(2) (relating to no de-  
21 duction for rollovers).

22 “(B) Section 219(f)(3) (relating to time  
23 when contributions deemed made).

1           “(C) Except as provided in section 106(b),  
2           section 219(f)(5) (relating to employer pay-  
3           ments).

4           “(D) Section 408(g) (relating to commu-  
5           nity property laws).

6           “(E) Section 408(h) (relating to custodial  
7           accounts).

8           “(e) TAX TREATMENT OF ACCOUNTS.—

9           “(1) IN GENERAL.—A medical savings account  
10          is exempt from taxation under this subtitle unless  
11          such account has ceased to be a medical savings ac-  
12          count by reason of paragraph (2) or (3). Notwith-  
13          standing the preceding sentence, any such account is  
14          subject to the taxes imposed by section 511 (relating  
15          to imposition of tax on unrelated business income of  
16          charitable, etc. organizations).

17          “(2) ACCOUNT TERMINATIONS.—Rules similar  
18          to the rules of paragraphs (2) and (4) of section  
19          408(e) shall apply to medical savings accounts, and  
20          any amount treated as distributed under such rules  
21          shall be treated as not used to pay qualified medical  
22          expenses.

23          “(f) TAX TREATMENT OF DISTRIBUTIONS.—

24          “(1) AMOUNTS USED FOR QUALIFIED MEDICAL  
25          EXPENSES.—

1           “(A) IN GENERAL.—Any amount paid or  
2 distributed out of a medical savings account  
3 which is used exclusively to pay qualified medi-  
4 cal expenses of any account holder (or any  
5 spouse or dependent of the holder) shall not be  
6 includible in gross income.

7           “(B) TREATMENT AFTER DEATH OF AC-  
8 COUNT HOLDER.—

9           “(i) TREATMENT IF HOLDER IS  
10 SPOUSE.—If, after the death of the ac-  
11 count holder, the account holder’s interest  
12 is payable to (or for the benefit of) the  
13 holder’s spouse, the medical savings ac-  
14 count shall be treated as if the spouse were  
15 the account holder.

16           “(ii) TREATMENT IF DESIGNATED  
17 HOLDER IS NOT SPOUSE.—In the case of  
18 an account holder’s interest in a medical  
19 savings account which is payable to (or for  
20 the benefit of) any person other than such  
21 holder’s spouse upon the death of such  
22 holder—

23           “(I) such account shall cease to  
24 be a medical savings account as of the  
25 date of death, and



1                   “(II) an amount equal to the fair  
2                   market value of the assets in such ac-  
3                   count on such date shall be includible  
4                   if such person is not the estate of  
5                   such holder, in such person’s gross in-  
6                   come for the taxable year which in-  
7                   cludes such date, or if such person is  
8                   the estate of such holder, in such  
9                   holder’s gross income for the last tax-  
10                  able year of such holder.

11               “(2) INCLUSION OF AMOUNTS NOT USED FOR  
12               QUALIFIED MEDICAL EXPENSES.—

13               “(A) IN GENERAL.—Any amount paid or  
14               distributed out of a medical savings account  
15               which is not used exclusively to pay the quali-  
16               fied medical expenses of the account holder or  
17               of the spouse or dependents of such holder shall  
18               be included in the gross income of such holder.

19               “(B) SPECIAL RULES.—For purposes of  
20               subparagraph (A)—

21               “(i) all medical savings accounts of  
22               the account holder shall be treated as 1 ac-  
23               count,

1                   “(ii) all payments and distributions  
2                   during any taxable year shall be treated as  
3                   1 distribution, and

4                   “(iii) any distribution of property  
5                   shall be taken into account at its fair mar-  
6                   ket value on the date of the distribution.

7                   “(3) EXCESS CONTRIBUTIONS RETURNED BE-  
8                   FORE DUE DATE OF RETURN.—Paragraph (2) shall  
9                   not apply to the distribution of any contribution paid  
10                  during a taxable year to a medical savings account  
11                  to the extent that such contribution exceeds the  
12                  amount under subsection (d)(1)(A)(ii) if—

13                  “(A) such distribution is received by the  
14                  individual on or before the last day prescribed  
15                  by law (including extensions of time) for filing  
16                  such individual’s return for such taxable year,  
17                  and

18                  “(B) such distribution is accompanied by  
19                  the amount of net income attributable to such  
20                  excess contribution.

21                  Any net income described in subparagraph (B) shall  
22                  be included in the gross income of the individual for  
23                  the taxable year in which it is received.

24                  “(4) PENALTY FOR DISTRIBUTIONS NOT USED  
25                  FOR QUALIFIED MEDICAL EXPENSES.—

1           “(A) IN GENERAL.—The tax imposed by  
2           this chapter on the account holder for any tax-  
3           able year in which there is a payment or dis-  
4           tribution from a medical savings account of  
5           such holder which is includible in gross income  
6           under paragraph (2) shall be increased by 10  
7           percent of the amount which is so includible.

8           “(B) EXCEPTION FOR DISABILITY OR  
9           DEATH.—Subparagraph (A) shall not apply if  
10          the payment or distribution is made after the  
11          account holder becomes disabled within the  
12          meaning of section 72(m)(7) or dies.

13          “(C) EXCEPTION FOR DISTRIBUTIONS  
14          AFTER AGE 59½.—Subparagraph (A) shall not  
15          apply to any payment or distribution after the  
16          date on which the account holder attains age  
17          59½.

18          “(5) ROLLOVER CONTRIBUTION.—An amount is  
19          described in this paragraph as a rollover contribu-  
20          tion if it meets the requirements of subparagraphs  
21          (A) and (B).

22          “(A) IN GENERAL.—Paragraph (2) shall  
23          not apply to any amount paid or distributed  
24          from a medical savings account to the account  
25          holder to the extent the amount received is paid

1           into a medical savings account for the benefit  
2           of such holder not later than the 60th day after  
3           the day on which the holder receives the pay-  
4           ment or distribution.

5           “(B) LIMITATION.—This paragraph shall  
6           not apply to any amount described in subpara-  
7           graph (A) received by an individual from a  
8           medical savings account if, at any time during  
9           the 1-year period ending on the day of such re-  
10          ceipt, such individual received any other amount  
11          described in subparagraph (A) from a medical  
12          savings account which was not includible in the  
13          individual’s gross income because of the appli-  
14          cation of this paragraph.

15          “(6) COORDINATION WITH MEDICAL EXPENSE  
16          DEDUCTION.—For purposes of determining the  
17          amount of the deduction under section 213, any pay-  
18          ment or distribution out of a medical savings ac-  
19          count for qualified medical expenses shall not be  
20          treated as an expense paid for medical care.

21          “(7) TRANSFER OF ACCOUNT INCIDENT TO DI-  
22          VORCE.—The transfer of an individual’s interest in  
23          a medical savings account to an individual’s spouse  
24          or former spouse under a divorce or separation in-  
25          strument described in subparagraph (A) of section

1       71(b)(2) shall not be considered a taxable transfer  
2       made by such individual notwithstanding any other  
3       provision of this subtitle, and such interest shall,  
4       after such transfer, be treated as a medical savings  
5       account with respect to which the spouse is the ac-  
6       count holder.

7       “(g) COST-OF-LIVING ADJUSTMENT.—

8               “(1) IN GENERAL.—In the case of any taxable  
9       year beginning in a calendar year after 1997, each  
10      dollar amount in subsection (b)(1), (c)(2), or  
11      (d)(1)(A) shall be increased by an amount equal  
12      to—

13                   “(A) such dollar amount, multiplied by

14                   “(B) the medical care cost adjustment for  
15      such calendar year.

16      If any increase under the preceding sentence is not  
17      a multiple of \$50, such increase shall be rounded to  
18      the nearest multiple of \$50.

19               “(2) MEDICAL CARE COST ADJUSTMENT.—For  
20      purposes of paragraph (1), the medical care cost ad-  
21      justment for any calendar year is the percentage (if  
22      any) by which—

23                   “(A) the medical care component of the  
24      Consumer Price Index (as defined in section

1           1(f)(5)) for August of the preceding calendar  
2           year, exceeds

3           “(B) such component for August of 1996.

4           “(h) REPORTS.—The Secretary may require the  
5 trustee of a medical savings account to make such reports  
6 regarding such account to the Secretary and to the ac-  
7 count holder with respect to contributions, distributions,  
8 and such other matters as the Secretary determines appro-  
9 priate. The reports required by this subsection shall be  
10 filed at such time and in such manner and furnished to  
11 such individuals at such time and in such manner as may  
12 be required by those regulations.”

13           (b) DEDUCTION ALLOWED WHETHER OR NOT INDIV-  
14 VIDUAL ITEMIZES OTHER DEDUCTIONS.—Subsection (a)  
15 of section 62 of such Code is amended by inserting after  
16 paragraph (15) the following new paragraph:

17           “(16) MEDICAL SAVINGS ACCOUNTS.—The de-  
18 duction allowed by section 220.”

19           (c) EXCLUSIONS FOR EMPLOYER CONTRIBUTIONS TO  
20 MEDICAL SAVINGS ACCOUNTS.—

21           (1) EXCLUSION FROM INCOME TAX.—The text  
22 of section 106 of such Code (relating to contribu-  
23 tions by employer to accident and health plans) is  
24 amended to read as follows:

1       “(a) GENERAL RULE.—Gross income of an employee  
2 does not include employer-provided coverage under an ac-  
3 cident or health plan.

4       “(b) CONTRIBUTIONS TO MEDICAL SAVINGS AC-  
5 COUNTS.—

6               “(1) IN GENERAL.—In the case of an employee  
7 who is an eligible individual, gross income does not  
8 include amounts contributed by such employee’s em-  
9 ployer to any medical savings account of such em-  
10 ployee.

11              “(2) COORDINATION WITH DEDUCTION LIMITA-  
12 TION.—The amount excluded from the gross income  
13 of an employee under this subsection for any taxable  
14 year shall not exceed the limitation under section  
15 220(b)(1) (determined without regard to this sub-  
16 section) which is applicable to such employee for  
17 such taxable year.

18              “(3) NO CONSTRUCTIVE RECEIPT.—No amount  
19 shall be included in the gross income of any em-  
20 ployee solely because the employee may choose be-  
21 tween the contributions referred to in paragraph (1)  
22 and employer contributions to another health plan of  
23 the employer.

24              “(4) SPECIAL RULE FOR DEDUCTION OF EM-  
25 PLOYER CONTRIBUTIONS.—Any employer contribu-

tion to a medical savings account, if otherwise allowable as a deduction under this chapter, shall be allowed only for the taxable year in which paid.

“(5) DEFINITIONS.—For purposes of this subsection, the terms ‘eligible individual’ and ‘medical savings account’ have the respective meanings given to such terms by section 220.”

(2) EXCLUSION FROM EMPLOYMENT TAXES.—

(A) SOCIAL SECURITY TAXES.—

(i) Subsection (a) of section 3121 of such Code is amended by striking “or” at the end of paragraph (20), by striking the period at the end of paragraph (21) and inserting “; or”, and by inserting after paragraph (21) the following new paragraph:

“(22) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b).”

(ii) Subsection (a) of section 209 of the Social Security Act is amended by striking “or” at the end of paragraph (17), by striking the period at the end of para-



1 graph (18) and inserting “; or”, and by in-  
2 serting after paragraph (18) the following  
3 new paragraph:

4 “(19) any payment made to or for the benefit  
5 of an employee if at the time of such payment it is  
6 reasonable to believe that the employee will be able  
7 to exclude such payment from income under section  
8 106(b) of the Internal Revenue Code of 1986.”

9 (B) RAILROAD RETIREMENT TAX.—Sub-  
10 section (e) of section 3231 of such Code is  
11 amended by adding at the end the following  
12 new paragraph:

13 “(10) MEDICAL SAVINGS ACCOUNT CONTRIBU-  
14 TIONS.—The term ‘compensation’ shall not include  
15 any payment made to or for the benefit of an em-  
16 ployee if at the time of such payment it is reason-  
17 able to believe that the employee will be able to ex-  
18 clude such payment from income under section  
19 106(b).”

20 (C) UNEMPLOYMENT TAX.—Subsection (b)  
21 of section 3306 of such Code is amended by  
22 striking “or” at the end of paragraph (15), by  
23 striking the period at the end of paragraph (16)  
24 and inserting “; or”, and by inserting after  
25 paragraph (16) the following new paragraph:

1           “(17) any payment made to or for the benefit  
2           of an employee if at the time of such payment it is  
3           reasonable to believe that the employee will be able  
4           to exclude such payment from income under section  
5           106(b).”

6                       (D) WITHHOLDING TAX.—Subsection (a)  
7           of section 3401 of such Code is amended by  
8           striking “or” at the end of paragraph (19), by  
9           striking the period at the end of paragraph (20)  
10          and inserting “; or”, and by inserting after  
11          paragraph (20) the following new paragraph:

12          “(21) any payment made to or for the benefit  
13          of an employee if at the time of such payment it is  
14          reasonable to believe that the employee will be able  
15          to exclude such payment from income under section  
16          106(b).”

17          (d) MEDICAL SAVINGS ACCOUNT CONTRIBUTIONS  
18          NOT AVAILABLE UNDER CAFETERIA PLANS.—Subsection  
19          (f) of section 125 of such Code is amended by inserting  
20          “106(b),” before “117”.

21          (e) EXCLUSION OF MEDICAL SAVINGS ACCOUNTS  
22          FROM ESTATE TAX.—Part IV of subchapter A of chapter  
23          11 of such Code is amended by adding at the end the fol-  
24          lowing new section:

1 **“SEC. 2057. MEDICAL SAVINGS ACCOUNTS.**

2 “For purposes of the tax imposed by section 2001,  
3 the value of the taxable estate shall be determined by de-  
4 ducting from the value of the gross estate an amount  
5 equal to the value of any medical savings account (as de-  
6 fined in section 220(d)) included in the gross estate.”

7 (f) TAX ON EXCESS CONTRIBUTIONS.—Section 4973  
8 of such Code (relating to tax on excess contributions to  
9 individual retirement accounts, certain section 403(b) con-  
10 tracts, and certain individual retirement annuities) is  
11 amended—

12 (1) by inserting “**MEDICAL SAVINGS AC-**  
13 **COUNTS,**” after “**ACCOUNTS,**” in the heading of  
14 such section,

15 (2) by striking “or” at the end of paragraph  
16 (1) of subsection (a),

17 (3) by redesignating paragraph (2) of sub-  
18 section (a) as paragraph (3) and by inserting after  
19 paragraph (1) the following:

20 “(2) a medical savings account (within the  
21 meaning of section 220(d)), or”, and

22 (4) by adding at the end the following new sub-  
23 section:

24 “(d) EXCESS CONTRIBUTIONS TO MEDICAL SAVINGS  
25 ACCOUNTS.—For purposes of this section, in the case of  
26 a medical savings account (within the meaning of section

1 220(d)), the term ‘excess contributions’ means the sum  
2 of—

3 “(1) the amount by which the amount contrib-  
4 uted for the taxable year to the account exceeds the  
5 amount which may be contributed to the account  
6 under section 220(d)(1)(B)(ii) for such taxable year,  
7 and

8 “(2) the amount determined under this sub-  
9 section for the preceding taxable year, reduced by  
10 the sum of distributions out of the account included  
11 in gross income under section 220(f) (2) or (3) and  
12 the excess (if any) of the maximum amount allow-  
13 able as a deduction under section 220 for the tax-  
14 able year over the amount contributed.

15 For purposes of this subsection, any contribution which  
16 is distributed out of the medical savings account in a dis-  
17 tribution to which section 220(f)(3) applies shall be treat-  
18 ed as an amount not contributed.”

19 (g) TAX ON PROHIBITED TRANSACTIONS.—

20 (1) Section 4975 of such Code (relating to tax  
21 on prohibited transactions) is amended by adding at  
22 the end of subsection (c) the following new para-  
23 graph:

24 “(4) SPECIAL RULE FOR MEDICAL SAVINGS AC-  
25 COUNTS.—An individual for whose benefit a medical

1       savings account (within the meaning of section  
2       220(d)) is established shall be exempt from the tax  
3       imposed by this section with respect to any trans-  
4       action concerning such account (which would other-  
5       wise be taxable under this section) if, with respect  
6       to such transaction, the account ceases to be a medi-  
7       cal savings account by reason of the application of  
8       section 220(e)(2) to such account.”

9               (2) Paragraph (1) of section 4975(e) of such  
10      Code is amended to read as follows:

11              “(1) PLAN.—For purposes of this section, the  
12      term ‘plan’ means—

13              “(A) a trust described in section 401(a)  
14              which forms a part of a plan, or a plan de-  
15              scribed in section 403(a), which trust or plan is  
16              exempt from tax under section 501(a),

17              “(B) an individual retirement account de-  
18              scribed in section 408(a),

19              “(C) an individual retirement annuity de-  
20              scribed in section 408(b),

21              “(D) a medical savings account described  
22              in section 220(d), or

23              “(E) a trust, plan, account, or annuity  
24              which, at any time, has been determined by the

1 Secretary to be described in any preceding sub-  
2 paragraph of this paragraph.”

3 (h) FAILURE TO PROVIDE REPORTS ON MEDICAL  
4 SAVINGS ACCOUNTS.—

5 (1) Subsection (a) of section 6693 of such Code  
6 (relating to failure to provide reports on individual  
7 retirement accounts or annuities) is amended to read  
8 as follows:

9 “(a) REPORTS.—

10 “(1) IN GENERAL.—If a person required to file  
11 a report under a provision referred to in paragraph  
12 (2) fails to file such report at the time and in the  
13 manner required by such provision, such person  
14 shall pay a penalty of \$50 for each failure unless it  
15 is shown that such failure is due to reasonable  
16 cause.

17 “(2) PROVISIONS.—The provisions referred to  
18 in this paragraph are—

19 “(A) subsections (i) and (l) of section 408  
20 (relating to individual retirement plans), and

21 “(B) section 220(h) (relating to medical  
22 savings accounts).”

23 (i) EXCEPTION FROM CAPITALIZATION OF POLICY  
24 ACQUISITION EXPENSES.—Subparagraph (B) of section  
25 848(e)(1) of such Code (defining specified insurance con-

1 tract) is amended by striking “and” at the end of clause  
 2 (ii), by striking the period at the end of clause (iii) and  
 3 inserting “, and”, and by adding at the end the following  
 4 new clause:

5 “(iv) any contract which is a medical  
 6 savings account (as defined in section  
 7 220(d)).”.

8 (j) CLERICAL AMENDMENT.—The table of sections  
 9 for part VII of subchapter B of chapter 1 of such Code  
 10 is amended by striking the last item and inserting the fol-  
 11 lowing:

“Sec. 220. Medical savings accounts.  
 “Sec. 221. Cross reference.”

12 (k) EFFECTIVE DATE.—The amendments made by  
 13 this section shall apply to taxable years beginning after  
 14 December 31, 1996.

15 **Subtitle B—Increase in Deduction**  
 16 **for Health Insurance Costs of**  
 17 **Self-Employed Individuals**

18 **SEC. 311. INCREASE IN DEDUCTION FOR HEALTH INSUR-**  
 19 **ANCE COSTS OF SELF-EMPLOYED INDIVID-**  
 20 **UALS.**

21 (a) IN GENERAL.—Paragraph (1) of section 162(l)  
 22 of the Internal Revenue Code of 1986 is amended to read  
 23 as follows:

24 “(1) ALLOWANCE OF DEDUCTION.—

1           “(A) IN GENERAL.—In the case of an indi-  
 2           vidual who is an employee within the meaning  
 3           of section 401(c)(1), there shall be allowed as  
 4           a deduction under this section an amount equal  
 5           to the applicable percentage of the amount paid  
 6           during the taxable year for insurance which  
 7           constitutes medical care for the taxpayer, his  
 8           spouse, and dependents.

9           “(B) APPLICABLE PERCENTAGE.—For  
 10          purposes of subparagraph (A), the applicable  
 11          percentage shall be determined under the fol-  
 12          lowing table:

<b>“For taxable years beginning in calendar year—</b>	<b>The applicable percentage is—</b>
1998 or 1999 .....	35 percent
2000 or 2001 .....	40 percent
2002 or thereafter .....	50 percent.”

13          (b) EFFECTIVE DATE.—The amendment made by  
 14          this section shall apply to taxable years beginning after  
 15          December 31, 1997.

○