104TH CONGRESS
2D SESSION

H. R. 3103

AN ACT

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

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erage, to simplify the administration of health insurance, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

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

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

TITLE I—IMPROVED AVAILABILITY AND PORTABILITY OF HEALTH INSURANCE COVERAGE

Subtitle A—Coverage Under Group Health Plans

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

(a) CREDITING PERIODS OF PREVIOUS COVERAGE TOWARD PREEXISTING CONDITION RESTRICTIONS.—Subject to the succeeding provisions of this section, a group health plan, and an insurer or health maintenance organization offering health insurance coverage in connection

with a group health plan, shall provide that any preexisting condition limitation period (as defined in subsection (b)(2)) is reduced by the length of the aggregate period of qualified prior coverage (if any, as defined in subsection (b)(3)) applicable to the participant or beneficiary as of the date of commencement of coverage under the plan.

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

(1) PREEXISTING CONDITION.—

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

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

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

whichever is earlier.

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

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

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

(3) AGGREGATE PERIOD OF QUALIFIED PRIOR COVERAGE.—

(A) IN GENERAL.—For purposes of this section, the term ''aggregate period of qualified prior coverage'' means, with respect to commencement of coverage of an individual under a group health plan or health insurance coverage offered in connection with a group health plan, the aggregate of the qualified coverage periods (as defined in subparagraph (B)) of such individual occurring before the date of such commencement. Such period shall be treated as

zero if there is more than a 60-day break in coverage under a group health plan (or health insurance coverage offered in connection with such a plan) between the date the most recent qualified coverage period ends and the date of such commencement.

(B) QUALIFIED COVERAGE PERIOD.—

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

(ii) DISREGARDING PERIODS BEFORE BREAKS IN COVERAGE.—Such term does not include any period occurring before

any 60-day break in coverage described in subparagraph (A).

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

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

(c) CERTIFICATIONS OF COVERAGE; CONFORMING COVERAGE.—

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

of the individual under such plan or coverage and of the waiting period (if any) imposed with respect to the individual for any coverage under the plan.

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

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

(A) the plan, insurer, or HMO shall prominently state in any disclosure statements concerning the plan or coverage and to each enrollee at the time of enrollment under the plan (or at the time the health insurance coverage is offered for sale in the group health market)

that the plan or coverage has made such election and shall include a description of the effect of this election; and

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

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

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

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

(a) LIMITATION OF PERIOD.—

(1) IN GENERAL.—Subject to the succeeding provisions of this section, a group health plan, and an insurer or HMO offering health insurance coverage in connection with a group health plan, shall provide that any preexisting condition limitation pe-

riod (as defined in section 101(b)(2)) does not exceed 12 months, counting from the effective date of coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

for purposes of this subtitle as a waiting period under the plan and shall run concurrently with any other applicable waiting period under the plan.

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

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

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

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

(b) PROHIBITION OF DISCRIMINATION IN PREMIUM CONTRIBUTIONS OF INDIVIDUAL PARTICIPANTS OR BENEFICIARIES BASED ON HEALTH STATUS.—

(1) IN GENERAL.—A group health plan, and an insurer or HMO offering health insurance coverage in connection with a group health plan, may not require a participant or beneficiary to pay a premium or contribution which is greater than such premium or contribution for a similarly situated participant or beneficiary solely on the basis of the health status of the participant or beneficiary.

(2) CONSTRUCTION.—Nothing in this subsection is intended—

(A) to effect the premium rates an insurer or HMO may charge an employer for health insurance coverage provided in connection a group health plan,

(B) to prevent a group health plan (or insurer or HMO in health insurance coverage offered in connection with such a plan) from establishing premium discounts or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention, or

(C) to prevent such a plan, insurer, or HMO from varying the premiums or contributions required of participants or beneficiaries based on factors (such as scope of benefits, geo-

graphic area of residence, or wage levels) that are not directly related to health status.

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

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

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

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

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

(d) DEPENDENT BENEFICIARIES.—

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

(A) is a newborn,

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

(C) is a spouse, at the time of marriage, if the participant has met any waiting period applicable to that participant.

(2) TIMELY ENROLLMENT.—

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

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

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

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

if family coverage is available as of such date.

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

(e) MULTIEMPLOYER PLANS, MULTIPLE EMPLOYER HEALTH PLANS, AND MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.—A group health plan which is a multiemployer plan, a multiple employer health plan (as defined in section 701(4) of the Employee Retirement Income Security Act of 1974), or a multiple employer welfare arrangement (to the extent to which benefits under the arrangement consist of medical care) may not deny

an employer whose employees are covered under such a plan or arrangement continued access to the same or different coverage under the terms of such a plan or arrangement, other than—

(1) for nonpayment of contributions,

(2) for fraud or other intentional misrepresentation of material fact by the employer,

(3) for noncompliance with material plan or arrangement provisions,

(4) because the plan or arrangement is ceasing to offer any coverage in a geographic area,

(5) for failure to meet the terms of an applicable collective bargaining agreement, to renew a collective bargaining or other agreement requiring or authorizing contributions to the plan, or to employ employees covered by such an agreement,

(6) in the case of a plan or arrangement to which subparagraph (C), (D), or (E) of section 3(40) of the Employee Retirement Income Security Act of 1974 applies, to the extent necessary to meet the requirements of such subparagraph, or

(7) in the case of a multiple employer health plan (as defined in section 701(4) of such Act), for failure to meet the requirements under part 7 of

subtitle B of title I of such Act for exemption under section 514(b)(6)(B) of such Act.

SEC. 104. ENFORCEMENT.

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

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

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

''(2) subject to subsection (h)—

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

''(B) section 103 (other than subsection (e)) of such Act with respect to any individual.''.

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

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

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

''(1) IN GENERAL.—

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

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

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

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

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

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

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

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

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

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

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

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

(2) FEDERAL ENFORCEMENT ONLY IF NO ENFORCEMENT THROUGH STATE.—The Secretary of Labor shall enforce each section referred to in paragraph (1) with respect to any entity which is an insurer or health maintenance organization regulated by a State only if the Secretary of Labor determines

that such State has not provided for enforcement of State laws which govern the same matters as are governed by such section and which require compliance by such entity with at least the same requirements as those provided under such section.

(3) LIMITATIONS ON LIABILITY.—

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

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

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

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

(c) ENFORCEMENT THROUGH CIVIL MONEY PENALTIES.—

(1) IMPOSITION.—

(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, any group health plan, insurer, or organization that fails to meet a requirement of this subtitle (other than section 103(e)) is subject to a civil money penalty under this section.

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

(C) AMOUNT OF PENALTY.—

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

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

(iii) LIMITATIONS.—

(I) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No civil money penalty shall be imposed under this paragraph on any failure during any period for which it is established to the satisfac-

tion of the Secretary that none of the persons against whom the penalty would be imposed knew, or exercising reasonable diligence would have known, that such failure existed.

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

(D) ADMINISTRATIVE REVIEW.—

(i) OPPORTUNITY FOR HEARING.—The person assessed shall be afforded an opportunity for hearing by the Secretary upon request made within 30 days after the date of the issuance of a notice of assessment. In such hearing the decision

shall be made on the record pursuant to section 554 of title 5, United States Code. If no hearing is requested, the assessment shall constitute a final and unappealable order.

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

(E) JUDICIAL REVIEW.—

(i) FILING OF ACTION FOR REVIEW.—Any person against whom an order imposing a civil money penalty has been entered after an agency hearing under this paragraph may obtain review by the United States district court for any district in

which such person is located or the United States District Court for the District of Columbia by filing a notice of appeal in such court within 30 days from the date of such order, and simultaneously sending a copy of such notice be registered mail to the Secretary.

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

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

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

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

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

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

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

(2) FEDERAL ENFORCEMENT ONLY IF NO ENFORCEMENT THROUGH STATE.—Paragraph (1) shall apply to enforcement of the requirements of section 101, 102, or 103 (other than section 103(e)) with

respect to any entity which offers health insurance coverage and which is an insurer or HMO regulated by a State only if the Secretary of Health and Human Services has determined that such State has not provided for enforcement of State laws which govern the same matters as are governed by such section and which require compliance by such entity with at least the same requirements as those provided under such section.

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

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

Subtitle B—Certain Requirements for Insurers and HMOs in the Group and Individual Markets

PART 1—AVAILABILITY OF GROUP HEALTH INSURANCE COVERAGE

SEC. 131. GUARANTEED AVAILABILITY OF GENERAL COVERAGE IN THE SMALL GROUP MARKET.

(a) ISSUANCE OF COVERAGE.—

(1) IN GENERAL.—Subject to the succeeding subsections of this section, each insurer or HMO that offers health insurance coverage in the small group market in a State—

(A) must accept every small employer in the State that applies for such coverage; and

(B) must accept for enrollment under such coverage every eligible individual (as defined in paragraph (2)) who applies for enrollment during the initial period in which the individual first becomes eligible for coverage under the group health plan and may not place any restriction which is inconsistent with section 103(a) on an individual being a participant or beneficiary so long as such individual is an eligible individual.

(2) ELIGIBLE INDIVIDUAL DEFINED.—In this section, the term ''eligible individual'' means, with respect to an insurer or HMO that offers health insurance coverage to any small employer in the small group market, such an individual in relation to the employer as shall be determined—

(A) in accordance with the terms of such plan,

(B) as provided by the insurer or HMO under rules of the insurer or HMO which are uniformly applicable, and

(C) in accordance with all applicable State laws governing such insurer or HMO.

(b) SPECIAL RULES FOR NETWORK PLANS AND HMOS.—

(1) IN GENERAL.—In the case of an insurer that offers health insurance coverage in the small group market through a network plan and in the case of an HMO that offers health insurance coverage in connection with such a plan, the insurer or HMO may—

(A) limit the employers that may apply for such coverage to those with eligible individuals whose place of employment or residence is in the service area for such plan or HMO;

(B) limit the individuals who may be enrolled under such coverage to those whose place of residence or employment is within the service area for such plan or HMO; and

(C) within the service area of such plan or HMO, deny such coverage to such employers if the insurer or HMO demonstrates that—

(i) it will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees, and

(ii) it is applying this paragraph uniformly to all employers without regard to the claims experience of those employers and their employees (and their beneficiaries) or the health status of such employees and beneficiaries.

(2) 180-DAY SUSPENSION UPON DENIAL OF COVERAGE.—An insurer or HMO, upon denying health insurance coverage in any service area in accordance with paragraph (1)(C), may not offer coverage in the small group market within such service area for a period of 180 days after such coverage is denied.

(c) SPECIAL RULE FOR FINANCIAL CAPACITY LIMITS.—

(1) IN GENERAL.—An insurer or HMO may deny health insurance coverage in the small group market if the insurer or HMO demonstrates to the applicable State authority that—

(A) it does not have the financial reserves necessary to underwrite additional coverage, and

(B) it is applying this paragraph uniformly to all employers without regard to the claims experience or duration of coverage of those employers and their employees (and their beneficiaries) or the health status of such employees and beneficiaries.

(2) 180-DAY SUSPENSION UPON DENIAL OF COVERAGE.—An insurer or HMO upon denying health insurance coverage in connection with group health plans in any service area in accordance with paragraph (1) may not offer coverage in connection with group health plans in the small group market within such service area for a period of 180 days after such coverage is denied.

(d) EXCEPTION TO REQUIREMENT FOR ISSUANCE OF COVERAGE BY REASON OF FAILURE BY PLAN TO MEET

CERTAIN MINIMUM PARTICIPATION OR CONTRIBUTION RULES.—

(1) IN GENERAL.—Subsection (a) shall not apply in the case of any group health plan with respect to which—

(A) participation rules of an insurer or HMO which are described in paragraph (2) are not met, or

(B) contribution rules of an insurer or HMO which are described in paragraph (3) are not met.

(2) PARTICIPATION RULES.—For purposes of paragraph (1)(A), participation rules (if any) of an insurer or HMO shall be treated as met with respect to a group health plan only if such rules are uniformly applicable and in accordance with applicable State law and the number or percentage of eligible individuals who, under the plan, are participants or beneficiaries equals or exceeds a level which is determined in accordance with such rules.

(3) CONTRIBUTION RULES.—For purposes of paragraph (1)(B), contribution rules (if any) of an insurer or HMO shall be treated as met with respect to a group health plan only if such rules are in accordance with applicable State law.

SEC. 132. GUARANTEED RENEWABILITY OF GROUP COVERAGE.

(a) IN GENERAL.—Except as provided in this section, if an insurer or health maintenance organization offers health insurance coverage in the small or large group market, the insurer or organization must renew or continue in force such coverage at the option of the employer.

(b) GENERAL EXCEPTIONS.—An insurer or organization may nonrenew or discontinue health insurance coverage offered an employer based only on one or more of the following:

(1) NONPAYMENT OF PREMIUMS.—The employer has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the insurer or organization has not received timely premium payments.

(2) FRAUD.—The employer has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) VIOLATION WITH PARTICIPATION OR CONTRIBUTION RULES.—The employer has failed to comply with a material plan provision relating to participation or contribution rules in accordance with section 131(d).

(4) TERMINATION OF PLAN.—Subject to subsection (c), the insurer or organization is ceasing to offer coverage in the small or large group market in a State (or, in the case of a network plan or HMO, in a geographic area).

(5) MOVEMENT OUTSIDE SERVICE AREA.—The employer has changed the place of employment in such manner that employees and dependents reside and are employed outside the service area of the insurer or organization or outside the area for which the insurer or organization is authorized to do business.

Paragraph (5) shall apply to an insurer or HMO only if it is applied uniformly without regard to the claims experience of employers and their employees (and their beneficiaries) or the health status of such employees and beneficiaries.

(c) EXCEPTIONS FOR UNIFORM TERMINATION OF COVERAGE.—

(1) PARTICULAR TYPE OF COVERAGE NOT OFFERED.—In any case in which a insurer or HMO decides to discontinue offering a particular type of health insurance coverage in the small or large group market, coverage of such type may be discontinued by the insurer or organization only if—

(A) the insurer or organization provides notice to each employer provided coverage of this type in such market (and participants and beneficiaries covered under such coverage) of such discontinuation at least 90 days prior to the date of the discontinuation of such coverage;

(B) the insurer or organization offers to each employer in the small employer or large employer market provided coverage of this type, the option to purchase any other health insurance coverage currently being offered by the insurer or organization for employers in such market; and

(C) in exercising the option to discontinue coverage of this type and in offering one or more replacement coverage, the insurer or organization acts uniformly without regard to the health status or insurability of participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.

(2) DISCONTINUANCE OF ALL COVERAGE.—

(A) IN GENERAL.—Subject to subparagraph (C), in any case in which an insurer or

HMO elects to discontinue offering all health insurance coverage in the small group market or the large group market, or both markets, in a State, health insurance coverage may be discontinued by the insurer or organization only if—

(i) the insurer or organization provides notice to the applicable State authority and to each employer (and participants and beneficiaries covered under such coverage) of such discontinuation at least 180 days prior to the date of the expiration of such coverage, and

(ii) all health insurance issued or delivered for issuance in the State in such market (or markets) are discontinued and coverage under such health insurance coverage in such market (or markets) is not renewed.

(B) PROHIBITION ON MARKET REENTRY.—In the case of a discontinuation under subparagraph (A) in one or both markets, the insurer or organization may not provide for the issuance of any health insurance coverage in the market and State involved during the 5-year pe-

riod beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(d) EXCEPTION FOR UNIFORM MODIFICATION OF COVERAGE.—At the time of coverage renewal, an insurer or HMO may modify the coverage offered to a group health plan in the group health market so long as such modification is effective on a uniform basis among group health plans with that type of coverage.

PART 2—AVAILABILITY OF INDIVIDUAL HEALTH INSURANCE COVERAGE

SEC. 141. GUARANTEED AVAILABILITY OF INDIVIDUAL HEALTH INSURANCE COVERAGE TO CERTAIN INDIVIDUALS WITH PRIOR GROUP COVERAGE.

(a) GOALS.—The goals of this section are—

(1) to guarantee that any qualifying individual (as defined in subsection (b)(1)) is able to obtain qualifying coverage (as defined in subsection (b)(2)); and

(2) to assure that qualifying individuals obtaining such coverage receive credit for their prior coverage toward the new coverage's preexisting condition exclusion period (if any) in a manner consistent with subsection (b)(3).

(b) QUALIFYING INDIVIDUAL AND HEALTH INSURANCE COVERAGE DEFINED.—In this section—

(1) QUALIFYING INDIVIDUAL.—The term ''qualifying individual'' means an individual—

(A)(i) for whom, as of the date on which the individual seeks coverage under this section, the aggregate of the qualified coverage periods (as defined in section 101(b)(3)(B)) is 18 or more months and (ii) whose most recent prior coverage was under a group health plan, governmental plan, or church plan (or health insurance coverage offered in connection with any such plan);

(B) who is not eligible for coverage under (i) a group health plan, (ii) part A or part B of title XVIII of the Social Security Act, or (iii) a State plan under title XIX of such Act (or any successor program), and does not have individual health insurance coverage;

(C) with respect to whom the most recent coverage within the coverage period described in subparagraph (A)(i) was not terminated based on a factor described in paragraph (1) or (2) of section 132(b);

(D) if the individual had been offered the option of continuation coverage under a COBRA continuation provision or under a similar State program, who elected such coverage; and

(E) who, if the individual elected such continuation coverage, has exhausted such continuation coverage.

In applying subparagraph (A)(i), the reference in section 101(b)(3)(B)(ii) to a 60-day break in coverage is deemed a reference to a 60-day break in any coverage described in section 101(b)(3)(B)(i).

(2) QUALIFYING COVERAGE.—

(A) IN GENERAL.—The term ''qualifying coverage'' means, with respect to an insurer or HMO in relation to an qualifying individual, individual health insurance coverage for which the actuarial value of the benefits is not less than—

(i) the weighted average actuarial value of the benefits provided by all the individual health insurance coverage issued by the insurer or HMO in the State during the previous year (not including coverage issued under this section), or

(ii) the weighted average of the actuarial value of the benefits provided by all the individual health insurance coverage issued by all insurers and HMOs in the State during the previous year (not including coverage issued under this section),

as elected by the plan or by the State under subsection (c)(1).

(B) ASSUMPTIONS.—For purposes of subparagraph (A), the actuarial value of benefits provided under individual health insurance coverage shall be calculated based on a standardized population and a set of standardized utilization and cost factors.

(3) CREDITING FOR PREVIOUS COVERAGE.—Crediting is consistent with this paragraph only if any preexisting condition exclusion period is reduced at least to the extent such a period would be reduced if the coverage under this section were under a group health plan to which section 101(a) applies. In carrying out this subsection, provisions similar to the provisions of section 101(c) shall apply.

(c) OPTIONAL STATE ESTABLISHMENT OF MECHANISMS TO ACHIEVE GOALS OF GUARANTEEING AVAILABILITY OF COVERAGE.—

(1) IN GENERAL.—Any State may establish, to the extent of the State's authority, public or private mechanisms reasonably designed to meet the goals specified in subsection (a). If a State implements such a mechanism by the deadline specified in paragraph (4), the State may elect to have such mechanisms apply instead of having subsection (d)(3) apply in the State. An election under this paragraph shall be by notice from the chief executive officer of the State to the Secretary of Health and Human Services on a timely basis consistent with the deadlines specified in paragraph (4). In establishing what is qualifying coverage under such a mechanism under this subsection, a State may exercise the election described in subsection (b)(2)(A) with respect to each insurer or HMO in the State (or on a collective basis after exercising such election for each such insurer or HMO).

(2) TYPES OF MECHANISMS.—State mechanisms under this subsection may include one or more (or a combination) of the following:

(A) Health insurance coverage pools or programs authorized or established by the State.

(B) Mandatory group conversion policies.

(C) Guaranteed issue of one or more plans of individual health insurance coverage to qualifying individuals.

(D) Open enrollment by one or more insurers or HMOs.

The mechanisms described in the previous sentence are not an exclusive list of the mechanisms (or combinations of mechanisms) that may be used under this subsection.

(3) SAFE HARBOR FOR BENEFITS UNDER CURRENT RISK POOLS.—In the case of a State that has a health insurance coverage pool or risk pool in effect on March 12, 1996, and that implements the mechanism described in paragraph (2)(A), the benefits under such mechanism (or benefits the actuarial value of which is not less than the actuarial value of such current benefits, using the assumptions described in subsection (b)(2)(B)) are deemed, for purposes of this section, to constitute qualified coverage.

(4) DEADLINE FOR STATE IMPLEMENTATION.—

(A) IN GENERAL.—Subject to subparagraph (B), the deadline under this paragraph is July 1, 1997.

(B) EXTENSION TO PERMIT LEGISLATION.—The deadline under this paragraph is

July 1, 1998, in the case of a State the legislature of which does not have a regular legislative session at any time between January 1, 1997, and June 30, 1997.

(C) CONSTRUCTION.—Nothing in this section shall be construed as preventing a State from—

(i) implementing guaranteed availability mechanisms before the deadline,

(ii) continuing in effect mechanisms that are in effect before the date of the enactment of this Act,

(iii) offering guaranteed availability of coverage that is not qualifying coverage, or

(iv) offering guaranteed availability of coverage to individuals who are not qualifying individuals.

(d) FALLBACK PROVISIONS.—

(1) NO STATE ELECTION.—If a State has not provided notice to the Secretary of an election on a timely basis under subsection (c), the Secretary shall notify the State that paragraph (3) will be applied in the State.

(2) PRELIMINARY DETERMINATION AFTER STATE ELECTION.—If—

(A) a State has provided notice of an election on a timely basis under subsection (c), and

(B) the Secretary finds, after consultation with the chief executive officer of the State and the insurance commissioner or chief insurance regulatory official of the State, that such a mechanism (for which notice was provided) is not reasonably designed to meet the goals specified in subsection (a),

the Secretary shall notify the State of such preliminary determination, of the consequences under paragraph (3) of a failure to implement such a mechanism, and permit the State a reasonable opportunity in which to modify the mechanism (or to adopt another mechanism) that is reasonably designed to meet the goals specified in subsection (a). The Secretary shall not make such a determination on any basis other than the basis described in subparagraph (B). If, after providing such notice and opportunity, the Secretary finds that the State has not implemented such a mechanism, the Secretary shall notify the State that paragraph (3) will be applied in the State.

(3) DESCRIPTION OF FALLBACK MECHANISM.—As provided under paragraphs (1) and (2) and sub-

ject to paragraph (5), each insurer or HMO in the State involved that issues individual health insurance coverage—

(A) shall offer qualifying health insurance coverage, in which qualifying individuals obtaining such coverage receive credit for their prior coverage toward the new coverage's preexisting condition exclusion period (if any) in a manner consistent with subsection (b)(3), to each qualifying individual in the State, and

(B) may not decline to issue such coverage to such an individual based on health status (except as permitted under paragraph (4)).

(4) APPLICATION OF NETWORK AND CAPACITY LIMITS.—Under regulations, the provisions of subsections (b) and (c) of section 131 shall apply to an individual in the individual health insurance market under this subsection in the same manner as they apply under section 131 to an employer in the small group market.

(5) TERMINATION OF FALLBACK MECHANISM.—The provisions of this subsection shall cease to apply to a State if the Secretary finds that a State has implemented a mechanism that is reasonably designed to meet the goals specified in subsection (a), and

until the Secretary finds that such mechanism is no longer being implemented.

(e) CONSTRUCTION.—

(1) PREMIUMS.—Nothing in this section shall be construed to affect the determination of an insurer or HMO as to the amount of the premium payable under an individual health insurance coverage under applicable state law.

(2) MARKET REQUIREMENTS.—

(A) IN GENERAL.—The provisions of subsection (a) shall not be construed to require that an insurer or HMO offering health insurance coverage only in connection with a group health plan or an association offer individual health insurance coverage.

(B) CONVERSION POLICIES.—An insurer or HMO offering health insurance coverage in connection with a group health plan under subtitle A shall not be deemed to be an insurer or HMO offering an individual health insurance coverage solely because such insurer or HMO offers a conversion policy.

(3) DISREGARD OF ASSOCIATION COVERAGE.—An insurer or HMO that offers health insurance coverage only in connection with a group health plan or

in connection with individuals based on affiliation with one or more bona fide associations is not considered, for purposes of this subtitle, to be offering individual health insurance coverage.

(4) MARKETING OF PLANS.—Nothing in this section shall be construed to prevent a State from requiring insurer or HMOs offering individual health insurance coverage to actively market such coverage.

SEC. 142. GUARANTEED RENEWABILITY OF INDIVIDUAL HEALTH INSURANCE COVERAGE.

(a) GUARANTEED RENEWABILITY.—Subject to the succeeding provisions of this section, an insurer or HMO that provides individual health insurance coverage to an individual shall renew or continue such coverage at the option of the individual.

(b) NONRENEWAL PERMITTED IN CERTAIN CASES.—An insurer or HMO may nonrenew or discontinue individual health insurance coverage of an individual only based on one or more of the following:

(1) NONPAYMENT.—The individual fails to pay payment of premiums or contributions in accordance with the terms of the coverage or the insurer or organization has not failed to receive timely premium payments.

(2) FRAUD.—The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) TERMINATION OF COVERAGE.—Subject to subsection (c), the insurer or HMO is ceasing to offer health insurance coverage in the individual market in a State (or, in the case of a network plan or HMO, in a geographic area).

(4) MOVEMENT OUTSIDE SERVICE AREA.—The individual has changed residence and resides outside the service area of the insurer or organization or outside the area for which the insurer or organization is authorized to do business.

Paragraph (4) shall apply to an insurer or HMO only if it is applied uniformly without regard to the claims experience of employers and their employees (and their beneficiaries) or the health status of such employees and beneficiaries.

(c) TERMINATION OF INDIVIDUAL COVERAGE.—The provisions of section 132(c) shall apply to this section in the same manner as they apply under section 132, except that any reference to an employer or market is deemed a reference to the covered individual or the individual market, respectively.

(d) EXCEPTION FOR UNIFORM MODIFICATION OF COVERAGE.—The provisions of section 132(d) shall apply to individual health insurance coverage in the individual market under this section in the same manner as it applies to health insurance coverage offered in connection with a group health plan in the group market under such section.

PART 3—ENFORCEMENT

SEC. 151. INCORPORATION OF PROVISIONS FOR STATE ENFORCEMENT WITH FEDERAL FALLBACK AUTHORITY.

The provisions of paragraphs (1) and (2) of section 104(c) shall apply to enforcement of requirements in each section in part 1 or part 2 with respect to insurers and HMOs regulated by a State in the same manner as such provisions apply to enforcement of requirements in section 101, 102, or 103 with respect to insurers and HMOs regulated by a State.

Subtitle C—Affordable and Available Health Coverage Through Multiple Employer Pooling Arrangements

SEC. 161. CLARIFICATION OF DUTY OF THE SECRETARY OF LABOR TO IMPLEMENT PROVISIONS OF CURRENT LAW PROVIDING FOR EXEMPTIONS AND SOLVENCY STANDARDS FOR MULTIPLE EMPLOYER HEALTH PLANS.

(a) RULES GOVERNING REGULATION OF MULTIPLE EMPLOYER HEALTH PLANS.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 (as amended by the preceding provisions of this title) is amended by inserting after part 6 the following new part:

"PART 7—RULES GOVERNING REGULATION OF MULTIPLE EMPLOYER HEALTH PLANS

"SEC. 701. DEFINITIONS.

''For purposes of this part—

''(1) FULLY INSURED.—A particular benefit under a group health plan or a multiple employer welfare arrangement is 'fully insured' if such benefit (irrespective of any recourse available against other parties) is provided by an insurer or a health maintenance organization in a manner so that such bene-

fit constitutes insurance regulated by the law of a State (within the meaning of section 514(b)(2)(A)).

''(2) INSURER.—The term 'insurer' means an insurance company, insurance service, or insurance organization which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2)(A)).

''(3) HEALTH MAINTENANCE ORGANIZATION.—The terms 'health maintenance organization' means—

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

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

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

if it is subject to State law which regulates insurance (within the meaning of section 514(b)(2)(A)).

''(4) MULTIPLE EMPLOYER HEALTH PLAN.—The term 'multiple employer health plan' means a multiple employer welfare arrangement which provides medical care and which is or has been exempt under section 514(b)(6)(B).

''(5) PARTICIPATING EMPLOYER.—The term 'participating employer' means, in connection with a multiple employer welfare arrangement, any employer if any of its employees, or any of the individuals who are dependents (as defined under the terms of the arrangement) of its employees, are or were covered under such arrangement in connection with the employment of the employees.

''(6) SPONSOR.—The term 'sponsor' means, in connection with a multiple employer welfare arrangement, the association or other entity which establishes or maintains the arrangement.

''(7) STATE INSURANCE COMMISSIONER.—The term 'State insurance commissioner' means the insurance commissioner (or similar official) of a State.

"SEC. 702. CLARIFICATION OF DUTY OF THE SECRETARY TO IMPLEMENT PROVISIONS OF CURRENT LAW PROVIDING FOR EXEMPTIONS AND SOLVENCY STANDARDS FOR MULTIPLE EMPLOYER HEALTH PLANS.

''(a) TREATMENT AS EMPLOYEE WELFARE BENEFIT PLAN WHICH IS A GROUP HEALTH PLAN.—

''(1) IN GENERAL.—A multiple employer welfare arrangement—

''(A) under which the benefits consist solely of medical care (disregarding such incidental benefits as the Secretary shall specify by regulation), and

''(B) under which some or all benefits are not fully insured,

shall be treated for purposes of subtitle A and the other parts of this title as an employee welfare benefit plan which is a group health plan if the arrangement is exempt under section 514(b)(6)(B) in accordance with this part.

''(2) EXCEPTION.—In the case of a multiple employer welfare arrangement which would be described in section 3(40)(A)(i) but solely for the failure to meet the requirements of section 3(40)(C)(ii), paragraph (1) shall apply with respect to such ar-

rangement, but only with respect to benefits provided thereunder which constitute medical care.

''(b) TREATMENT UNDER PREEMPTION RULES.—

''(1) IN GENERAL.—The Secretary shall prescribe regulations described in section 514(b)(6)(B)(i), applicable to multiple employer welfare arrangements described in subparagraphs (A) and (B) of subsection (a)(1), providing a procedure for granting exemptions from section 514(b)(6)(A)(ii) with respect to such arrangements. Under such regulations, any such arrangement treated under subsection (a) as an employee welfare benefit plan shall be deemed to be an arrangement described in section 514(b)(6)(B)(ii).

''(2) STANDARDS.—Under the procedure prescribed pursuant to paragraph (1), the Secretary shall grant an arrangement described in subsection (a) an exemption described in subsection (a) only if the Secretary finds that—

''(A) such exemption—

''(i) is administratively feasible,

''(ii) is not adverse to the interests of the individuals covered under the arrangement, and

"(iii) is protective of the rights and benefits of the individuals covered under the arrangement,

"(B) the application for the exemption meets the requirements of paragraph (3), and

"(C) the requirements of sections 703 and 704 are met with respect to the arrangement.

"(3) INFORMATION TO BE INCLUDED IN APPLICATION FOR EXEMPTION.—An application for an exemption described in subsection (a) meets the requirements of this paragraph only if it includes, in a manner and form prescribed in regulations of the Secretary, at least the following information:

"(A) IDENTIFYING INFORMATION.—The names and addresses of—

"(i) the sponsor, and

"(ii) the members of the board of trustees of the arrangement.

"(B) STATES IN WHICH ARRANGEMENT INTENDS TO DO BUSINESS.—The States in which individuals covered under the arrangement are to be located and the number of such individuals expected to be located in each such State.

"(C) BONDING REQUIREMENTS.—Evidence provided by the board of trustees that the bond-

ing requirements of section 412 will be met as of the date of the application or (if later) commencement of operations.

''(D) PLAN DOCUMENTS.—A copy of the documents governing the arrangement (including any bylaws and trust agreements), the summary plan description, and other material describing the benefits and coverage that will be provided to individuals covered under the arrangement.

''(E) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the arrangement and contract administrators and other service providers.

''(F) FUNDING REPORT.—A report setting forth information determined as of a date within the 120-day period ending with the date of the application, including the following:

''(i) RESERVES.—A statement, certified by the board of trustees of the arrangement, and a statement of actuarial opinion, signed by a qualified actuary, that all applicable requirements of section 705 are or will be met in accordance with regulations which the Secretary shall prescribe.

"(ii) ADEQUACY OF CONTRIBUTION RATES.—A statement of actuarial opinion, signed by a qualified actuary, which sets forth a description of the extent to which contribution rates are adequate to provide for the payment of all obligations and the maintenance of required reserves under the arrangement for the 12-month period beginning with such date within such 120-day period, taking into account the expected coverage and experience of the arrangement. If the contribution rates are not fully adequate, the statement of actuarial opinion shall indicate the extent to which the rates are inadequate and the changes needed to ensure adequacy.

"(iii) CURRENT AND PROJECTED VALUE OF ASSETS AND LIABILITIES.—A statement of actuarial opinion signed by a qualified actuary, which sets forth the current value of the assets and liabilities accumulated under the arrangement and a projection of the assets, liabilities, income, and expenses of the arrangement for the 12-month period referred to in clause (ii).

The income statement shall identify separately the arrangement's administrative expenses and claims.

''(iv) COSTS OF COVERAGE TO BE CHARGED AND OTHER EXPENSES.—A statement of the costs of coverage to be charged, including an itemization of amounts for administration, reserves, and other expenses associated with the operation of the arrangement.

''(v) OTHER INFORMATION.—Any other information which may be prescribed in regulations of the Secretary as necessary to carry out the purposes of this part.

''(4) FILING FEE.—Under the procedure prescribed pursuant to paragraph (1), a multiple employer welfare arrangement shall pay to the Secretary at the time of filing an application for an exemption referred to in subsection (a) a filing fee in the amount of $5,000, which shall be available, to the extent provided in appropriation Acts, to the Secretary for the sole purpose of administering the exemption procedures applicable with respect to such arrangement.

''(5) CLASS EXEMPTION TREATMENT FOR EXISTING LARGE ARRANGEMENTS.—Under the procedure prescribed pursuant to paragraph (1), if—

''(A) at the time of application for an exemption under section 514(b)(6)(B) with respect to an arrangement which has been in existence as of the date of the enactment of the Health Coverage Availability and Affordability Act of 1996 for at least 3 years, either (A) the arrangement covers at least 1,000 participants and beneficiaries, or (B) with respect to the arrangement there are at least 2,000 employees of eligible participating employers,

''(B) a complete application for the exemption with respect to the arrangement has been filed and is pending, and

''(C) the application meets such requirements (if any) as the Secretary may provide with respect to class exemptions under this subsection,

the exemption shall be treated as having been granted with respect to the arrangement unless and until the Secretary provides appropriate notice that the exemption has been denied.

''(c) FILING NOTICE OF EXEMPTION WITH STATES.—An exemption granted under section 514(b)(6)(B) to a multiple employer welfare arrangement shall not be effective unless written notice of such exemption is filed with the State insurance commissioner of each State in which at least 5 percent of the individuals covered under the arrangement are located. For purposes of this subsection, an individual shall be considered to be located in the State in which a known address of such individual is located or in which such individual is employed. The Secretary may by regulation provide in specified cases for the application of the preceding sentence with lesser percentages in lieu of such 5 percent amount.

''(d) NOTICE OF MATERIAL CHANGES.—In the case of any multiple employer welfare arrangement exempt under section 514(b)(6)(B), descriptions of material changes in any information which was required to be submitted with the application for the exemption under this part shall be filed in such form and manner as shall be prescribed in regulations of the Secretary. The Secretary may require by regulation prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the exemption.

''(e) REPORTING REQUIREMENTS.—Under regulations of the Secretary, the requirements of sections 102,

103, and 104 shall apply with respect to any multiple employer welfare arrangement which is or has been exempt under section 514(b)(6)(B) in the same manner and to the same extent as such requirements apply to employee welfare benefit plans, irrespective of whether such exemption continues in effect. The annual report required under section 103 for any plan year in the case of any such multiple employer welfare arrangement shall also include information described in subsection (b)(3)(F) with respect to the plan year and, notwithstanding section 104(a)(1)(A), shall be filed not later than 90 days after the close of the plan year.

''(f) ENGAGEMENT OF QUALIFIED ACTUARY.—The board of trustees of each multiple employer welfare arrangement which is or has been exempt under section 514(b)(6)(B) shall engage, on behalf of all covered individuals, a qualified actuary who shall be responsible for the preparation of the materials comprising information necessary to be submitted by a qualified actuary under this part. The qualified actuary shall utilize such assumptions and techniques as are necessary to enable such actuary to form an opinion as to whether the contents of the matters reported under this part—

''(1) are in the aggregate reasonably related to the experience of the arrangement and to reasonable expectations, and

''(2) represent such actuary's best estimate of anticipated experience under the arrangement.

The opinion by the qualified actuary shall be made with respect to, and shall be made a part of, the annual report.

''SEC. 703. REQUIREMENTS RELATING TO SPONSORS, BOARDS OF TRUSTEES, AND PLAN OPERATIONS.

''(a) IN GENERAL.—A complete application for an exemption under section 514(b)(6)(B) shall include information which the Secretary determines to be complete and accurate and sufficient to demonstrate that the following requirements are met with respect to the arrangement:

''(1) SPONSOR.—The sponsor is, and has been (together with its immediate predecessor, if any) for a continuous period of not less than 5 years before the date of the application, organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis, as a trade association, an industry association, a professional association, or a chamber of commerce (or similar business group, including a corporation or

similar organization that operates on a cooperative basis (within the meaning of section 1381 of the Internal Revenue Code of 1986)), for substantial purposes other than that of obtaining or providing medical care (within the meaning of section 607(1)), and the applicant demonstrates to the satisfaction of the Secretary that the sponsor is established as a permanent entity which receives the active support of its members and collects dues or contributions from its members on a periodic basis, without conditioning such dues or contributions on the basis of the health status of the employees of such members or the dependents of such employees or on the basis of participation in a group health plan. Any sponsor consisting of an association of entities meeting the preceding requirements of this paragraph shall be treated as meeting the requirements of this paragraph.

''(2) BOARD OF TRUSTEES.—The arrangement is operated, pursuant to a trust agreement, by a board of trustees which has complete fiscal control over the arrangement and which is responsible for all operations of the arrangement, and the board of trustees has in effect rules of operation and financial controls, based on a 3-year plan of operation, ade-

quate to carry out the terms of the arrangement and to meet all requirements of this title applicable to the arrangement. The members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business. No such member is an owner, officer, director, or employee of, or partner in, a contract administrator or other service provider to the arrangement, except that officers or employees of a sponsor which is a service provider (other than a contract administrator) to the arrangement may be members of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the arrangement other than on behalf of the sponsor. The board has sole authority to approve applications for participation in the arrangement and to contract with a service provider to administer the day-to-day affairs of the arrangement.

''(3) COVERED PERSONS.—The instruments governing the arrangement include a written instrument which provides that, effective upon becoming

an arrangement exempt under section 514(b)(6)(B)—

"(A) all participating employers must be members or affiliated members of the sponsor, except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or affiliated member of the sponsor, participating employers may also include such employer,

"(B) all individuals thereafter commencing coverage under the arrangement must be—

"(i) active or retired owners (including self-employed individuals), officers, directors, or employees of, or partners in, participating employers, or

"(ii) the beneficiaries of individuals described in clause (i), and

"(C) no participating employer may provide health insurance coverage in the individual market for any employee not covered under the arrangement which is similar to the coverage

contemporaneously provided to employees of the employer under the arrangement, if such exclusion of the employee from coverage under the arrangement is based in whole or in part on the health status of the employee and such employee would, but for such exclusion on such basis, be eligible for coverage under the arrangement.

''(4) INCLUSION OF ELIGIBLE EMPLOYERS AND EMPLOYEES.—No employer described in paragraph (3) is excluded as a participating employer (except to the extent that requirements of the type referred to in section 131(d)(2) of the Health Coverage Availability and Affordability Act of 1996 are not met) and the requirements of section 103 of such Act (as referred to in section 104(b)(1) of such Act) are met.

''(5) RESTRICTION ON VARIATIONS OF PREMIUM RATES.—Premium rates under the arrangement with respect to any particular employer do not vary on the basis of the claims experience of such employer alone.

''(b) TREATMENT OF FRANCHISE NETWORKS.—In the case of a multiple employer welfare arrangement which is established and maintained by a franchisor for a fran-

chise network consisting of its franchisees, the requirements of subsection (a)(1) shall not apply with respect to such network in any case in which such requirements would be met if the franchisor were deemed to be the sponsor referred to in subsection (a)(1), such network were deemed to be an association described in subsection (a)(1), and each franchisee were deemed to be a member (of the association and the sponsor) referred to in subsection (a)(1).

''(c) CERTAIN COLLECTIVELY BARGAINED ARRANGEMENTS.—In the case of a multiple employer welfare arrangement in existence on March 6, 1996, which would be described in section 3(40)(A)(i) but solely for the failure to meet the requirements of section 3(40)(C)(ii) or (to the extent provided in regulations of the Secretary) solely for the failure to meet the requirements of subparagraph (D) or (F) of section 3(40)—

''(1) subsection (a)(1) shall not apply, and

''(2) the joint board of trustees shall be considered the board of trustees required under subsection (a)(2).

''(d) CERTAIN ARRANGEMENTS NOT MEETING SINGLE EMPLOYER REQUIREMENT.—

''(1) IN GENERAL.—In any case in which the majority of the employees covered under a multiple

employer welfare arrangement are employees of a single employer (within the meaning of clauses (i) and (ii) of section 3(40)(B)), if all other employees covered under the arrangement are employed by employers who are related to such single employer—

"(A) subsection (a)(1) shall not apply if the sponsor of the arrangement is the person who would be the plan sponsor if the related employers were disregarded in determining whether the requirements of section 3(40)(B) are met, and

"(B) subsection (a)(2) shall be treated as satisfied if the board of trustees is the named fiduciary in connection with the arrangement.

"(2) RELATED EMPLOYERS.—For purposes of paragraph (1), employers are 'related' if there is among all such employers a common ownership interest or a substantial commonality of business operations based on common suppliers or customers.

"SEC. 704. OTHER REQUIREMENTS FOR EXEMPTION.

"A multiple employer welfare arrangement exempt under section 514(b)(6)(B) shall meet the following requirements:

"(1) CONTENTS OF GOVERNING INSTRUMENTS.—The instruments governing the arrange-

ment include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—

"(A) provides that the board of trustees serves as the named fiduciary required for plans under section 402(a)(1) and serves in the capacity of a plan administrator (referred to in section 3(16)(A)),

"(B) provides that the sponsor of the arrangement is to serve as plan sponsor (referred to in section 3(16)(B)), and

"(C) incorporates the requirements of section 705.

"(2) CONTRIBUTION RATES.—The contribution rates referred to in section 702(b)(3)(F)(ii) are adequate.

"(3) REGULATORY REQUIREMENTS.—Such other requirements as the Secretary may prescribe by regulation as necessary to carry out the purposes of this part.

"SEC. 705. MAINTENANCE OF RESERVES.

"(a) IN GENERAL.—Each multiple employer welfare arrangement which is or has been exempt under section 514(b)(6)(B) and under which benefits are not fully in-

sured shall establish and maintain reserves, consisting of—

''(1) a reserve sufficient for unearned contributions,

''(2) a reserve sufficient for benefit liabilities which have been incurred, which have not been satisfied, and for which risk of loss has not yet been transferred, and for expected administrative costs with respect to such benefit liabilities, and

''(3) a reserve, in an amount recommended by the qualified actuary, for any other obligations of the arrangement.

''(b) MINIMUM AMOUNT FOR CERTAIN RESERVES.—The total of the reserves described in subsection (a)(2) shall not be less than an amount equal to the greater of—

''(1) 25 percent of expected incurred claims and expenses for the plan year, or

''(2) $400,000.

''(c) REQUIRED MARGIN.—In determining the amounts of reserves required under this section in connection with any multiple employer welfare arrangement, the qualified actuary shall include a margin for error and other fluctuations taking into account the specific circumstances of such arrangement.

''(d) ADDITIONAL REQUIREMENTS.—The Secretary may provide such additional requirements relating to reserves and excess/stop loss coverage as the Secretary considers appropriate. Such requirements may be provided, by regulation or otherwise, with respect to any arrangement or any class of arrangements.

''(e) ADJUSTMENTS FOR EXCESS/STOP LOSS COVERAGE.—The Secretary may provide for adjustments to the levels of reserves otherwise required under subsections (a) and (b) with respect to any arrangement or class of arrangements to take into account excess/stop loss coverage provided with respect to such arrangement or arrangements.

''(f) ALTERNATIVE MEANS OF COMPLIANCE.—The Secretary may permit an arrangement to substitute, for all or part of the requirements of this section, such security, guarantee, hold-harmless arrangement, or other financial arrangement as the Secretary determines to be adequate to enable the arrangement to fully meet all its financial obligations on a timely basis. The Secretary may take into account, for purposes of this subsection, evidence provided by the arrangement or sponsor which demonstrates an assumption of liability with respect to the arrangement. Such evidence may be in the form of a contract of indemnification, lien, bonding, insurance, letter of

credit, recourse under applicable terms of the arrangement in the form of assessments of participating employers, security, or other financial arrangement.

"SEC. 706. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

"Except as provided in section 707(b), a multiple employer welfare arrangement which is or has been exempt under section 514(b)(6)(B) may terminate only if the board of trustees—

"(1) not less than 60 days before the proposed termination date, provides to the participants and beneficiaries a written notice of intent to terminate stating that such termination is intended and the proposed termination date,

"(2) develops a plan for winding up the affairs of the arrangement in connection with such termination in a manner which will result in timely payment of all benefits for which the arrangement is obligated, and

"(3) submits such plan in writing to the Secretary.

Actions required under this paragraph shall be taken in such form and manner as may be prescribed in regulations of the Secretary.

"SEC. 707. CORRECTIVE ACTIONS AND MANDATORY TERMINATION.

"(a) ACTIONS TO AVOID DEPLETION OF RESERVES.—A multiple employer welfare arrangement which is or has been exempt under section 514(b)(6)(B) shall continue to meet the requirements of section 705, irrespective of whether such exemption continues in effect. The board of trustees of such arrangement shall determine quarterly whether the requirements of section 705 are met. In any case in which the committee determines that there is reason to believe that there is or will be a failure to meet such requirements, or the Secretary makes such a determination and so notifies the committee, the committee shall immediately notify the qualified actuary engaged by the arrangement, and such actuary shall, not later than the end of the next following month, make such recommendations to the committee for corrective action as the actuary determines necessary to ensure compliance with section 705. Not later than 10 days after receiving from the actuary recommendations for corrective actions, the committee shall notify the Secretary (in such form and manner as the Secretary may prescribe by regulation) of such recommendations of the actuary for corrective action, together with a description of the actions (if any) that the committee has taken or plans to take in response to such recommendations. The committee shall thereafter report

to the Secretary, in such form and frequency as the Secretary may specify to the committee, regarding corrective action taken by the committee until the requirements of section 705 are met.

''(b) MANDATORY TERMINATION.—In any case in which—

''(1) the Secretary has been notified under subsection (a) of a failure of a multiple employer welfare arrangement which is or has been exempt under section 514(b)(6)(B) to meet the requirements of section 705 and has not been notified by the board of trustees of the arrangement that corrective action has restored compliance with such requirements, and

''(2) the Secretary determines that the continuing failure to meet the requirements of section 705 can be reasonably expected to result in a continuing failure to pay benefits for which the arrangement is obligated,

the board of trustees of the arrangement shall, at the direction of the Secretary, terminate the arrangement and, in the course of the termination, take such actions as the Secretary may require, including recovering for the arrangement any liability under section 705(f), as necessary to ensure that the affairs of the arrangement will be, to the maximum extent possible, wound up in a manner

which will result in timely provision of all benefits for which the arrangement is obligated.

"SEC. 708. ADDITIONAL RULES REGARDING STATE AUTHORITY.

"(a) EXCLUSION OF ARRANGEMENTS FROM THE SMALL GROUP MARKET IN ANY STATE UPON STATE'S CERTIFICATION OF GUARANTEED ACCESS TO HEALTH INSURANCE COVERAGE IN SUCH STATE.—

"(1) IN GENERAL.—If a State certifies to the Secretary that such State provides to its residents guaranteed access to health insurance coverage, during the period for which such certification is in effect, the law of such State may regulate any health care coverage provided in the small group market in such State (or prohibit the provision of such coverage) by a multiple employer welfare arrangement which is otherwise exempt under section 514(b)(6)(B) and whose sponsor is described in section 703(a)(1), notwithstanding such exemption. Any such certification shall be in effect for such period, not greater than 3 years, as is designated in such certification. Such certification shall apply with respect to such arrangements as are identified, individually or by class, in the certification.

''(2) GUARANTEED ACCESS.—For purposes of this subsection, the certification by a State that such State provides 'guaranteed access' to health insurance coverage to the residents of such State means—

''(A) certification that the number of residents of such State who are covered by a group health plan or otherwise have health insurance coverage exceeds 90 percent of the total number of the residents of such State, or

''(B) certification that—

''(i) the small group market in such State provides guaranteed issue for employees with respect to at least one option of health insurance coverage offered by insurers and health maintenance organizations in such market, and

''(ii) the State has implemented rating reforms in the small group market in such State which are designed to make health insurance coverage more affordable.

''(b) EXCEPTIONS.—

''(1) CERTAIN MULTISTATE ASSOCIATIONS.—Subsection (a) shall not apply in the case of a multiple employer welfare arrangement operating in any

State which has made a certification under subsection (a)(2)(B) if—

''(A) in the application for the exemption under section 514(b)(6)(B), the sponsor of such arrangement demonstrates to the Secretary (in such form and manner as shall be prescribed in regulations of the Secretary) that—

''(i) such sponsor operates in the majority of the 50 States and in at least 2 of the regions of the United States, and

''(ii) the arrangement covers, or is to cover (in the case of a newly established arrangement), at least 7,500 participants and beneficiaries, and

''(B) at the time of such application, the arrangement does not have pending against it any enforcement action by the State.

''(2) EXISTING ARRANGEMENTS.—Subsection (a) shall not apply with respect to an arrangement operating in any State if—

''(A) such arrangement was operating in such State as of March 6, 1996, and

''(B) at the time of the application for the exemption under section 514(b)(6), the ar-

rangement does not have pending against it any enforcement action by the State.

"(3) LIMITATIONS.—Paragraphs (1) and (2) shall not apply in the case of any State which has made a certification under subsection (a) and which, as of January 1, 1996, had enacted a law that either—

"(A) provided guaranteed issue of individual health insurance coverage offered by insurers and health maintenance organizations in the individual market using pure community rating and did not provide for any transition period (after the effective date of the guaranteed issue requirement) in the implementation of pure community rating; or

"(B) required insurers offering health insurance coverage in connection with group health plans to reimburse insurers offering individual health insurance coverage for losses resulting from those insurers offering individual health insurance coverage on an open enrollment basis.

Regulations under this part may provide for an exemption from the applicability of paragraph (1) in

the case of certain arrangements that are limited to a single industry.

''(c) ASSESSMENT AUTHORITY WITH RESPECT TO NEW ARRANGEMENTS.—

''(1) IN GENERAL.—Notwithstanding section 514, a State may impose by law a premium tax on multiple employer welfare arrangements which are otherwise exempt under section 514(b)(6)(B) and the sponsor of which is described in section 703(a)(1)—

''(A) in the case of an arrangement established after March 6, 1996, and

''(B) in the case of an arrangement in existence as of March 6, 1996, if the arrangement commenced operations in such State after March 6, 1996.

''(2) PREMIUM TAX.—For purposes of this subsection, the term 'premium tax' imposed by a State on a multiple employer welfare arrangement means any tax imposed by such State if—

''(A) such tax is computed by applying a rate to the amount of premiums or contributions received by the arrangement from participating employers located in such State with re-

spect to individuals covered under the arrangement who are residents of such State,

"(B) the rate of such tax does not exceed the rate of any tax imposed by such State on premiums or contributions received by insurers or health maintenance organizations for health insurance coverage offered in such State in connection with a group health plan,

"(C) such tax is otherwise nondiscriminatory, and

"(D) the amount of any such tax assessed on the arrangement is reduced by the amount of any tax or assessment imposed by the State on premiums or contributions received by insurers or health maintenance organizations for health insurance coverage (or other insurance related to the provision of medical care under the arrangement) provided by such insurers or health maintenance organizations in such State to such arrangement.

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

"(1) SMALL GROUP MARKET.—The term 'small group market' means the health insurance coverage market under which individuals obtain health insurance coverage (directly or through any arrangement)

on behalf of themselves (and their dependents) on the basis of employment or other relationship with respect to a small employer.

''(2) SMALL EMPLOYER.—The term 'small employer' means, in connection with a group health plan with respect to a calandar year, an employer who employs at least 2 but fewer than 51 employees on a typical business day in the year. For purposes of this paragraph, 2 or more trades or businesses, whether or not incorporated, shall be deemed a single employer if such trades or businesses are within the same control group (within the meaning of section 3(40)(B)(ii)).

''(3) REGION.—The term 'region' means any of the following regions:

''(A) The East Region, consisting of the States of Maine, New Hampshire, Vermont, New York, Massachusetts, Rhode Island, Connecticut, New Jersey, Pennsylvania, Delaware, Maryland, West Virginia, and Ohio, and the District of Columbia.

''(B) The Southeast Region, consisting of the States of Texas, Arkansas, Louisiana, Mississippi, Alabama, Georgia, Florida, South

Carolina, North Carolina, Virginia, and Tennessee.

''(C) The Midwest Region, consisting of the States of Montana, South Dakota, North Dakota, Nebraska, Kansas, Oklahoma, Minnesota, Iowa, Missouri, Wisconsin, Michigan, Illinois, and Indiana.

''(D) The West Region, consisting of the States of Oregon, Washington, Idaho, Nevada, California, New Mexico, Arizona, Nebraska, Wyoming, Hawaii, Alaska, Colorado, and Utah.''.

(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

(1) Section 514(b)(6)(A)(i) of such Act (29 U.S.C. 1144(b)(6)(A)(i)) is amended by striking ''is fully insured'' and inserting ''under which all benefits are fully insured'', and by inserting ''and which is not described in section 702(a)(1)'' after ''subparagraph (B)''.

(2) Section 514(b)(6)(B) of such Act (29 U.S.C. 1144(b)(6)(B)) is amended—

(A) by inserting ''(i)'' after ''(B)'';

(B) by striking ''which are not fully insured'' and inserting ''under which any benefit is not fully insured''; and

(C) by striking ''Any such exemption'' and inserting:

''(ii) Subject to part 7, any exemption under clause (i)''.

(c) CONFORMING AMENDMENT TO DEFINITION OF PLAN SPONSOR.—Section 3(16)(B) of such Act (29 U.S.C. 1002(16)(B)) is amended by adding at the end the following new sentence: ''Such term also includes the sponsor (as defined in section 701(6)) of a multiple employer welfare arrangement which is or has been a multiple employer health plan (as defined in section 701(4)).''.

(d) DEFINITIONS.—

(1) GROUP HEALTH PLAN.—Section 3 of such Act (29 U.S.C. 1002) is amended by adding at the end the following new paragraph:

''(42) Except as otherwise provided in this title, the term 'group health plan' means an employee welfare benefit plan to the extent that the plan provides medical care (within the meaning of section 607(1)) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.''.

(2) INCLUSION OF CERTAIN PARTNERS AND SELF-EMPLOYED SPONSORS IN DEFINITION OF PARTICIPANT.—Section 3(7) of such Act (29 U.S.C. 1002(7)) is amended—

(A) by inserting ''(A)'' after ''(7)''; and

(B) by adding at the end the following new paragraph:

''(B) In the case of a group health plan, such term includes—

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

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

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

(3) HEALTH INSURANCE COVERAGE.—Section 3 of such Act (as amended by paragraph (1)) is amended further by adding at the end the following new paragraph:

''(43)(A) Except as provided in subparagraph (B), the term 'health insurance coverage' means benefits con-

sisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization group contract offered by an insurer or a health maintenance organization.

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

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

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

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

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

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

''(vi) Automobile medical-payment insurance.

''(vii) Coverage for a specified disease or illness.

''(viii) Hospital or fixed indemnity insurance.

''(ix) Short-term limited duration insurance.

''(x) Such other coverage, comparable to that described in previous clauses, as may be specified in regulations.''.

(4) MEDICAL CARE.—Section 607(1) of such Act (29 U.S.C. 1167(1)) is amended—

(A) by striking ''The term'' and inserting the following:

''(A) IN GENERAL.—The term'';

(B) by striking ''(as defined'' and all that follows through ''1986)''; and

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

''(B) MEDICAL CARE.—For purposes of this paragraph, the term 'medical care' means—

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

"(ii) amounts paid for, or services in the form of, transportation primarily for and essential to medical care referred to in clause (i), and

"(iii) amounts paid for insurance covering medical care referred to in clauses (i) and (ii).".

(5) OTHER DEFINITIONS.—Section 514 of such Act is further amended by adding at the end the following new subsection:

"(e) For purposes of this section, the terms 'fully insured', 'health maintenance organization', and 'insurer' have the meanings given such terms in section 701.".

(e) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 (as amended by section 102(g)) is amended by inserting after the item relating to section 609 the following new items:

"PART 7—RULES GOVERNING REGULATION OF MULTIPLE EMPLOYER HEALTH PLANS

SEC. 162. AFFORDABLE AND AVAILABLE FULLY INSURED HEALTH COVERAGE THROUGH VOLUNTARY HEALTH INSURANCE ASSOCIATIONS.

Section 514 of the Employee Retirement Income Security Act of 1974 is amended—

(1) by redesignating subsections (d) as subsection (e); and

(2) by inserting after subsection (c) the following new subsection:

''(d)(1) The provisions of this title shall supercede any and all State laws which regulate insurance insofar as they may now or hereafter—

''(A) preclude an insurer or health maintenance organization from offering health insurance coverage under voluntary health insurance associations,

''(B) preclude an insurer or health maintenance organization from setting premium rates under a voluntary health insurance association based on the claims experience of the voluntary health insurance association (without varying the premium rates of any particular employer on the basis of the claims experience of such employer alone), or

''(C) require—

''(i) health insurance coverage in connection with a voluntary health insurance associa-

tion to include specific items or services consisting of medical care, or

''(ii) an insurer or health maintenance organization offering health insurance coverage in connection with a voluntary health insurance association to include in such health insurance coverage specific items or services consisting of medical care,

except to the extent that such State laws prohibit an exclusion for a specific disease in such health insurance coverage.

Subparagraph (C) shall apply only with respect to items and services which shall be specified in a list which shall be prescribed in regulations of the Secretary.

''(2)(A) If a State certifies to the Secretary that such State provides to its residents guaranteed access to health insurance coverage, during the period for which such certification is in effect, the law of such State may regulate any health insurance coverage provided in the small group market in such State (or prohibit the provision of such coverage) by a voluntary health insurance association. Any such certification shall be in effect for such period, not greater than 3 years, as is designated in such certification.

''(B) For purposes of this paragraph, the certification by a State that such State provides 'guaranteed access'

to health insurance coverage to the residents of such State means—

''(i) certification that the number of residents of such State who are covered by a group health plan or otherwise have health insurance coverage exceeds 90 percent of the total number of the residents of such State, or

''(ii) certification that—

''(I) the small group market in such State provides guaranteed issue for employees with respect to at least one option of health insurance coverage offered by insurers and health maintenance organizations in such market, and

''(II) the State has implemented rating reforms in the small group market in such State which are designed to make health insurance coverage more affordable.

''(3)(A) Paragraph (2) shall not apply in the case of any voluntary health insurance association with respect to any State if the qualified association demonstrates to the Secretary (in such form and manner as shall be prescribed in regulations of the Secretary) that—

''(i) such qualified association operates in the majority of the 50 States and in at least 2 of the regions of the United States,

''(ii) the arrangement covers, or is to cover (in the case of a newly established arrangement), at least 7,500 participants and beneficiaries, and

''(iii) under the terms of the arrangement, either—

''(I) the qualified association does not exclude from membership any small employer in the State, or

''(II) the arrangement accepts every small employer in the State that applies for coverage.

''(B)(i) Subject to clause (ii), paragraph (2) shall not apply with respect to a voluntary health insurance association operating in any State if such association was operating in such State as of March 6, 1996.

''(ii) Clause (i) shall apply in the case of an arrangement in connection with any State only if the qualified association demonstrates to the Secretary (in such form and manner as shall be prescribed in regulations of the Secretary) either—

''(I) that the qualified association does not exclude from membership any small employer in the State, or

''(II) that the arrangement accepts every small employer in such State that applies for coverage.

''(C) Subparagraphs (A) and (B) shall not apply in the case of any State which has made a certification under paragraph (2) and which, as of January 1, 1996, had enacted a law that either—

''(i) provided guaranteed issue of individual health insurance coverage offered by insurers and health maintenance organizations in the individual market using pure community rating and did not provide for any transition period (after the effective date of the guaranteed issue requirement) in the implementation of pure community rating; or

''(ii) required insurers offering health insurance coverage in connection with group health plans to reimburse insurers offering individual health insurance coverage for losses resulting from those insurers offering individual health insurance coverage on an open enrollment basis.

''(5) For purposes of this subsection—

''(A) The term 'voluntary health insurance association' means a multiple employer welfare arrangement—

''(i) under which benefits include medical care (within the meaning of section 607(1)),

''(ii) under which all benefits consisting of such medical care are fully insured,

"(iii) which is maintained by a qualified association,

"(iv) under which no employer is excluded as a participating employer (except to the extent that requirements of the type referred to in section 131(d)(2) of the Health Coverage Availability and Affordability Act of 1996 are not met), the requirements of section 103 of such Act (as referred to in section 104(b)(1) of such Act) are met, and all health insurance coverage options are aggressively marketed to eligible employees and their dependents, and

"(v) under which, with respect to the operations of the arrangement in any State, the health insurance coverage is provided by an insurer or health maintenance organization to which the laws of such State applies.

"(B) The term 'qualified association' means an association with respect to which the following requirements are met:

"(i) The sponsor of the association is, and has been (together with its immediate predecessor, if any) for a continuous period of not less than 5 years, organized and maintained in good faith, with a constitution and bylaws spe-

cifically stating its purpose, as a trade association, an industry association, a professional association, or a chamber of commerce (or similar business group), for substantial purposes other than that of obtaining or providing medical care (within the meaning of section 607(1)).

''(ii) The sponsor of the association is established as a permanent entity which receives the active support of its members.

''(iii) The constitution and bylaws of the association provide for periodic meetings on at least an annual basis.

''(iv) The association collects dues or contributions from its members on a periodic basis, without conditioning such dues or contributions on the basis of the health status of the employees of such members or the dependents of such employees or on the basis of participation in a group health plan or voluntary health insurance association.

Such term includes a group of qualified associations, as defined in the preceding provisions of this clause.

''(C) The term 'small group market' means the health insurance coverage market under which individuals obtain health insurance coverage (directly or

through any arrangement) on behalf of themselves (and their dependents) on the basis of employment or other relationship with respect to a small employer.

''(D) The term 'small employer' means, in connection with a group health plan with respect to a calandar year, an employer who employs at least 2 but fewer than 51 employees on a typical business day in the year. For purposes of this paragraph, 2 or more trades or businesses, whether or not incorporated, shall be deemed a single employer if such trades or businesses are within the same control group (within the meaning of section 3(40)(B)(ii)).

''(E) The term 'region' means any of the following regions:

''(i) The East Region, consisting of the States of Maine, New Hampshire, Vermont, New York, Massachusetts, Rhode Island, Connecticut, New Jersey, Pennsylvania, Delaware, Maryland, West Virginia, and Ohio and the District of Columbia.

''(ii) The Southeast Region, consisting of the States of Texas, Arkansas, Louisiana, Mississippi, Alabama, Georgia, Florida, South

Carolina, North Carolina, Virginia, and Tennessee.

''(iii) The Midwest Region, consisting of the States of Montana, South Dakota, North Dakota, Nebraska, Kansas, Oklahoma, Minnesota, Iowa, Missouri, Wisconsin, Michigan, Illinois, and Indiana.

''(iv) The West Region, consisting of the States of Oregon, Washington, Idaho, Nevada, California, New Mexico, Arizona, Nebraska, Wyoming, Hawaii, Alaska, Colorado, and Utah.''.

SEC. 163. STATE AUTHORITY FULLY APPLICABLE TO SELF-INSURED MULTIPLE EMPLOYER WELFARE ARRANGEMENTS PROVIDING MEDICAL CARE WHICH ARE NOT EXEMPTED UNDER NEW PART 7.

(a) IN GENERAL.—Section 514(b)(6)(A)(ii) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(6)(A)(ii)) is amended by inserting before the period the following: '', except that, in any such case, if the arrangement provides medical care (within the meaning of section 607(1)), such a law of any State may apply without limitation under this title''.

(b) CROSS-REFERENCE.—Section 514(b)(6) of such Act (29 U.S.C. 1144(b)(6)) (as amended by section 301) is amended by adding at the end the following new subparagraph:

''(G) For additional rules relating to exemption from subparagraph (A)(ii) of multiple employer health plans, see part 7.''.

SEC. 164. CLARIFICATION OF TREATMENT OF SINGLE EMPLOYER ARRANGEMENTS.

Section 3(40)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amended—

(1) in clause (i), by inserting ''for any plan year of any such plan, or any fiscal year of any such other arrangement,'' after ''single employer'', and by inserting ''during such year or at any time during the preceding 1-year period'' after ''control group'';

(2) in clause (iii)—

(A) by striking ''common control shall not be based on an interest of less than 25 percent'' and inserting ''an interest of greater than 25 percent may not be required as the minimum interest necessary for common control''; and

(B) by striking ''similar to'' and inserting ''consistent and coextensive with'';

(3) by redesignating clauses (iv) and (v) as clauses (v) and (vi), respectively; and

(4) by inserting after clause (iii) the following new clause:

''(iv) in determining, after the application of clause (i), whether benefits are provided to employees of two or more employers, the arrangement shall be treated as having only 1 participating employer if, after the application of clause (i), the number of individuals who are employees and former employees of any one participating employer and who are covered under the arrangement is greater than 75 percent of the aggregate number of all individuals who are employees or former employees of participating employers and who are covered under the arrangement,''.

SEC. 165. CLARIFICATION OF TREATMENT OF CERTAIN COLLECTIVELY BARGAINED ARRANGEMENTS.

(a) IN GENERAL.—Section 3(40)(A)(i) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(A)(i)) is amended to read as follows:

''(i)(I) under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d)

of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws, and (II) in accordance with subparagraphs (C), (D), and (E),''.

(b) LIMITATIONS.—Section 3(40) of such Act (29 U.S.C. 1002(40)) is amended by adding at the end the following new subparagraphs:

''(C) A plan or other arrangement is established or maintained in accordance with this subparagraph only if the following requirements are met:

''(i) The plan or other arrangement, and the employee organization or any other entity sponsoring the plan or other arrangement, do not—

''(I) utilize the services of any licensed insurance agent or broker for soliciting or enrolling employers or individuals as participating employers or covered individuals under the plan or other arrangement, or

''(II) pay a commission or any other type of compensation to a person, other than a full time employee of the employee organization (or a member of the organization to the extent pro-

vided in regulations of the Secretary), that is related either to the volume or number of employers or individuals solicited or enrolled as participating employers or covered individuals under the plan or other arrangement, or to the dollar amount or size of the contributions made by participating employers or covered individuals to the plan or other arrangement,

except to the extent that the services used by the plan, arrangement, organization, or other entity consist solely of preparation of documents necessary for compliance with the reporting and disclosure requirements of part 1 or administrative, investment, or consulting services unrelated to solicitation or enrollment of covered individuals.

''(ii) As of the end of the preceding plan year, the number of covered individuals under the plan or other arrangement who are identified to the plan or arrangement and who are neither—

''(I) employed within a bargaining unit covered by any of the collective bargaining agreements with a participating employer (nor covered on the basis of an individual's employment in such a bargaining unit), nor

''(II) present employees (or former employees who were covered while employed) of the sponsoring employee organization, of an employer who is or was a party to any of the collective bargaining agreements, or of the plan or other arrangement or a related plan or arrangement (nor covered on the basis of such present or former employment),

does not exceed 15 percent of the total number of individuals who are covered under the plan or arrangement and who are present or former employees who are or were covered under the plan or arrangement pursuant to a collective bargaining agreement with a participating employer. The requirements of the preceding provisions of this clause shall be treated as satisfied if, as of the end of the preceding plan year, such covered individuals are comprised solely of individuals who were covered individuals under the plan or other arrangement as of the date of the enactment of the Health Coverage Availability and Affordability Act 1996 and, as of the end of the preceding plan year, the number of such covered individuals does not exceed 25 percent of the total number of present and former employees enrolled under the plan or other arrangement.

''(iii) The employee organization or other entity sponsoring the plan or other arrangement certifies to the Secretary each year, in a form and manner which shall be prescribed in regulations of the Secretary that the plan or other arrangement meets the requirements of clauses (i) and (ii).

''(D) A plan or arrangement is established or maintained in accordance with this subparagraph only if—

''(i) all of the benefits provided under the plan or arrangement are fully insured (as defined in section 701(2)), or

''(ii)(I) the plan or arrangement is a multiemployer plan, and

''(II) the requirements of clause (B) of the proviso to clause (5) of section 302(c) of the Labor Management Relations Act, 1947 (29 U.S.C. 186(c)) are met with respect to such plan or other arrangement.

''(E) A plan or arrangement is established or maintained in accordance with this subparagraph only if—

''(i) the plan or arrangement is in effect as of the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, or

''(ii) the employee organization or other entity sponsoring the plan or arrangement—

''(I) has been in existence for at least 3 years or is affiliated with another employee organization which has been in existence for at least 3 years, or

''(II) demonstrates to the satisfaction of the Secretary that the requirements of subparagraphs (C) and (D) are met with respect to the plan or other arrangement.''.

(c) CONFORMING AMENDMENTS TO DEFINITIONS OF PARTICIPANT AND BENEFICIARY.—Section 3(7) of such Act (29 U.S.C. 1002(7)) is amended by adding at the end the following new sentence: ''Such term includes an individual who is a covered individual described in paragraph (40)(C)(ii).''.

SEC. 166. TREATMENT OF CHURCH PLANS.

(a) SPECIAL RULES FOR CHURCH PLANS.—

(1) IN GENERAL.—Part 7 of subtitle B of title I of such Act (as added and amended by the preceding provisions of this Act) is amended by adding at the end the following new section:

''SEC. 709. SPECIAL RULES FOR CHURCH PLANS.

''(a) ELECTION FOR CHURCH PLANS.—

''(1) IN GENERAL.—Notwithstanding section 4(b)(2), if the church or convention or association of churches which maintains a church plan covered

under this section makes an election with respect to such plan under this subsection (in such form and manner as the Secretary may by regulations prescribe), then, subject to this section, the provisions of this part (and other provisions of this title to the extent that they apply to group health plans which are multiple employer welfare arrangements) shall apply to such church plan, with respect to benefits provided under such plan consisting of medical care, as if—

''(A) section 4(b)(2) did not contain an exclusion for church plans, and

''(B) such plan were an arrangement eligible to apply for an exemption under this part.

''(2) ELECTION IRREVOCABLE.—An election under this subsection with respect to any church plan shall be binding with respect to such plan, and, once made, shall be irrevocable.

''(b) COVERED CHURCH PLANS.—A church plan is covered under this section if such plan provides benefits which include medical care and some or all of such benefits are not fully insured.

''(c) SPONSOR AND BOARD OF TRUSTEES.—For purposes of this part, in the case of a church plan to which this part applies pursuant to an election under subsection

(a), in treating such plan as if it were a multiple employer welfare arrangement under this part—

''(1) the church, convention or association of churches, or other organization described in section 3(33)(C)(i) which is the entity maintaining the plan shall be treated as the sponsor referred to in section 703(a)(1), and the requirements of section 703(a)(1) shall not apply, and

''(2) the board of trustees, board of directors, or other similar governing body of such sponsor shall be treated as the board of trustees referred to in section 703(a)(2), and the requirements of section 703(a)(2) shall be deemed satisfied with respect to the board of trustees.

''(d) DEEMED SATISFACTION OF TRUST REQUIREMENTS.—The requirements of section 403 shall not be treated as not satisfied with respect to a church plan to which this part applies pursuant to an election under subsection (a) solely because assets of the plan are held by an organization described in section 3(33)(C)(i), if—

''(1) such organization is incorporated separately from the church or convention or association of churches involved, and

''(2) such assets with respect to medical care are separately accounted for.

''(e) DEEMED SATISFACTION OF EXCLUSIVE BENEFIT REQUIREMENTS.—The requirements of section 404 shall not be treated as not satisfied with respect to a church plan to which this part applies pursuant to an election under subsection (a) solely because assets of the plan which are in excess of reserves required for exemption under section 514(b)(6)(B) are held in a fund in which such assets are pooled with assets of other church plans, if the assets held by such fund may not, under the terms of the plan and the terms governing such fund, be used for, or diverted to, any purpose other than for the exclusive benefit of the participants and beneficiaries of the church plans whose assets are pooled in such fund.

''(f) INAPPLICABILITY OF CERTAIN PROVISIONS.—

''(1) PROHIBITED TRANSACTIONS.—Section 406 shall not apply to a church plan by reason of an election under subsection (a).

''(2) CONTINUATION COVERAGE.—Section 601 shall not apply to a church plan by reason of an election under subsection (a).''.

(b) CONFORMING AMENDMENTS.—

(1) Section 4(b)(2) of such Act (29 U.S.C. 1003(b)(2)) is amended by inserting before the semicolon the following: '', except with respect to provi-

sions made applicable under any election made under section 704(a) of this Act''.

(2) Section 514 of such Act (29 U.S.C. 1144) is amended—

(A) in subsection (a), by inserting ''(including a church plan which is not exempt under section 4(b)(2) by reason of an election under section 704)'' before the period in the first sentence; and

(B) in subsection (b)(2)(B), by inserting ''and including a church plan which is not exempt under section 4(b)(2) by reason of an election under section 704'' after ''death benefits''.

(c) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act (as amended by the preceding provisions of this title) is further amended by inserting after the item relating to section 703 the following new item:

''Sec. 709. Special rules for church plans.''.

SEC. 167. ENFORCEMENT PROVISIONS RELATING TO MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.

(a) ENFORCEMENT OF FILING REQUIREMENTS.—Section 502 of the Employee Retirement Income Security

Act of 1974 (29 U.S.C. 1132) (as amended by sections 102(c)) is further amended—

(1) in subsection (a)(6), by striking ''paragraph (2) or (5)'' and inserting ''paragraph (2), (5), or (6)''; and

(2) by adding at the end of subsection (c) the following new paragraph:

''(6) The Secretary may assess a civil penalty against any person of up to $1,000 a day from the date of such person's failure or refusal to file the information required to be filed with the Secretary under section 101(g).''.

(b) ACTIONS BY STATES IN FEDERAL COURT.—Section 502(a) of such Act (29 U.S.C. 1132(a)) is amended—

(1) in paragraph (8), by striking ''or'' at the end;

(2) in paragraph (9), by striking the period and inserting '', or''; and

(3) by adding at the end the following:

''(10) by a State official having authority under the law of such State to enforce the laws of such State regulating insurance, to enjoin any act or practice which violates any requirement under part 7 for an exemption under section 514(b)(6)(B) which such State has the power to enforce pursuant to section 506(c)(1).''.

(c) CRIMINAL PENALTIES FOR CERTAIN WILLFUL MISREPRESENTATIONS.—Section 501 of such Act (29 U.S.C. 1131) is amended—

(1) by inserting ''(a)'' after ''SEC. 501.''; and

(2) by adding at the end the following new subsection:

''(b) Any person who, either willfully or with willful blindness, falsely represents, to any employee, any employee's beneficiary, any employer, the Secretary, or any State, an arrangement established or maintained for the purpose of offering or providing any benefit described in section 3(1) to employees or their beneficiaries as—

''(1) being a multiple employer welfare arrangement to which an exemption has been granted under section 514(b)(6)(B),

''(2) having been established or maintained under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws, or

''(3) being a plan or arrangement with respect to which the requirements of subparagraph (C), (D), or (E) of section 3(40) are met,

shall, upon conviction, be imprisoned not more than five years, be fined under title 18, United States Code, or both.''.

(d) CESSATION OF ACTIVITIES IN ABSENCE OF EFFECTIVE STATE REGULATION UNLESS STANDARDS UNDER ERISA EXEMPTION ARE MET.—Section 502 of such Act (29 U.S.C. 1132) is amended by adding at the end the following new subsection:

''(n)(1) Subject to paragraph (2), upon application by the Secretary showing the operation, promotion, or marketing of a multiple employer welfare arrangement providing benefits consisting of medical care (within the meaning of section 607(1)) that—

''(A) is not licensed, registered, or otherwise approved under the insurance laws of the States in which the arrangement offers or provides benefits, and

''(B) if there is in effect with respect to such arrangement an exemption under section 514(b)(6)(B), is not operating in accordance with the requirements under part 7 for such an exemption,

a district court of the United States shall enter an order requiring that the arrangement cease activities.

''(2) Paragraph (1) shall not apply in the case of a multiple employer welfare arrangement if the arrangement shows that—

''(A) all benefits under it referred to in paragraph (1) are fully insured, within the meaning of section 701(1), and

''(B) with respect to each State in which the arrangement offers or provides benefits, the arrangement is operating in accordance with applicable State insurance laws that are not superseded under section 514.

''(3) The court may grant such additional equitable relief, including any relief available under this title, as it deems necessary to protect the interests of the public and of persons having claims for benefits against the arrangement.''.

(e) RESPONSIBILITY FOR CLAIMS PROCEDURE.—Section 503 of such Act (29 U.S.C. 1133) is amended by adding at the end (after and below paragraph (2)) the following new sentence: ''The terms of each multiple employer health plan (within the meaning of section 701(4)) shall require the board of trustees or the named fiduciary (as applicable) to ensure that the requirements of this sec-

tion are met in connection with claims filed under the plan.''.

SEC. 168. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

''(c) STATE AUTHORITY WITH RESPECT TO MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.—

''(1) STATE ENFORCEMENT.—

''(A) AGREEMENTS WITH STATES.—A State may enter into an agreement with the Secretary for delegation to the State of some or all of the Secretary's authority under sections 502 and 504 to enforce the requirements under section 514(d) or the requirements under part 7 for an exemption under section 514(b)(6)(B). The Secretary shall enter into the agreement if the Secretary determines that the delegation provided for therein would not result in a lower level or quality of enforcement of the provisions of this title.

''(B) DELEGATIONS.—Any department, agency, or instrumentality of a State to which authority is delegated pursuant to an agree-

ment entered into under this paragraph may, if authorized under State law and to the extent consistent with such agreement, exercise the powers of the Secretary under this title which relate to such authority.

''(C) CONCURRENT AUTHORITY OF THE SECRETARY.—If the Secretary delegates authority to a State in an agreement entered into under subparagraph (A), the Secretary may continue to exercise such authority concurrently with the State.

''(D) RECOGNITION OF PRIMARY DOMICILE STATE.—In entering into any agreement with a State under subparagraph (A), the Secretary shall ensure that, as a result of such agreement and all other agreements entered into under subparagraph (A), only one State will be recognized, with respect to any particular multiple employer welfare arrangement, as the primary domicile State to which authority has been delegated pursuant to such agreements.

''(2) ASSISTANCE TO STATES.—The Secretary shall—

''(A) provide enforcement assistance to the States with respect to multiple employer welfare

arrangements, including, but not limited to, coordinating Federal and State efforts through the establishment of cooperative agreements with appropriate State agencies under which the Pension and Welfare Benefits Administration keeps the States informed of the status of its cases and makes available to the States information obtained by it,

''(B) provide continuing technical assistance to the States with respect to issues involving multiple employer welfare arrangements and this Act,

''(C) make readily available to the States timely and complete responses to requests for advisory opinions on issues described in subparagraph (B), and

''(D) distribute copies of all advisory opinions described in subparagraph (C) to the State insurance commissioner of each State.''.

SEC. 169. FILING AND DISCLOSURE REQUIREMENTS FOR MULTIPLE EMPLOYER WELFARE ARRANGEMENTS OFFERING HEALTH BENEFITS.

(a) IN GENERAL.—Section 101 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1021) is amended—

(1) by redesignating subsection (g) as subsection (i); and

(2) by inserting after subsection (f) the following new subsections:

''(g) REGISTRATION OF MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.—(1) Each multiple employer welfare arrangement shall file with the Secretary a registration statement described in paragraph (2) within 60 days before commencing operations (in the case of an arrangement commencing operations on or after January 1, 1997) and no later than February 15 of each year (in the case of an arrangement in operation since the beginning of such year), unless, as of the date by which such filing otherwise must be made, such arrangement provides no benefits consisting of medical care (within the meaning of section 607(1)).

''(2) Each registration statement—

''(A) shall be filed in such form, and contain such information concerning the multiple employer welfare arrangement and any persons involved in its operation (including whether coverage under the arrangement is fully insured), as shall be provided in regulations which shall be prescribed by the Secretary, and

''(B) if any benefits under the arrangement consisting of medical care (within the meaning of section 607(1)) are not fully insured, shall contain a certification that copies of such registration statement have been transmitted by certified mail to—

''(i) in the case of an arrangement which is a multiple employer health plan (as defined in section 701(4)), the State insurance commissioner of the domicile State of such arrangement, or

''(ii) in the case of an arrangement which is not a multiple employer health plan, the State insurance commissioner of each State in which the arrangement is located.

''(3) The person or persons responsible for filing the annual registration statement are—

''(A) the trustee or trustees so designated by the terms of the instrument under which the multiple employer welfare arrangement is established or maintained, or

''(B) in the case of a multiple employer welfare arrangement for which the trustee or trustees cannot be identified, or upon the failure of the trustee or trustees of an arrangement to file, the person or persons actually responsible for the acquisition, dis-

position, control, or management of the cash or property of the arrangement, irrespective of whether such acquisition, disposition, control, or management is exercised directly by such person or persons or through an agent designated by such person or persons.

''(4) Any agreement entered into under section 506(c) with a State as the primary domicile State with respect to any multiple employer welfare arrangement shall provide for simultaneous filings of reports required under this subsection with the Secretary and with the State insurance commissioner of such State.

''(5) For purposes of this subsection, the term 'domicile State' means, in connection with a multiple employer welfare arrangement, the State in which, according to the application for an exemption under this 514(b)(6)(B), most individuals to be covered under the arrangement are located, except that, in any case in which information contained in the latest annual report of the arrangement filed under this part indicates that most individuals covered under the arrangement are located in a different State, such term means such different State.

''(6) The Secretary may exempt from the requirements of this subsection such class of multiple employer welfare arrangements as the Secretary deems appropriate.

''(h) FILING REQUIREMENTS FOR MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.—

''(1) IN GENERAL.—A multiple employer welfare arrangement which provides benefits consisting of medical care (within the meaning of section 607(1)) shall issue to each participating employer—

''(A) a document equivalent to the summary plan description required of plans under this part,

''(B) information describing the contribution rates applicable to participating employers, and

''(C) a statement indicating—

''(i) that the arrangement is not a licensed insurer under the laws of any State,

''(ii) the extent to which any benefits under the arrangement are fully insured,

''(iii) if any benefits under the arrangement are not fully insured, whether the arrangement has been granted an exemption under section 514(b)(6)(B) (or whether such an exemption has ceased to be effective).

''(2) TIME FOR DISCLOSURE.—Such information shall be issued to employers within such reason-

able period of time before becoming participating employers as may be prescribed in regulations of the Secretary.''.

(b) EFFECTIVE DATES.—Section 101(g) of the Employee Retirement Income Security Act of 1974 (added by subsection (a)) shall take effect on the date of the enactment of this Act. Section 101(h) of such Act (added by subsection (a)) shall take effect as provided in section 171.

SEC. 170. SINGLE ANNUAL FILING FOR ALL PARTICIPATING EMPLOYERS.

(a) IN GENERAL.—Section 110 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1030) is amended by adding at the end the following new subsection:

''(c) The Secretary shall prescribe by regulation or otherwise an alternative method providing for the filing of a single annual report (as referred to in section 104(a)(1)(A)) with respect to all employers who are participating employers under a multiple employer welfare arrangement under which all coverage consists of medical care (within the meaning of section 607(1)) and is fully insured (as defined in section 701(1)).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act. The Secretary of Labor shall prescribe

the alternative method referred to in section 110(c) of the Employee Retirement Income Security Act of 1974, as added by such amendment, within 90 days after the date of the enactment of this Act.

SEC. 171. EFFECTIVE DATE; TRANSITIONAL RULE.

(a) EFFECTIVE DATE.—Except as otherwise provided in section 170(b), the amendments made by this subtitle shall take effect January 1, 1998. The Secretary shall issue all regulations necessary to carry out the amendments made by this subtitle before January 1, 1998.

(b) TRANSITIONAL RULE.—

(1) IN GENERAL.—If the sponsor of a multiple employer welfare arrangement which, as of the effective date specified in subsection (a), provides benefits consisting of medical care (within the meaning of section 607(1) of the Employee Retirement Income Security Act of 1974) files with the Secretary of Labor an application for an exemption under section 514(b)(6)(B) of such Act within 180 days after such date and the Secretary has not, as of 90 days after receipt of such application, found such application to be materially deficient, then section 514(b)(6)(A) of such Act (29 U.S.C. 1144(b)(6)(A)) shall not apply with respect to such arrangement

during the period following such date and ending on the earlier of—

(A) the date on which the Secretary denies the application under the amendments made by this title or determines, in the Secretary's sole discretion, that such exclusion from coverage under the provisions of such section 514(b)(6)(A) of such arrangement would be detrimental to the interests of individuals covered under such arrangement, or

(B) 18 months after such effective date.

(2) NO PENDING STATE ACTION.—Subparagraph (A) shall apply in the case of an arrangement only if, at the time of the application for the exemption under section 514(b)(6)(B), the arrangement does not have pending against it an enforcement action by a State.

Subtitle D—Definitions; General Provisions

SEC. 191. DEFINITIONS; SCOPE OF COVERAGE.

(a) GROUP HEALTH PLAN.—

(1) DEFINITION.—Subject to the succeeding provisions of this subsection and subsection (d)(1), the term ''group health plan'' means an employee welfare benefit plan to the extent that the plan pro-

vides medical care (as defined in subsection (c)(9)) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise, and includes a group health plan (within the meaning of section 5000(b)(1) of the Internal Revenue Code of 1986).

(2) LIMITATION OF REQUIREMENTS TO PLANS WITH 2 OR MORE EMPLOYEE PARTICIPANTS.—The requirements of subtitle A and part 1 of subtitle B shall apply in the case of a group health plan for any plan year, or for health insurance coverage offered in connection with a group health plan for a year, only if the group health plan has two or more participants as current employees on the first day of the plan year.

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

(4) TREATMENT OF CHURCH PLANS.—

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

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

(5) TREATMENT OF GOVERNMENTAL PLANS.—

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

(B) OPTIONAL DISREGARD IN DETERMINING PERIOD OF COVERAGE IF ELECTION MADE.—For purposes of applying section

101(b)(3)(B)(i), a group health plan may elect to disregard periods of coverage of an individual under a governmental plan that, under an election under subparagraph (A), is not subject to the requirements of this title.

(6) TREATMENT OF MEDICAID PLAN AS GROUP HEALTH PLAN.—A State plan under title XIX of the Social Security Act shall be treated as a group health plan for purposes of applying section 101(c)(1), unless the State elects not to be so treated.

(7) TREATMENT OF MEDICARE AND INDIAN HEALTH SERVICE PROGRAMS AS GROUP HEALTH PLAN.—Title XVIII of the Social Security Act and a program of the Indian Health Service shall be treated as a group health plan for purposes of applying section 101(c)(1).

(b) INCORPORATION OF CERTAIN DEFINITIONS IN EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—Except as provided in this section, the terms ''beneficiary'', ''church plan'', ''employee'', ''employee welfare benefit plan'', ''employer'', ''governmental plan'', ''multiemployer plan'', ''multiple employer welfare arrangement'', ''participant'', ''plan sponsor'', and ''State'' have

the meanings given such terms in section 3 of the Employee Retirement Income Security Act of 1974.

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

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

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

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

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

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

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

(E) does not make health insurance coverage offered through the association available to any individual who is not a member (or de-

pendent of a member) of the association at the time the coverage is initially issued,

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

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

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

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

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

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

(4) HEALTH INSURANCE COVERAGE.—

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

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

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

(ii) Medicare supplemental health insurance (within the meaning of section 1882(g)(1) of the Social Security Act (42 U.S.C. 1395ss(g)(1))) and similar supple-

mental coverage provided under a group health plan.

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

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

(v) Workers' compensation or similar insurance.

(vi) Automobile medical-payment insurance.

(vii) Coverage for a specified disease or illness.

(viii) Hospital or fixed indemnity insurance.

(ix) Short-term limited duration insurance.

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

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

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

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

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

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

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

(7) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The term ''individual health insurance coverage'' means health insurance coverage offered to individuals if the coverage is not offered in connection with a group health plan (other than such a

plan that has fewer than two participants as current employees on the first day of the plan year).

(8) INSURER.—The term ''insurer'' means an insurance company, insurance service, or insurance organization which is licensed to engage in the business of insurance in a State and which (except for purposes of part 2 of subtitle B) is subject to State law which regulates insurance (within the meaning of section 514(b)(2)(A) of the Employee Retirement Income Security Act of 1974).

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

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

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

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

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

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

(d) TREATMENT OF PARTNERSHIPS.—

(1) TREATMENT AS A GROUP HEALTH PLAN.—Any plan, fund, or program which would not be (but for this paragraph) an employee welfare benefit plan and which is established or maintained by a partnership, to the extent that such plan, fund, or program provides medical care to present or former partners in the partnership or to their dependents (as defined under the terms of the plan, fund, or program), directly or through insurance, reimbursement, or oth-

erwise, shall be treated (subject to paragraph (1)) as an employee welfare benefit plan which is a group health plan.

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

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

(B) the term ''participant'' includes—

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

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

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

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

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

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

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

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

SEC. 192. STATE FLEXIBILITY TO PROVIDE GREATER PROTECTION.

(a) STATE FLEXIBILITY TO PROVIDE GREATER PROTECTION.—Subject to subsection (b), nothing in this subtitle or subtitle A or B shall be construed to preempt State laws—

(1) that relate to matters not specifically addressed in such subtitles; or

(2) that require insurers or HMOs—

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

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

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

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

SEC. 193. EFFECTIVE DATE.

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

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

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

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

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

SEC. 194. RULE OF CONSTRUCTION.

Nothing in this title or any amendment made thereby may be construed to require (or to authorize any regulation that requires) the coverage of any specific procedure, treatment, or service under a group health plan or health insurance coverage.

SEC. 195. FINDINGS RELATING TO EXERCISE OF COMMERCE CLAUSE AUTHORITY.

Congress finds the following in relation to the provisions of this title:

(1) Provisions in group health plans and health insurance coverage that impose certain pre-existing

conditions impact the ability of employees to seek employment in interstate commerce, thereby impeding such commerce.

(2) Health insurance coverage is commercial in nature and is in and affects interstate commerce.

(3) It is a necessary and proper exercise of Congressional authority to impose requirements under this title on group health plans and health insurance coverage (including coverage offered to individuals previously covered under group health plans) in order to promote commerce among the States.

(4) Congress, however, intends to defer to States, to the maximum extent practicable, in carrying out such requirements with respect to insurers and health maintenance organizations that are subject to State regulation, consistent with the provisions of the Employee Retirement Income Security Act of 1974.

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

SEC. 200. REFERENCES IN TITLE.

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

Subtitle A—Fraud and Abuse Control Program

SEC. 201. FRAUD AND ABUSE CONTROL PROGRAM.

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

''FRAUD AND ABUSE CONTROL PROGRAM

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

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

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

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

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

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

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

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

''(3) GUIDELINES.—

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

''(B) INFORMATION GUIDELINES.—

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

''(ii) CONFIDENTIALITY.—Such guidelines shall include procedures to assure that such information is provided and utilized in a manner that appropriately protects the confidentiality of the information and the privacy of individuals receiving health care services and items.

''(iii) QUALIFIED IMMUNITY FOR PROVIDING INFORMATION.—The provisions of section 1157(a) (relating to limitation on

liability) shall apply to a person providing information to the Secretary or the Attorney General in conjunction with their performance of duties under this section.

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

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

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

''(1) REIMBURSEMENTS FOR INVESTIGATIONS.—The Inspector General of the Department of Health and Human Services is authorized to receive and retain for current use reimbursement for the costs of conducting investigations and audits and for monitoring compliance plans when such costs are

ordered by a court, voluntarily agreed to by the payor, or otherwise.

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

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

''(1) a policy of health insurance;

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

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

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

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

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

''(2) APPROPRIATED AMOUNTS TO TRUST FUND.—

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

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

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

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

''(B) AUTHORIZATION TO ACCEPT GIFTS.—The Trust Fund is authorized to accept on behalf of the United States money gifts and bequests made unconditionally to the Trust Fund,

for the benefit of the Account or any activity financed through the Account.

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

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

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

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

''(iv) Penalties and damages obtained and otherwise creditable to miscellaneous receipts of the general fund of the Treasury obtained under sections 3729 through 3733 of title 31, United States Code

(known as the False Claims Act), in cases involving claims related to the provision of health care items and services (other than funds awarded to a relator, for restitution or otherwise authorized by law).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"(ii) investigations;

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

"(iv) inspections and other evaluations; and

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 202. MEDICARE INTEGRITY PROGRAM.

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

''MEDICARE INTEGRITY PROGRAM

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

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

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

''(2) Audit of cost reports.

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

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

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

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

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

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

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

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

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

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

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

''(2)(A) Except as provided in subparagraph (B), the provisions of section 1153(e)(1) shall apply

to contracts and contracting authority under this section.

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

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

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

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

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

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

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

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

SEC. 203. BENEFICIARY INCENTIVE PROGRAMS.

(a) CLARIFICATION OF REQUIREMENT TO PROVIDE EXPLANATION OF MEDICARE BENEFITS.—The Secretary

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

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

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

not relevant or material to the imposition of such a sanction.

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

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

(1) ESTABLISHMENT OF PROGRAM.—Not later than 3 months after the date of the enactment of this Act, the Secretary shall establish a program under which the Secretary shall encourage individuals to submit to the Secretary suggestions on methods to improve the efficiency of the medicare program.

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

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

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

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

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

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

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

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

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

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

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

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

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

''(1) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the

health insurance program under chapter 89 of title 5, United States Code); or

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

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

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

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

''GUIDANCE REGARDING APPLICATION OF HEALTH CARE FRAUD AND ABUSE SANCTIONS

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

''(1) IN GENERAL.—

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

''(i) modifications to existing safe harbors issued pursuant to section 14(a) of the Medicare and Medicaid Patient and

Program Protection Act of 1987 (42 U.S.C. 1320a–7b note);

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"(I) Any other factors the Secretary deems appropriate in the interest of preventing fraud

and abuse in Federal health care programs (as so defined).

''(b) ADVISORY OPINIONS.—

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

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

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

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

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

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

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

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

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

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

''(4) EFFECT OF ADVISORY OPINIONS.—

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

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

''(5) REGULATIONS.—

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

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

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

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

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

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

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

''(i) the Secretary shall be required to respond to a party requesting an advisory

opinion by not later than 30 days after the request is received; and

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

"(c) SPECIAL FRAUD ALERTS.—

"(1) IN GENERAL.—

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

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

special fraud alerts issued pursuant to this subparagraph shall be published in the Federal Register.

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

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

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

Subtitle B—Revisions to Current Sanctions for Fraud and Abuse

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

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

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

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

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

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

''(A) of a criminal offense consisting of a misdemeanor relating to fraud, theft, embezzle-

ment, breach of fiduciary responsibility, or other financial misconduct—

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

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

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

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

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

"(4) FELONY CONVICTION RELATING TO CONTROLLED SUBSTANCE.—Any individual or entity

that has been convicted after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.''.

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

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

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

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

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

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

Secretary determines in accordance with published regulations that a shorter period is appropriate because of mitigating circumstances or that a longer period is appropriate because of aggravating circumstances.

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

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

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

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

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

''(i) who has a direct or indirect ownership or control interest in a sanctioned entity and who knows or should know (as defined in section 1128A(i)(6)) of the action constituting the

basis for the conviction or exclusion described in subparagraph (B); or

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

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

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

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

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

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

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

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

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

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

(2) by striking the third sentence.

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

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

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

ganization if the Secretary determines that the organization—

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

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

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

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

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

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

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

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

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

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

''(A) the Secretary first provides the organization with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's de-

termination under paragraph (1) and the organization fails to develop or implement such a plan;

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

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

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

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

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

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

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

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

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

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

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

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

diem payment, or any other similar risk arrangement which places the individual or entity at substantial financial risk.''.

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

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

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

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

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

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

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

SEC. 218. EFFECTIVE DATE.

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

Subtitle C—Data Collection

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

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

"HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM

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

"(b) REPORTING OF INFORMATION.—

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

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

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

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

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

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

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

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

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

''(c) DISCLOSURE AND CORRECTION OF INFORMATION.—

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

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

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

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

''(d) ACCESS TO REPORTED INFORMATION.—

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

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

''(e) PROTECTION FROM LIABILITY FOR REPORTING.—No person or entity, including the agency designated by the Secretary in subsection (b)(5) shall be held liable in any civil action with respect to any report made

as required by this section, without knowledge of the falsity of the information contained in the report.

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

''(1) FINAL ADVERSE ACTION.—

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

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

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

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

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

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

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

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

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

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

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

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

''(A) The Department of Justice.

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

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

''(D) State law enforcement agencies.

''(E) State medicaid fraud control units.

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

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

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

(b) IMPROVED PREVENTION IN ISSUANCE OF MEDICARE PROVIDER NUMBERS.—Section 1842(r) (42 U.S.C. 1395u(r)) is amended by adding at the end the following

new sentence: ''Under such system, the Secretary may impose appropriate fees on such physicians to cover the costs of investigation and recertification activities with respect to the issuance of the identifiers.''.

Subtitle D—Civil Monetary Penalties

SEC. 231. SOCIAL SECURITY ACT CIVIL MONETARY PENALTIES.

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

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

(2) In subsection (f)—

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

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

''(3) With respect to amounts recovered arising out of a claim under a Federal health care program (as defined in section 1128B(f)), the portion of such amounts as is determined to have been paid by the program shall be repaid to the program, and the portion of such amounts attributable to the amounts

recovered under this section by reason of the amendments made by the Health Coverage Availability and Affordability Act of 1996 (as estimated by the Secretary) shall be deposited into the Federal Hospital Insurance Trust Fund pursuant to section 1817(k)(2)(C).''.

(3) In subsection (i)—

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

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

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

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

''(m)(1) For purposes of this section, with respect to a Federal health care program not contained in this Act, references to the Secretary in this section shall be deemed to be references to the Secretary or Administrator of the

department or agency with jurisdiction over such program and references to the Inspector General of the Department of Health and Human Services in this section shall be deemed to be references to the Inspector General of the applicable department or agency.

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

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

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

''(B) If the conditions specified in subparagraph (A) are fulfilled, the Inspector General of the department or agency initiating the action is authorized to exercise all powers granted under the Inspector General Act of 1978 with respect to the claims submitted to the other depart-

ments or agencies to the same manner and extent as provided in that Act with respect to claims submitted to such departments or agencies.''.

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

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

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

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

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

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

''(A) retains a direct or indirect ownership or control interest in an entity that is participating in a program under title XVIII or a State health care program, and who knows or

should know of the action constituting the basis for the exclusion; or

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

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

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

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

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

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

(1) in subparagraph (A) by striking ''claimed,'' and inserting ''claimed, including any person who engages in a pattern or practice of presenting or causing to be presented a claim for an item or serv-

ice that is based on a code that the person knows or should know will result in a greater payment to the person than the code the person knows or should know is applicable to the item or service actually provided,'';

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

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

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

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

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

''(D) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under subparagraph (B)(i) or (C)(i) in the same 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)), as amended by subsection (b), is amended—

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

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

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

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

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

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

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

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

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

''(iii) the person—

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

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

''(III) provides for any permissible waiver as specified in section

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

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

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

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

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

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

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

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

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

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

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

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

''(B) acts in reckless disregard of the truth or falsity of the information,

and no proof of specific intent to defraud is required.''.

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

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

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

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

''(i) $5,000, or

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

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

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

Subtitle E—Revisions to Criminal Law

SEC. 241. DEFINITIONS RELATING TO FEDERAL HEALTH CARE OFFENSE.

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

"§ 24. Definitions relating to Federal health care offense

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

''(1) section 669, 1035, 1347, or 1518 of this title; or

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

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

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

"24. Definitions relating to Federal health care offense.".

SEC. 242. HEALTH CARE FRAUD.

(a) OFFENSE.—

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

"§ 1347. Health care fraud

''Whoever knowingly executes, or attempts to execute, a scheme or artifice—

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

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

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

shall be fined under this title, or imprisoned for any term of years or for life, or both.''.

(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 knowingly converts to the use of any person other than the rightful owner, or intentionally misapplies any of the moneys, funds, securities, premiums, credits, property, or other assets of a health care benefit program, shall be fined under this title or imprisoned not more than

10 years, or both; but if the value of such property does not exceed the sum of $100 the defendant shall be fined under this title or imprisoned not more than one year, or both.

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

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

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

SEC. 244. FALSE STATEMENTS.

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

''§ 1035. False statements relating to health care matters

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

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

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

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

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

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

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

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

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

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

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

''(b) As used in this section the term 'criminal investigator' means any individual duly authorized by a depart-

ment, agency, or armed force of the United States to conduct or engage in investigations for prosecutions for violations of health care offenses.''.

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

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

SEC. 246. LAUNDERING OF MONETARY INSTRUMENTS.

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

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

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

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

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

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

(3) by adding at the end the following:

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

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

SEC. 248. AUTHORIZED INVESTIGATIVE DEMAND PROCEDURES.

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

''§ 3486. Authorized investigative demand procedures

''(a) AUTHORIZATION.—In any investigation relating to any act or activity involving a Federal health care offense, the Attorney General or the Attorney General's designee may issue in writing and cause to be served a subpoena requiring the production of any records (including any books, papers, documents, electronic media, or other objects or tangible things), which may be relevant to an authorized law enforcement inquiry, that a person or legal entity may possess or have care, custody, or control. A subpoena shall describe the objects required to be produced and prescribe a return date within a reasonable period of time within which the objects can be assembled and made available.

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

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

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

''(d) IMMUNITY FROM CIVIL LIABILITY.—Notwithstanding any Federal, State, or local law, any person, in-

cluding officers, agents, and employees, receiving a summons under this section, who complies in good faith with the summons and thus produces the materials sought, shall not be liable in any court of any State or the United States to any customer or other person for such production or for nondisclosure of that production to the customer.

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

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

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

any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.''.

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

''3486. Authorized investigative demand procedures.''.

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

SEC. 249. FORFEITURES FOR FEDERAL HEALTH CARE OFFENSES.

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

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

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

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

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

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

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

(i) contract services;

(ii) the employment of outside contractors to operate and manage properties or provide other specialized services nec-

essary to dispose of such properties in an effort to maximize the return from such properties; and

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

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

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

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

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

SEC. 250. RELATION TO ERISA AUTHORITY.

Nothing in this subtitle shall be construed as affecting the authority of the Secretary of Labor under section 506(b) of the Employee Retirement Income Security Act of 1974, including the Secretary's authority with respect to violations of title 18, United States Code (as amended by this subtitle).

Subtitle F—Administrative Simplification

SEC. 251. PURPOSE.

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

SEC. 252. ADMINISTRATIVE SIMPLIFICATION.

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

''PART C—ADMINISTRATIVE SIMPLIFICATION

''DEFINITIONS

''SEC. 1171. For purposes of this part:

''(1) CLEARINGHOUSE.—The term 'clearinghouse' means a public or private entity that processes or facilitates the processing of nonstandard data elements of health information into standard data elements.

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

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

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

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

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

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

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

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

"(B) The medicaid program under title XIX.

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

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

"(E) Health benefits of an employee welfare benefit plan, as defined in section 3(1) of

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

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

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

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

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

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

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

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

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

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

"(i) identifies the individual; or

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

"(7) STANDARD.—The term 'standard', when used with reference to a data element of health information or a transaction referred to in section

1173(a)(1), means any such data element or transaction that meets each of the standards and implementation specifications adopted or established by the Secretary with respect to the data element or transaction under sections 1172 through 1174.

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

''GENERAL REQUIREMENTS FOR ADOPTION OF STANDARDS

''SEC. 1172. (a) APPLICABILITY.—Any standard adopted under this part shall apply, in whole or in part, to the following persons:

''(1) A health plan.

''(2) A clearinghouse.

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

''(b) REDUCTION OF COSTS.—Any standard adopted under this part shall be consistent with the objective of

reducing the administrative costs of providing and paying for health care.

''(c) ROLE OF STANDARD SETTING ORGANIZATIONS.—

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

''(2) SPECIAL RULES.—

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

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

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

''(B) NO STANDARD BY STANDARD SETTING ORGANIZATION.—If no standard setting organization has developed, adopted, or modified any standard relating to a standard that

the Secretary is authorized or required to adopt under this part—

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

"(ii) subsection (f) shall apply.

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

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

"(f) ASSISTANCE TO THE SECRETARY.—In complying with the requirements of this part, the Secretary shall rely on the recommendations of the National Committee on Vital and Health Statistics established under section 306(k) of the Public Health Service Act (42 U.S.C. 242k(k)) and shall consult with appropriate Federal and State agencies and private organizations. The Secretary shall publish in the Federal Register any recommendation of the National Committee on Vital and Health Statistics regarding the adoption of a standard under this part.

"(g) APPLICATION TO MODIFICATIONS OF STANDARDS.—This section shall apply to a modification to a

standard (including an addition to a standard) adopted under section 1174(b) in the same manner as it applies to an initial standard adopted under section 1174(a).

''STANDARDS FOR INFORMATION TRANSACTIONS AND DATA ELEMENTS

''SEC. 1173. (a) STANDARDS TO ENABLE ELECTRONIC EXCHANGE.—

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

''(A) the financial and administrative transactions described in paragraph (2); and

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

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

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

''(B) Claims attachments.

''(C) Enrollment and disenrollment.

''(D) Eligibility.

"(E) Health care payment and remittance advice.

"(F) Premium payments.

"(G) First report of injury.

"(H) Claims status.

"(I) Referral certification and authorization.

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

"(b) UNIQUE HEALTH IDENTIFIERS.—

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

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

''(c) CODE SETS.—

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

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

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

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

''(d) SECURITY STANDARDS FOR HEALTH INFORMATION.—

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

''(A) take into account—

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

''(ii) the costs of security measures;

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

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

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

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

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

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

''(B) to protect against any reasonably anticipated—

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

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

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

''(e) PRIVACY STANDARDS FOR HEALTH INFORMATION.—The Secretary shall adopt standards with respect to the privacy of individually identifiable health information transmitted in connection with the transactions referred to in subsection (a)(1). Such standards shall include standards concerning at least the following:

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

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

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

''(f) ELECTRONIC SIGNATURE.—

''(1) IN GENERAL.—

''(A) STANDARDS.—The Secretary, in coordination with the Secretary of Commerce, shall adopt standards specifying procedures for the electronic transmission and authentication

of signatures with respect to the transactions referred to in subsection (a)(1).

''(B) EFFECT OF COMPLIANCE.—Compliance with the standards adopted under subparagraph (A) shall be deemed to satisfy Federal and State statutory requirements for written signatures with respect to the transactions referred to in subsection (a)(1).

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

''(g) TRANSFER OF INFORMATION AMONG HEALTH PLANS.—The Secretary shall adopt standards for transferring among health plans appropriate standard data elements needed for the coordination of benefits, the sequential processing of claims, and other data elements for individuals who have more than one health plan.

''TIMETABLES FOR ADOPTION OF STANDARDS

''SEC. 1174. (a) INITIAL STANDARDS.—The Secretary shall carry out section 1173 not later than 18 months after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, except that standards relating to claims attachments shall be adopted not later than 30 months after such date.

''(b) ADDITIONS AND MODIFICATIONS TO STANDARDS.—

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

''(2) SPECIAL RULES.—

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

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

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

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

"REQUIREMENTS

"SEC. 1175. (a) CONDUCT OF TRANSACTIONS BY PLANS.—

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

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

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

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

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

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

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

"(3) TIMETABLE FOR COMPLIANCE.—Paragraph (1) shall not be construed to require a health plan to comply with any standard, implementation specification, or modification to a standard or specification adopted or established by the Secretary

under sections 1172 through 1174 at any time prior to the date on which the plan is required to comply with the standard or specification under subsection (b).

"(b) COMPLIANCE WITH STANDARDS.—

"(1) INITIAL COMPLIANCE.—

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

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

"(2) COMPLIANCE WITH MODIFIED STANDARDS.—If the Secretary adopts a modification to a standard or implementation specification under this part, each person to whom the standard or implementation specification applies shall comply with the modified standard or implementation specification at

such time as the Secretary determines appropriate, taking into account the time needed to comply due to the nature and extent of the modification. The time determined appropriate under the preceding sentence may not be earlier than the last day of the 180-day period beginning on the date such modification is adopted. The Secretary may extend the time for compliance for small health plans, if the Secretary determines that such extension is appropriate.

''GENERAL PENALTY FOR FAILURE TO COMPLY WITH REQUIREMENTS AND STANDARDS

''SEC. 1176. (a) GENERAL PENALTY.—

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

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

''(b) LIMITATIONS.—

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

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

''(3) FAILURES DUE TO REASONABLE CAUSE.—

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

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

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

''(B) EXTENSION OF PERIOD.—

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

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

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

''WRONGFUL DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

''SEC. 1177. (a) OFFENSE.—A person who knowingly and in violation of this part—

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

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

''(3) discloses individually identifiable health information to another person,

shall be punished as provided in subsection (b).

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

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

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

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

''EFFECT ON STATE LAW

''SEC. 1178. (a) GENERAL EFFECT.—

''(1) GENERAL RULE.—Except as provided in paragraph (2), a provision or requirement under this part, or a standard or implementation specification adopted or established under sections 1172 through

1174, shall supersede any contrary provision of State law, including a provision of State law that requires medical or health plan records (including billing information) to be maintained or transmitted in written rather than electronic form.

''(2) EXCEPTIONS.—A provision or requirement under this part, or a standard or implementation specification adopted or established under sections 1172 through 1174, shall not supersede a contrary provision of State law, if the provision of State law—

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

''(B) is a provision the Secretary determines—

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

''(ii) addresses controlled substances.

''(b) PUBLIC HEALTH REPORTING.—Nothing in this part shall be construed to invalidate or limit the authority, power, or procedures established under any law providing

for the reporting of disease or injury, child abuse, birth, or death, public health surveillance, or public health investigation or intervention.''.

(b) CONFORMING AMENDMENTS.—

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

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

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

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

''(R) to contract only with a clearinghouse (as defined in section 1171) that meets each standard and implementation specification adopted or established under part C of title XI on or after the date on which the clearinghouse is required to comply with the standard or specification.''.

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

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

SEC. 253. CHANGES IN MEMBERSHIP AND DUTIES OF NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS.

Section 306(k) of the Public Health Service Act (42 U.S.C. 242k(k)) is amended—

(1) in paragraph (1), by striking ''16'' and inserting ''18'';

(2) by amending paragraph (2) to read as follows:

''(2) The members of the Committee shall be appointed from among persons who have distinguished themselves in the fields of health statistics, electronic interchange of health care information, privacy and security of electronic information, population-based public health, purchasing or financing health care services, integrated computerized health information systems, health services research, consumer interests in health information, health data standards, epidemiology, and the provision of health services. Members of the Committee shall be appointed for terms of 4 years.'';

(3) by redesignating paragraphs (3) through (5) as paragraphs (4) through (6), respectively, and inserting after paragraph (2) the following:

''(3) Of the members of the Committee—

''(A) 1 shall be appointed, not later than 60 days after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, by the Speaker of the House of Representatives after consultation with the minority leader of the House of Representatives;

''(B) 1 shall be appointed, not later than 60 days after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, by the President pro tempore of the Senate after consultation with the minority leader of the Senate; and

''(C) 16 shall be appointed by the Secretary.'';

(4) by amending paragraph (5) (as so redesignated) to read as follows:

''(5) The Committee—

''(A) shall assist and advise the Secretary—

''(i) to delineate statistical problems bearing on health and health services which are of national or international interest;

"(ii) to stimulate studies of such problems by other organizations and agencies whenever possible or to make investigations of such problems through subcommittees;

"(iii) to determine, approve, and revise the terms, definitions, classifications, and guidelines for assessing health status and health services, their distribution and costs, for use (I) within the Department of Health and Human Services, (II) by all programs administered or funded by the Secretary, including the Federal-State-local cooperative health statistics system referred to in subsection (e), and (III) to the extent possible as determined by the head of the agency involved, by the Department of Veterans Affairs, the Department of Defense, and other Federal agencies concerned with health and health services;

"(iv) with respect to the design of and approval of health statistical and health information systems concerned with the collection, processing, and tabulation of health statistics within the Department of Health and Human Services, with respect to the Cooperative Health Statistics System established under subsection (e),

and with respect to the standardized means for the collection of health information and statistics to be established by the Secretary under subsection (j)(1);

''(v) to review and comment on findings and proposals developed by other organizations and agencies and to make recommendations for their adoption or implementation by local, State, national, or international agencies;

''(vi) to cooperate with national committees of other countries and with the World Health Organization and other national agencies in the studies of problems of mutual interest;

''(vii) to issue an annual report on the state of the Nation's health, its health services, their costs and distributions, and to make proposals for improvement of the Nation's health statistics and health information systems; and

''(viii) in complying with the requirements imposed on the Secretary under part C of title XI of the Social Security Act;

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

''(C) shall report to the Secretary not later than 4 years after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996 recommendations and legislative proposals for such standards and electronic exchange; and

''(D) shall be responsible generally for advising the Secretary and the Congress on the status of the implementation of part C of title XI of the Social Security Act.''; and

(5) by adding at the end the following:

''(7) Not later than 1 year after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, and annually thereafter, the Committee shall submit to the Congress, and make public, a report regarding—

''(A) the extent to which persons required to comply with part C of title XI of the Social Security Act are cooperating in implementing the standards adopted under such part;

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

''(C) whether the Federal and State Governments are receiving information of sufficient quality to meet their responsibilities under such part;

''(D) any problems that exist with respect to implementation of such part; and

''(E) the extent to which timetables under such part are being met.''.

Subtitle G—Duplication and Coordination of Medicare-Related Plans

SEC. 261. DUPLICATION AND COORDINATION OF MEDICARE-RELATED PLANS.

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

(1) in clause (iii), by striking ''clause (i)'' and inserting ''clause (i)(II)''; and

(2) by adding at the end the following:

''(iv) For purposes of this subparagraph, a health insurance policy providing for benefits which are payable to or on behalf of an individual without regard to other health benefit coverage of such individual is not considered to 'duplicate' any health benefits under this title, under

title XIX, or under a health insurance policy, and subclauses (I) and (III) of clause (i) does not apply to such a policy.

''(v)(I) For purposes of this subparagraph, a health insurance policy (or a rider to an insurance contract which is not a health insurance policy), providing benefits for long-term care, nursing home care, home health care, or community-based care and that coordinates against or excludes items and services available or paid for under this title and (for policies sold or issued on or after 90 days after the date of enactment of this clause) that discloses such coordination or exclusion in the policy's outline of coverage, is not considered to 'duplicate' health benefits under this title.

''(II) For purposes of this subparagraph, a health insurance policy (which may be a contract with a health maintenance organization) that is a replacement product for another health insurance policy that is being terminated by the issuer, that is being provided to an individual entitled to benefits under part A on the basis of section 226(b), and that coordinates against or excludes items and services available or paid for under this title is not considered to 'duplicate' health benefits under this title.

''(III) For purposes of this clause, the terms 'coordinates' and 'coordination' mean, with respect to a policy

in relation to health benefits under this title, that the policy under its terms is secondary to, or excludes from payment, items and services to the extent available or paid for under this title.

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

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

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

(1) in subparagraph (C)—

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

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

(2) by striking subparagraph (D).

Subtitle H—Medical Liability Reform

PART 1—GENERAL PROVISIONS

SEC. 271. FEDERAL REFORM OF HEALTH CARE LIABILITY ACTIONS.

(a) APPLICABILITY.—This subtitle shall apply with respect to any health care liability action brought in any State or Federal court, except that this subtitle shall not apply to—

(1) an action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the action, or

(2) an action under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.).

(b) PREEMPTION.—This subtitle shall preempt any State law to the extent such law is inconsistent with the limitations contained in this subtitle. This subtitle shall not preempt any State law that provides for defenses or places limitations on a person's liability in addition to those contained in this subtitle or otherwise imposes greater restrictions than those provided in this subtitle.

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

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

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

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

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

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

(d) AMOUNT IN CONTROVERSY.—In an action to which this subtitle applies and which is brought under section 1332 of title 28, United States Code, the amount of noneconomic damages or punitive damages, and attorneys' fees or costs, shall not be included in determining whether the matter in controversy exceeds the sum or value of $50,000.

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

SEC. 272. DEFINITIONS.

As used in this subtitle:

(1) ACTUAL DAMAGES.—The term ''actual damages'' means damages awarded to pay for economic loss.

(2) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system established under Federal or State law that provides for the resolution of health care liability claims in a manner other than through health care liability actions.

(3) CLAIMANT.—The term ''claimant'' means any person who brings a health care liability action and any person on whose behalf such an action is brought. If such action is brought through or on behalf of an estate, the term includes the claimant's decedent. If such action is brought through or on behalf of a minor or incompetent, the term includes the claimant's legal guardian.

(4) CLEAR AND CONVINCING EVIDENCE.—The term ''clear and convincing evidence'' is that measure or degree of proof that will produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established. Such measure or degree of proof is more than that required under preponderance of the evidence but less than that required for proof beyond a reasonable doubt.

(5) COLLATERAL SOURCE PAYMENTS.—The term ''collateral source payments'' means any amount paid or reasonably likely to be paid in the future to or on behalf of a claimant, or any service, product, or other benefit provided or reasonably likely to be provided in the future to or on behalf of a claimant, as a result of an injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident or workers' compensation Act;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(6) DRUG.—The term ''drug'' has the meaning given such term in section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)(1)).

(7) ECONOMIC LOSS.—The term ''economic loss'' means any pecuniary loss resulting from injury (including the loss of earnings or other benefits related to employment, medical expense loss, replacement services loss, loss due to death, burial costs, and loss of business or employment opportunities), to the extent recovery for such loss is allowed under applicable State law.

(8) HARM.—The term ''harm'' means any legally cognizable wrong or injury for which punitive damages may be imposed.

(9) HEALTH BENEFIT PLAN.—The term ''health benefit plan'' means—

(A) a hospital or medical expense incurred policy or certificate,

(B) a hospital or medical service plan contract,

(C) a health maintenance subscriber contract,

(D) a multiple employer welfare arrangement or employee benefit plan (as defined under the Employee Retirement Income Security Act of 1974), or

(E) a MedicarePlus product (offered under part C of title XVIII of the Social Security Act),

that provides benefits with respect to health care services.

(10) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action brought in a State or Federal court against a health care provider, an entity which is obligated to provide or pay for health benefits under any health

benefit plan (including any person or entity acting under a contract or arrangement to provide or administer any health benefit), or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, in which the claimant alleges a claim (including third party claims, cross claims, counter claims, or distribution claims) based upon the provision of (or the failure to provide or pay for) health care services or the use of a medical product, regardless of the theory of liability on which the claim is based or the number of plaintiffs, defendants, or causes of action.

(11) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a claim in which the claimant alleges that injury was caused by the provision of (or the failure to provide) health care services.

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

(13) HEALTH CARE SERVICE.—The term ''health care service'' means any service for which payment may be made under a health benefit plan including services related to the delivery or administration of such service.

(14) MEDICAL DEVICE.—The term ''medical device'' has the meaning given such term in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h)).

(15) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages paid to an individual for pain and suffering, inconvenience, emotional distress, mental anguish, loss of consortium, injury to reputation, humiliation, and other nonpecuniary losses.

(16) PERSON.—The term ''person'' means any individual, corporation, company, association, firm, partnership, society, joint stock company, or any other entity, including any governmental entity.

(17) PRODUCT SELLER.—The term ''product seller'' means a person who, in the course of a business conducted for that purpose, sells, distributes, rents, leases, prepares, blends, packages, labels a product, is otherwise involved in placing a product in the stream of commerce, or installs, repairs, or

maintains the harm-causing aspect of a product. The term does not include—

(A) a seller or lessor of real property;

(B) a provider of professional services in any case in which the sale or use of a product is incidental to the transaction and the essence of the transaction is the furnishing of judgment, skill, or services; or

(C) any person who—

(i) acts in only a financial capacity with respect to the sale of a product; or

(ii) leases a product under a lease arrangement in which the selection, possession, maintenance, and operation of the product are controlled by a person other than the lessor.

(18) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded against any person not to compensate for actual injury suffered, but to punish or deter such person or others from engaging in similar behavior in the future.

(19) STATE.—The term ''State'' means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa,

the Northern Mariana Islands, and any other territory or possession of the United States.

SEC. 273. EFFECTIVE DATE.

This subtitle will apply to any health care liability action brought in a Federal or State court and to any health care liability claim subject to an alternative dispute resolution system, that is initiated on or after the date of enactment of this subtitle, except that any health care liability claim or action arising from an injury occurring prior to the date of enactment of this subtitle shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

PART 2—UNIFORM STANDARDS FOR HEALTH CARE LIABILITY ACTIONS

SEC. 281. STATUTE OF LIMITATIONS.

A health care liability action may not be brought after the expiration of the 2-year period that begins on the date on which the alleged injury that is the subject of the action was discovered or should reasonably have been discovered, but in no case after the expiration of the 5-year period that begins on the date the alleged injury occurred.

SEC. 282. CALCULATION AND PAYMENT OF DAMAGES.

(a) TREATMENT OF NONECONOMIC DAMAGES.—

(1) LIMITATION ON NONECONOMIC DAMAGES.—The total amount of noneconomic damages that may be awarded to a claimant for losses resulting from the injury which is the subject of a health care liability action may not exceed $250,000, regardless of the number of parties against whom the action is brought or the number of actions brought with respect to the injury.

(2) JOINT AND SEVERAL LIABILITY.—In any health care liability action brought in State or Federal court, a defendant shall be liable only for the amount of noneconomic damages attributable to such defendant in direct proportion to such defendant's share of fault or responsibility for the claimant's actual damages, as determined by the trier of fact. In all such cases, the liability of a defendant for noneconomic damages shall be several and not joint.

(b) TREATMENT OF PUNITIVE DAMAGES.—

(1) GENERAL RULE.—Punitive damages may, to the extent permitted by applicable State law, be awarded in any health care liability action for harm in any Federal or State court against a defendant if the claimant establishes by clear and convincing evi-

dence that the harm suffered was the result of conduct—

(A) specifically intended to cause harm, or

(B) conduct manifesting a conscious, flagrant indifference to the rights or safety of others.

(2) PROPORTIONAL AWARDS.—The amount of punitive damages that may be awarded in any health care liability action subject to this subtitle shall not exceed 3 times the amount of damages awarded to the claimant for economic loss, or $250,000, whichever is greater. This paragraph shall be applied by the court and shall not be disclosed to the jury.

(3) APPLICABILITY.—This subsection shall apply to any health care liability action brought in any Federal or State court on any theory where punitive damages are sought. This subsection does not create a cause of action for punitive damages. This subsection does not preempt or supersede any State or Federal law to the extent that such law would further limit the award of punitive damages.

(4) BIFURCATION.—At the request of any party, the trier of fact shall consider in a separate proceeding whether punitive damages are to be awarded and the amount of such award. If a sepa-

rate proceeding is requested, evidence relevant only to the claim of punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether actual damages are to be awarded.

(5) DRUGS AND DEVICES.—

(A) IN GENERAL.—(i) Punitive damages shall not be awarded against a manufacturer or product seller of a drug or medical device which caused the claimant's harm where—

(I) such drug or device was subject to premarket approval by the Food and Drug Administration with respect to the safety of the formulation or performance of the aspect of such drug or device which caused the claimant's harm, or the adequacy of the packaging or labeling of such drug or device which caused the harm, and such drug, device, packaging, or labeling was approved by the Food and Drug Administration; or

(II) the drug is generally recognized as safe and effective pursuant to conditions established by the Food and Drug Admin-

istration and applicable regulations, including packaging and labeling regulations.

(ii) Clause (i) shall not apply in any case in which the defendant, before or after premarket approval of a drug or device—

(I) intentionally and wrongfully withheld from or misrepresented to the Food and Drug Administration information concerning such drug or device required to be submitted under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) or section 351 of the Public Health Service Act (42 U.S.C. 262) that is material and relevant to the harm suffered by the claimant, or

(II) made an illegal payment to an official or employee of the Food and Drug Administration for the purpose of securing or maintaining approval of such drug or device.

(B) PACKAGING.—In a health care liability action for harm which is alleged to relate to the adequacy of the packaging or labeling of a drug which is required to have tamper-resistant packaging under regulations of the Secretary of

Health and Human Services (including labeling regulations related to such packaging), the manufacturer or product seller of the drug shall not be held liable for punitive damages unless such packaging or labeling is found by the court by clear and convincing evidence to be substantially out of compliance with such regulations.

(c) PERIODIC PAYMENTS FOR FUTURE LOSSES.—

(1) GENERAL RULE.—In any health care liability action in which the damages awarded for future economic and noneconomic loss exceeds $50,000, a person shall not be required to pay such damages in a single, lump-sum payment, but shall be permitted to make such payments periodically based on when the damages are found likely to occur, as such payments are determined by the court.

(2) FINALITY OF JUDGMENT.—The judgment of the court awarding periodic payments under this subsection may not, in the absence of fraud, be reopened at any time to contest, amend, or modify the schedule or amount of the payments.

(3) LUMP-SUM SETTLEMENTS.—This subsection shall not be construed to preclude a settlement providing for a single, lump-sum payment.

(d) TREATMENT OF COLLATERAL SOURCE PAYMENTS.—

(1) INTRODUCTION INTO EVIDENCE.—In any health care liability action, any defendant may introduce evidence of collateral source payments. If any defendant elects to introduce such evidence, the claimant may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the claimant to secure the right to such collateral source payments.

(2) NO SUBROGATION.—No provider of collateral source payments shall recover any amount against the claimant or receive any lien or credit against the claimant's recovery or be equitably or legally subrogated the right of the claimant in a health care liability action.

(3) APPLICATION TO SETTLEMENTS.—This subsection shall apply to an action that is settled as well as an action that is resolved by a fact finder.

SEC. 283. ALTERNATIVE DISPUTE RESOLUTION.

Any ADR used to resolve a health care liability action or claim shall contain provisions relating to statute of limitations, non-economic damages, joint and several liability, punitive damages, collateral source rule, and periodic pay-

ments which are identical to the provisions relating to such matters in this subtitle.

TITLE III—TAX-RELATED HEALTH PROVISIONS

SEC. 300. AMENDMENT OF 1986 CODE.

Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

Subtitle A—Medical Savings Accounts

SEC. 301. MEDICAL SAVINGS ACCOUNTS.

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

"SEC. 220. MEDICAL SAVINGS ACCOUNTS.

''(a) DEDUCTION ALLOWED.—In the case of an individual who is an eligible individual for any month during the taxable year, there shall be allowed as a deduction for the taxable year an amount equal to the aggregate amount

paid in cash during such taxable year by such individual to a medical savings account of such individual.

''(b) LIMITATIONS.—

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

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

''(i) $2,000, or

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

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

''(i) $4,000, or

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

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

''(2) SPECIAL RULE FOR MARRIED INDIVIDUALS.—

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

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

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

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

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

''(4) PRORATION OF LIMITATION.—

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

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

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

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

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

"(5) DENIAL OF DEDUCTION TO DEPENDENTS.—No deduction shall be allowed under this

section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

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

''(1) ELIGIBLE INDIVIDUAL.—

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

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

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

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

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

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

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

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

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

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

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

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

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

"(A) Medicare supplemental insurance,

"(B) insurance if substantially all of the coverage provided under such insurance relates to—

"(i) liabilities incurred under workers' compensation laws,

"(ii) tort liabilities,

"(iii) liabilities relating to ownership or use of property, or

"(iv) such other similar liabilities as the Secretary may specify by regulations,

"(C) insurance for a specified disease or illness, and

"(D) insurance paying a fixed amount per day (or other period) of hospitalization.

"(d) MEDICAL SAVINGS ACCOUNT.—For purposes of this section—

"(1) MEDICAL SAVINGS ACCOUNT.—The term 'medical savings account' means a trust created or organized in the United States exclusively for the purpose of paying the qualified medical expenses of the account holder, but only if the written governing instrument creating the trust meets the following requirements:

"(A) Except in the case of a rollover contribution described in subsection (f)(5), no contribution will be accepted—

"(i) unless it is in cash, or

"(ii) to the extent such contribution, when added to previous contributions to the trust for the calendar year, exceeds $4,000.

"(B) The trustee is a bank (as defined in section 408(n)), an insurance company (as defined in section 816), or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with the requirements of this section.

"(C) No part of the trust assets will be invested in life insurance contracts.

"(D) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

"(E) The interest of an individual in the balance in his account is nonforfeitable.

"(2) QUALIFIED MEDICAL EXPENSES.—

''(A) IN GENERAL.—The term 'qualified medical expenses' means, with respect to an account holder, amounts paid by such holder for medical care (as defined in section 213(d)) for such individual, the spouse of such individual, and any dependent (as defined in section 152) of such individual, but only to the extent such amounts are not compensated for by insurance or otherwise.

''(B) HEALTH INSURANCE MAY NOT BE PURCHASED FROM ACCOUNT.—

''(i) IN GENERAL.—Subparagraph (A) shall not apply to any payment for insurance.

''(ii) EXCEPTIONS.—Clause (i) shall not apply to any expense for coverage under—

''(I) a health plan during any period of continuation coverage required under any Federal law,

''(II) a qualified long-term care insurance contract (as defined in section 7702B(b)), or

''(III) a health plan during a period in which the individual is receiv-

ing unemployment compensation under any Federal or State law.

''(3) ACCOUNT HOLDER.—The term 'account holder' means the individual on whose behalf the medical savings account was established.

''(4) CERTAIN RULES TO APPLY.—Rules similar to the following rules shall apply for purposes of this section:

''(A) Section 219(d)(2) (relating to no deduction for rollovers).

''(B) Section 219(f)(3) (relating to time when contributions deemed made).

''(C) Except as provided in section 106(b), section 219(f)(5) (relating to employer payments).

''(D) Section 408(g) (relating to community property laws).

''(E) Section 408(h) (relating to custodial accounts).

''(e) TAX TREATMENT OF ACCOUNTS.—

''(1) IN GENERAL.—A medical savings account is exempt from taxation under this subtitle unless such account has ceased to be a medical savings account by reason of paragraph (2) or (3). Notwithstanding the preceding sentence, any such account is

subject to the taxes imposed by section 511 (relating to imposition of tax on unrelated business income of charitable, etc. organizations).

''(2) ACCOUNT TERMINATIONS.—Rules similar to the rules of paragraphs (2) and (4) of section 408(e) shall apply to medical savings accounts, and any amount treated as distributed under such rules shall be treated as not used to pay qualified medical expenses.

''(f) TAX TREATMENT OF DISTRIBUTIONS.—

''(1) AMOUNTS USED FOR QUALIFIED MEDICAL EXPENSES.—

''(A) IN GENERAL.—Any amount paid or distributed out of a medical savings account which is used exclusively to pay qualified medical expenses of any account holder (or any spouse or dependent of the holder) shall not be includible in gross income.

''(B) TREATMENT AFTER DEATH OF ACCOUNT HOLDER.—

''(i) TREATMENT IF HOLDER IS SPOUSE.—If, after the death of the account holder, the account holder's interest is payable to (or for the benefit of) the holder's spouse, the medical savings ac-

count shall be treated as if the spouse were the account holder.

''(ii) TREATMENT IF DESIGNATED HOLDER IS NOT SPOUSE.—In the case of an account holder's interest in a medical savings account which is payable to (or for the benefit of) any person other than such holder's spouse upon the death of such holder—

''(I) such account shall cease to be a medical savings account as of the date of death, and

''(II) an amount equal to the fair market value of the assets in such account on such date shall be includible if such person is not the estate of such holder, in such person's gross income for the taxable year which includes such date, or if such person is the estate of such holder, in such holder's gross income for the last taxable year of such holder.

''(2) INCLUSION OF AMOUNTS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

"(A) IN GENERAL.—Any amount paid or distributed out of a medical savings account which is not used exclusively to pay the qualified medical expenses of the account holder or of the spouse or dependents of such holder shall be included in the gross income of such holder.

"(B) SPECIAL RULES.—For purposes of subparagraph (A)—

"(i) all medical savings accounts of the account holder shall be treated as 1 account,

"(ii) all payments and distributions during any taxable year shall be treated as 1 distribution, and

"(iii) any distribution of property shall be taken into account at its fair market value on the date of the distribution.

"(3) EXCESS CONTRIBUTIONS RETURNED BEFORE DUE DATE OF RETURN.—If the aggregate contributions (other than rollover contributions) for a taxable year to the medical savings accounts of an individual exceed the amount allowable as a deduction under this section for such contributions, paragraph (2) shall not apply to distributions from such

accounts (in an amount not greater than such excess) if—

"(A) such distribution is received by the individual on or before the last day prescribed by law (including extensions of time) for filing such individual's return for such taxable year, and

"(B) such distribution is accompanied by the amount of net income attributable to such excess contribution.

Any net income described in subparagraph (B) shall be included in the gross income of the individual for the taxable year in which it is received.

"(4) PENALTY FOR DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

"(A) IN GENERAL.—The tax imposed by this chapter on the account holder for any taxable year in which there is a payment or distribution from a medical savings account of such holder which is includible in gross income under paragraph (2) shall be increased by 10 percent of the amount which is so includible.

"(B) EXCEPTION FOR DISABILITY OR DEATH.—Subparagraph (A) shall not apply if the payment or distribution is made after the

account holder becomes disabled within the meaning of section 72(m)(7) or dies.

''(C) EXCEPTION FOR DISTRIBUTIONS AFTER AGE 59½.—Subparagraph (A) shall not apply to any payment or distribution after the date on which the account holder attains age 59½.

''(5) ROLLOVER CONTRIBUTION.—An amount is described in this paragraph as a rollover contribution if it meets the requirements of subparagraphs (A) and (B).

''(A) IN GENERAL.—Paragraph (2) shall not apply to any amount paid or distributed from a medical savings account to the account holder to the extent the amount received is paid into a medical savings account for the benefit of such holder not later than the 60th day after the day on which the holder receives the payment or distribution.

''(B) LIMITATION.—This paragraph shall not apply to any amount described in subparagraph (A) received by an individual from a medical savings account if, at any time during the 1-year period ending on the day of such receipt, such individual received any other amount

described in subparagraph (A) from a medical savings account which was not includible in the individual's gross income because of the application of this paragraph.

''(6) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—For purposes of determining the amount of the deduction under section 213, any payment or distribution out of a medical savings account for qualified medical expenses shall not be treated as an expense paid for medical care.

''(7) TRANSFER OF ACCOUNT INCIDENT TO DIVORCE.—The transfer of an individual's interest in a medical savings account to an individual's spouse or former spouse under a divorce or separation instrument described in subparagraph (A) of section 71(b)(2) shall not be considered a taxable transfer made by such individual notwithstanding any other provision of this subtitle, and such interest shall, after such transfer, be treated as a medical savings account with respect to which the spouse is the account holder.

''(g) COST-OF-LIVING ADJUSTMENT.—

''(1) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1997, each dollar amount in subsection (b)(1), (c)(2), or

(d)(1)(A) shall be increased by an amount equal to—

"(A) such dollar amount, multiplied by

"(B) the medical care cost adjustment for such calendar year.

If any increase under the preceding sentence is not a multiple of $50, such increase shall be rounded to the nearest multiple of $50.

"(2) MEDICAL CARE COST ADJUSTMENT.—For purposes of paragraph (1), the medical care cost adjustment for any calendar year is the percentage (if any) by which—

"(A) the medical care component of the Consumer Price Index (as defined in section 1(f)(5)) for August of the preceding calendar year, exceeds

"(B) such component for August of 1996.

"(h) REPORTS.—The Secretary may require the trustee of a medical savings account to make such reports regarding such account to the Secretary and to the account holder with respect to contributions, distributions, and such other matters as the Secretary determines appropriate. The reports required by this subsection shall be filed at such time and in such manner and furnished to

such individuals at such time and in such manner as may be required by those regulations.''

(b) DEDUCTION ALLOWED WHETHER OR NOT INDIVIDUAL ITEMIZES OTHER DEDUCTIONS.—Subsection (a) of section 62 is amended by inserting after paragraph (15) the following new paragraph:

''(16) MEDICAL SAVINGS ACCOUNTS.—The deduction allowed by section 220.''

(c) EXCLUSIONS FOR EMPLOYER CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

(1) EXCLUSION FROM INCOME TAX.—The text of section 106 (relating to contributions by employer to accident and health plans) is amended to read as follows:

''(a) GENERAL RULE.—Except as otherwise provided in this section, gross income of an employee does not include employer-provided coverage under an accident or health plan.

''(b) CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

''(1) IN GENERAL.—In the case of an employee who is an eligible individual, gross income does not include amounts contributed by such employee's employer to any medical savings account of such employee.

''(2) COORDINATION WITH DEDUCTION LIMITATION.—The amount excluded from the gross income of an employee under this subsection for any taxable year shall not exceed the limitation under section 220(b)(1) (determined without regard to this subsection) which is applicable to such employee for such taxable year.

''(3) NO CONSTRUCTIVE RECEIPT.—No amount shall be included in the gross income of any employee solely because the employee may choose between the contributions referred to in paragraph (1) and employer contributions to another health plan of the employer.

''(4) SPECIAL RULE FOR DEDUCTION OF EMPLOYER CONTRIBUTIONS.—Any employer contribution to a medical savings account, if otherwise allowable as a deduction under this chapter, shall be allowed only for the taxable year in which paid.

''(5) DEFINITIONS.—For purposes of this subsection, the terms 'eligible individual' and 'medical savings account' have the respective meanings given to such terms by section 220.''

(2) EXCLUSION FROM EMPLOYMENT TAXES.—

(A) SOCIAL SECURITY TAXES.—

(i) Subsection (a) of section 3121 is amended by striking ''or'' at the end of paragraph (20), by striking the period at the end of paragraph (21) and inserting ''; or'', and by inserting after paragraph (21) the following new paragraph:

''(22) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b).''

(ii) Subsection (a) of section 209 of the Social Security Act is amended by striking ''or'' at the end of paragraph (17), by striking the period at the end of paragraph (18) and inserting ''; or'', and by inserting after paragraph (18) the following new paragraph:

''(19) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b) of the Internal Revenue Code of 1986.''

(B) RAILROAD RETIREMENT TAX.—Subsection (e) of section 3231 is amended by adding at the end the following new paragraph:

''(10) MEDICAL SAVINGS ACCOUNT CONTRIBUTIONS.—The term 'compensation' shall not include any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b).''

(C) UNEMPLOYMENT TAX.—Subsection (b) of section 3306 is amended by striking ''or'' at the end of paragraph (15), by striking the period at the end of paragraph (16) and inserting ''; or'', and by inserting after paragraph (16) the following new paragraph:

''(17) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b).''

(D) WITHHOLDING TAX.—Subsection (a) of section 3401 is amended by striking ''or'' at the end of paragraph (19), by striking the period at the end of paragraph (20) and inserting

''; or'', and by inserting after paragraph (20) the following new paragraph:

''(21) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b).''

(d) MEDICAL SAVINGS ACCOUNT CONTRIBUTIONS NOT AVAILABLE UNDER CAFETERIA PLANS.—Subsection (f) of section 125 of such Code is amended by inserting ''106(b),'' before ''117''.

(e) EXCLUSION OF MEDICAL SAVINGS ACCOUNTS FROM ESTATE TAX.—Part IV of subchapter A of chapter 11 is amended by adding at the end the following new section:

''SEC. 2057. MEDICAL SAVINGS ACCOUNTS.

''For purposes of the tax imposed by section 2001, the value of the taxable estate shall be determined by deducting from the value of the gross estate an amount equal to the value of any medical savings account (as defined in section 220(d)) included in the gross estate.''

(f) TAX ON EXCESS CONTRIBUTIONS.—Section 4973 (relating to tax on excess contributions to individual retirement accounts, certain section 403(b) contracts, and certain individual retirement annuities) is amended—

(1) by inserting ''**MEDICAL SAVINGS ACCOUNTS,**'' after ''**ACCOUNTS,**'' in the heading of such section,

(2) by striking ''or'' at the end of paragraph (1) of subsection (a),

(3) by redesignating paragraph (2) of subsection (a) as paragraph (3) and by inserting after paragraph (1) the following:

''(2) a medical savings account (within the meaning of section 220(d)), or'', and

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

''(d) EXCESS CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—For purposes of this section, in the case of a medical savings accounts (within the meaning of section 220(d)), the term 'excess contributions' means the sum of—

''(1) the amount by which the amount contributed for the taxable year to the accounts (other than rollover contributions described in section 220(f)(5)) exceeds the amount allowable as a deduction under section 220 for such contributions, and

''(2) the amount determined under this subsection for the preceding taxable year, reduced by the sum of distributions out of the account included

in gross income under section 220(f) (2) or (3) and the excess (if any) of the maximum amount allowable as a deduction under section 220 for the taxable year over the amount contributed to the accounts.

For purposes of this subsection, any contribution which is distributed out of the medical savings account in a distribution to which section 220(f)(3) applies shall be treated as an amount not contributed.''

(g) TAX ON PROHIBITED TRANSACTIONS.—

(1) Section 4975 (relating to tax on prohibited transactions) is amended by adding at the end of subsection (c) the following new paragraph:

''(4) SPECIAL RULE FOR MEDICAL SAVINGS ACCOUNTS.—An individual for whose benefit a medical savings account (within the meaning of section 220(d)) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a medical savings account by reason of the application of section 220(e)(2) to such account.''

(2) Paragraph (1) of section 4975(e) is amended to read as follows:

''(1) PLAN.—For purposes of this section, the term 'plan' means—

''(A) a trust described in section 401(a) which forms a part of a plan, or a plan described in section 403(a), which trust or plan is exempt from tax under section 501(a),

''(B) an individual retirement account described in section 408(a),

''(C) an individual retirement annuity described in section 408(b),

''(D) a medical savings account described in section 220(d), or

''(E) a trust, plan, account, or annuity which, at any time, has been determined by the Secretary to be described in any preceding subparagraph of this paragraph.''

(h) FAILURE TO PROVIDE REPORTS ON MEDICAL SAVINGS ACCOUNTS.—

(1) Subsection (a) of section 6693 (relating to failure to provide reports on individual retirement accounts or annuities) is amended to read as follows:

''(a) REPORTS.—

''(1) IN GENERAL.—If a person required to file a report under a provision referred to in paragraph (2) fails to file such report at the time and in the

manner required by such provision, such person shall pay a penalty of $50 for each failure unless it is shown that such failure is due to reasonable cause.

''(2) PROVISIONS.—The provisions referred to in this paragraph are—

''(A) subsections (i) and (l) of section 408 (relating to individual retirement plans), and

''(B) section 220(h) (relating to medical savings accounts).''

(i) EXCEPTION FROM CAPITALIZATION OF POLICY ACQUISITION EXPENSES.—Subparagraph (B) of section 848(e)(1) (defining specified insurance contract) is amended by striking ''and'' at the end of clause (ii), by striking the period at the end of clause (iii) and inserting '', and'', and by adding at the end the following new clause:

''(iv) any contract which is a medical savings account (as defined in section 220(d)).''.

(j) CLERICAL AMENDMENTS.—

(1) The table of sections for part VII of subchapter B of chapter 1 is amended by striking the last item and inserting the following:

''Sec. 220. Medical savings accounts.
''Sec. 221. Cross reference.''.

(2) The table of sections for part IV of subchapter A of chapter 11 is amended by adding at the end the following new item:

"Sec. 2057. Medical savings accounts.".

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

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

SEC. 311. INCREASE IN DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

(a) IN GENERAL.—Paragraph (1) of section 162(l) is amended to read as follows:

"(1) ALLOWANCE OF DEDUCTION.—

"(A) IN GENERAL.—In the case of an individual who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an amount equal to the applicable percentage of the amount paid during the taxable year for insurance which constitutes medical care for the taxpayer, his spouse, and dependents.

"(B) APPLICABLE PERCENTAGE.—For purposes of subparagraph (A), the applicable

percentage shall be determined under the following table:

"For taxable years beginning in calendar year—	The applicable percentage is—
1998	35 percent
1999, 2000, or 2001	40 percent
2002	45 percent
2003 or thereafter	50 percent.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 1997.

Subtitle C—Long-Term Care Services and Contracts

PART I—GENERAL PROVISIONS

SEC. 321. TREATMENT OF LONG-TERM CARE INSURANCE.

(a) GENERAL RULE.—Chapter 79 (relating to definitions) is amended by inserting after section 7702A the following new section:

"SEC. 7702B. TREATMENT OF QUALIFIED LONG-TERM CARE INSURANCE.

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

''(1) a qualified long-term care insurance contract shall be treated as an accident and health insurance contract,

''(2) amounts (other than policyholder dividends, as defined in section 808, or premium refunds) received under a qualified long-term care insurance contract shall be treated as amounts re-

ceived for personal injuries and sickness and shall be treated as reimbursement for expenses actually incurred for medical care (as defined in section 213(d)),

''(3) any plan of an employer providing coverage under a qualified long-term care insurance contract shall be treated as an accident and health plan with respect to such coverage,

''(4) except as provided in subsection (e)(3), amounts paid for a qualified long-term care insurance contract providing the benefits described in subsection (b)(2)(A) shall be treated as payments made for insurance for purposes of section 213(d)(1)(D), and

''(5) a qualified long-term care insurance contract shall be treated as a guaranteed renewable contract subject to the rules of section 816(e).

''(b) QUALIFIED LONG-TERM CARE INSURANCE CONTRACT.—For purposes of this title—

''(1) IN GENERAL.—The term 'qualified long-term care insurance contract' means any insurance contract if—

''(A) the only insurance protection provided under such contract is coverage of qualified long-term care services,

''(B) such contract does not pay or reimburse expenses incurred for services or items to the extent that such expenses are reimbursable under title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount,

''(C) such contract is guaranteed renewable,

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

''(i) paid, assigned, or pledged as collateral for a loan, or

''(ii) borrowed,

other than as provided in subparagraph (E) or paragraph (2)(C),

''(E) all refunds of premiums, and all policyholder dividends or similar amounts, under such contract are to be applied as a reduction in future premiums or to increase future benefits, and

''(F) such contract meets the requirements of subsection (f).

''(2) SPECIAL RULES.—

"(A) PER DIEM, ETC. PAYMENTS PERMITTED.—A contract shall not fail to be described in subparagraph (A) or (B) of paragraph (1) by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

"(B) SPECIAL RULES RELATING TO MEDICARE.—

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

"(ii) No provision of law shall be construed or applied so as to prohibit the offering of a qualified long-term care insurance contract on the basis that the contract coordinates its benefits with those provided under such title.

"(C) REFUNDS OF PREMIUMS.—Paragraph (1)(E) shall not apply to any refund on the death of the insured, or on a complete surrender or cancellation of the contract, which cannot exceed the aggregate premiums paid under the contract. Any refund on a complete surren-

der or cancellation of the contract shall be includible in gross income to the extent that any deduction or exclusion was allowable with respect to the premiums.

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

''(1) IN GENERAL.—The term 'qualified long-term care services' means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, which—

''(A) are required by a chronically ill individual, and

''(B) are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

''(2) CHRONICALLY ILL INDIVIDUAL.—

''(A) IN GENERAL.—The term 'chronically ill individual' means any individual who has been certified by a licensed health care practitioner as—

''(i) being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living

for a period of at least 90 days due to a loss of functional capacity,

''(ii) having a level of disability similar (as determined by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in clause (i), or

''(iii) requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment.

Such term shall not include any individual otherwise meeting the requirements of the preceding sentence unless within the preceding 12-month period a licensed health care practitioner has certified that such individual meets such requirements.

''(B) ACTIVITIES OF DAILY LIVING.—For purposes of subparagraph (A), each of the following is an activity of daily living:

''(i) Eating.

''(ii) Toileting.

''(iii) Transferring.

''(iv) Bathing.

''(v) Dressing.

"(vi) Continence.

Nothing in this section shall be construed to require a contract to take into account all of the preceding activities of daily living.

"(3) MAINTENANCE OR PERSONAL CARE SERVICES.—The term 'maintenance or personal care services' means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

"(4) LICENSED HEALTH CARE PRACTITIONER.—The term 'licensed health care practitioner' means any physician (as defined in section 1861(r)(1) of the Social Security Act) and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary.

"(d) AGGREGATE PAYMENTS IN EXCESS OF LIMITS.—

"(1) IN GENERAL.—If the aggregate amount of periodic payments under all qualified long-term care insurance contracts with respect to an insured for any period exceeds the dollar amount in effect for

such period under paragraph (3), such excess payments shall be treated as made for qualified long-term care services only to the extent of the costs incurred by the payee (not otherwise compensated for by insurance or otherwise) for qualified long-term care services provided during such period for such insured.

''(2) PERIODIC PAYMENTS.—For purposes of paragraph (1), the term 'periodic payment' means any payment (whether on a periodic basis or otherwise) made without regard to the extent of the costs incurred by the payee for qualified long-term care services.

''(3) DOLLAR AMOUNT.—The dollar amount in effect under this subsection shall be $175 per day (or the equivalent amount in the case of payments on another periodic basis).

''(4) INFLATION ADJUSTMENT.—In the case of a calendar year after 1997, the dollar amount contained in paragraph (3) shall be increased at the same time and in the same manner as amounts are increased pursuant to section 213(d)(10).

''(e) TREATMENT OF COVERAGE PROVIDED AS PART OF A LIFE INSURANCE CONTRACT.—Except as otherwise provided in regulations prescribed by the Secretary, in the

case of any long-term care insurance coverage (whether or not qualified) provided by a rider on or as part of a life insurance contract—

''(1) IN GENERAL.—This section shall apply as if the portion of the contract providing such coverage is a separate contract.

''(2) APPLICATION OF 7702.—Section 7702(c)(2) (relating to the guideline premium limitation) shall be applied by increasing the guideline premium limitation with respect to a life insurance contract, as of any date—

''(A) by the sum of any charges (but not premium payments) against the life insurance contract's cash surrender value (within the meaning of section 7702(f)(2)(A)) for such coverage made to that date under the contract, less

''(B) any such charges the imposition of which reduces the premiums paid for the contract (within the meaning of section 7702(f)(1)).

''(3) APPLICATION OF SECTION 213.—No deduction shall be allowed under section 213(a) for charges against the life insurance contract's cash surrender value described in paragraph (2), unless such charges are includible in income as a result of

the application of section 72(e)(10) and the rider is a qualified long-term care insurance contract under subsection (b).

''(4) PORTION DEFINED.—For purposes of this subsection, the term 'portion' means only the terms and benefits under a life insurance contract that are in addition to the terms and benefits under the contract without regard to the coverage under a qualified long-term care insurance contract.''

(b) LONG-TERM CARE INSURANCE NOT PERMITTED UNDER CAFETERIA PLANS OR FLEXIBLE SPENDING ARRANGEMENTS.—

(1) CAFETERIA PLANS.—Section 125(f) is amended by adding at the end the following new sentence: ''Such term shall not include any long-term care insurance contract (as defined in section 4980C).''

(2) FLEXIBLE SPENDING ARRANGEMENTS.—Section 106 (relating to contributions by employer to accident and health plans), as amended by section 301(c), is amended by adding at the end the following new subsection:

''(c) INCLUSION OF LONG-TERM CARE BENEFITS PROVIDED THROUGH FLEXIBLE SPENDING ARRANGEMENTS.—

''(1) IN GENERAL.—Effective on and after January 1, 1997, gross income of an employee shall include employer-provided coverage for qualified long-term care services (as defined in section 7702B(c)) to the extent that such coverage is provided through a flexible spending or similar arrangement.

''(2) FLEXIBLE SPENDING ARRANGEMENT.—For purposes of this subsection, a flexible spending arrangement is a benefit program which provides employees with coverage under which—

''(A) specified incurred expenses may be reimbursed (subject to reimbursement maximums and other reasonable conditions), and

''(B) the maximum amount of reimbursement which is reasonably available to a participant for such coverage is less than 500 percent of the value of such coverage.

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

(c) CONTINUATION COVERAGE EXCISE TAX NOT TO APPLY.—Subsection (f) of section 4980B is amended by adding at the end the following new paragraph:

''(9) CONTINUATION OF LONG-TERM CARE COVERAGE NOT REQUIRED.—A group health plan shall

not be treated as failing to meet the requirements of this subsection solely by reason of failing to provide coverage under any qualified long-term care insurance contract (as defined in section 7702B(b)).''

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

''Sec. 7702B. Treatment of qualified long-term care insurance.''.

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to contracts issued after December 31, 1996.

(2) CONTINUATION OF EXISTING POLICIES.—In the case of any contract issued before January 1, 1997, which met the long-term care insurance requirements of the State in which the contract was situsued at the time the contract was issued—

(A) such contract shall be treated for purposes of the Internal Revenue Code of 1986 as a qualified long-term care insurance contract (as defined in section 7702B(b) of such Code), and

(B) services provided under, or reimbursed by, such contract shall be treated for such purposes as qualified long-term care services (as defined in section 7702B(c) of such Code).

(3) EXCHANGES OF EXISTING POLICIES.—If, after the date of enactment of this Act and before January 1, 1998, a contract providing for long-term care insurance coverage is exchanged solely for a qualified long-term care insurance contract (as defined in section 7702B(b) of such Code), no gain or loss shall be recognized on the exchange. If, in addition to a qualified long-term care insurance contract, money or other property is received in the exchange, then any gain shall be recognized to the extent of the sum of the money and the fair market value of the other property received. For purposes of this paragraph, the cancellation of a contract providing for long-term care insurance coverage and reinvestment of the cancellation proceeds in a qualified long-term care insurance contract within 60 days thereafter shall be treated as an exchange.

(4) ISSUANCE OF CERTAIN RIDERS PERMITTED.—For purposes of applying sections 101(f), 7702, and 7702A of the Internal Revenue Code of 1986 to any contract—

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

(B) the addition of any provision required to conform any other long-term care rider to be so treated,

shall not be treated as a modification or material change of such contract.

SEC. 322. QUALIFIED LONG-TERM CARE SERVICES TREATED AS MEDICAL CARE.

(a) GENERAL RULE.—Paragraph (1) of section 213(d) (defining medical care) is amended by striking ''or'' at the end of subparagraph (B), by redesignating subparagraph (C) as subparagraph (D), and by inserting after subparagraph (B) the following new subparagraph:

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

(b) TECHNICAL AMENDMENTS.—

(1) Subparagraph (D) of section 213(d)(1) (as redesignated by subsection (a)) is amended by inserting before the period ''or for any qualified long-term care insurance contract (as defined in section 7702B(b))''.

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

''In the case of a qualified long-term care insurance contract (as defined in section 7702B(b)), only eligi-

ble long-term care premiums (as defined in paragraph (10)) shall be taken into account under subparagraph (D).''

(B) Subsection (d) of section 213 is amended by adding at the end the following new paragraphs:

''(10) ELIGIBLE LONG-TERM CARE PREMIUMS.—

''(A) IN GENERAL.—For purposes of this section, the term 'eligible long-term care premiums' means the amount paid during a taxable year for any qualified long-term care insurance contract (as defined in section 7702B(b)) covering an individual, to the extent such amount does not exceed the limitation determined under the following table:

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

''(B) INDEXING.—

''(i) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1997, each dollar amount contained in subparagraph (A) shall be increased by the medical care cost adjustment of such

amount for such calendar year. If any increase determined under the preceding sentence is not a multiple of $10, such increase shall be rounded to the nearest multiple of $10.

''(ii) MEDICAL CARE COST ADJUSTMENT.—For purposes of clause (i), the medical care cost adjustment for any calendar year is the percentage (if any) by which—

''(I) the medical care component of the Consumer Price Index (as defined in section 1(f)(5)) for August of the preceding calendar year, exceeds

''(II) such component for August of 1996.

The Secretary shall, in consultation with the Secretary of Health and Human Services, prescribe an adjustment which the Secretary determines is more appropriate for purposes of this paragraph than the adjustment described in the preceding sentence, and the adjustment so prescribed shall apply in lieu of the adjustment described in the preceding sentence.

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

''(A) by the spouse of the individual or by a relative (directly or through a partnership, corporation, or other entity) unless the service is provided by a licensed professional with respect to such service, or

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

For purposes of this paragraph, the term 'relative' means an individual bearing a relationship to the individual which is described in any of paragraphs (1) through (8) of section 152(a). This paragraph shall not apply for purposes of section 105(b) with respect to reimbursements through insurance.'' .

(3) Paragraph (6) of section 213(d) is amended—

(A) by striking ''subparagraphs (A) and (B)'' and inserting ''subparagraphs (A), (B), and (C)'', and

(B) by striking ''paragraph (1)(C)'' in subparagraph (A) and inserting ''paragraph (1)(D)''.

(4) Paragraph (7) of section 213(d) is amended by striking ''subparagraphs (A) and (B)'' and inserting ''subparagraphs (A), (B), and (C)''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to taxable years beginning after December 31, 1996.

(2) DEDUCTION FOR LONG-TERM CARE SERVICES.—Amounts paid for qualified long-term care services (as defined in section 7702B(c) of the Internal Revenue Code of 1986, as added by this Act) furnished in any taxable year beginning before January 1, 1998, shall not be taken into account under section 213 of the Internal Revenue Code of 1986.

SEC. 323. REPORTING REQUIREMENTS.

(a) IN GENERAL.—Subpart B of part III of subchapter A of chapter 61 is amended by adding at the end the following new section:

''SEC. 6050Q. CERTAIN LONG-TERM CARE BENEFITS.

''(a) REQUIREMENT OF REPORTING.—Any person who pays long-term care benefits shall make a return, ac-

cording to the forms or regulations prescribed by the Secretary, setting forth—

"(1) the aggregate amount of such benefits paid by such person to any individual during any calendar year, and

"(2) the name, address, and TIN of such individual.

"(b) STATEMENTS TO BE FURNISHED TO PERSONS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required to be set forth in such return a written statement showing—

"(1) the name of the person making the payments, and

"(2) the aggregate amount of long-term care benefits paid to the individual which are required to be shown on such return.

The written statement required under the preceding sentence shall be furnished to the individual on or before January 31 of the year following the calendar year for which the return under subsection (a) was required to be made.

"(c) LONG-TERM CARE BENEFITS.—For purposes of this section, the term 'long-term care benefit' means—

''(1) any amount paid under a long-term care insurance policy (within the meaning of section 4980C(e)), and

''(2) payments which are excludable from gross income by reason of section 101(g).''.

(b) PENALTIES.—

(1) Subparagraph (B) of section 6724(d)(1) is amended by redesignating clauses (ix) through (xiv) as clauses (x) through (xv), respectively, and by inserting after clause (viii) the following new clause:

''(ix) section 6050Q (relating to certain long-term care benefits),''.

(2) Paragraph (2) of section 6724(d) is amended by redesignating subparagraphs (Q) through (T) as subparagraphs (R) through (U), respectively, and by inserting after subparagraph (P) the following new subparagraph:

''(Q) section 6050Q(b) (relating to certain long-term care benefits),''.

(c) CLERICAL AMENDMENT.—The table of sections for subpart B of part III of subchapter A of chapter 61 is amended by adding at the end the following new item:

''Sec. 6050Q. Certain long-term care benefits.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to benefits paid after December 31, 1996.

PART II—CONSUMER PROTECTION PROVISIONS

SEC. 325. POLICY REQUIREMENTS.

Section 7702B (as added by section 321) is amended by adding at the end the following new subsection:

''(f) CONSUMER PROTECTION PROVISIONS.—

''(1) IN GENERAL.—The requirements of this subsection are met with respect to any contract if any long-term care insurance policy issued under the contract meets—

''(A) the requirements of the model regulation and model Act described in paragraph (2),

''(B) the disclosure requirement of paragraph (3), and

''(C) the requirements relating to nonforfeitability under paragraph (4).

''(2) REQUIREMENTS OF MODEL REGULATION AND ACT.—

''(A) IN GENERAL.—The requirements of this paragraph are met with respect to any policy if such policy meets—

''(i) MODEL REGULATION.—The following requirements of the model regulation:

''(I) Section 7A (relating to guaranteed renewal or noncancellability), and the requirements of section 6B of

the model Act relating to such section 7A.

''(II) Section 7B (relating to prohibitions on limitations and exclusions).

''(III) Section 7C (relating to extension of benefits).

''(IV) Section 7D (relating to continuation or conversion of coverage).

''(V) Section 7E (relating to discontinuance and replacement of policies).

''(VI) Section 8 (relating to unintentional lapse).

''(VII) Section 9 (relating to disclosure), other than section 9F thereof.

''(VIII) Section 10 (relating to prohibitions against post-claims underwriting).

''(IX) Section 11 (relating to minimum standards).

''(X) Section 12 (relating to requirement to offer inflation protec-

tion), except that any requirement for a signature on a rejection of inflation protection shall permit the signature to be on an application or on a separate form.

''(XI) Section 23 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

''(ii) MODEL ACT.—The following requirements of the model Act:

''(I) Section 6C (relating to preexisting conditions).

''(II) Section 6D (relating to prior hospitalization).

''(B) DEFINITIONS.—For purposes of this paragraph—

''(i) MODEL PROVISIONS.—The terms 'model regulation' and 'model Act' mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of January 1993).

''(ii) COORDINATION.—Any provision of the model regulation or model Act listed under clause (i) or (ii) of subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision.

''(iii) DETERMINATION.—For purposes of this section and section 4980C, the determination of whether any requirement of a model regulation or the model Act has been met shall be made by the Secretary.

''(3) DISCLOSURE REQUIREMENT.—The requirement of this paragraph is met with respect to any policy if such policy meets the requirements of section 4980C(d)(1).

''(4) NONFORFEITURE REQUIREMENTS.—

''(A) IN GENERAL.—The requirements of this paragraph are met with respect to any level premium long-term care insurance policy, if the issuer of such policy offers to the policyholder, including any group policyholder, a nonforfeiture provision meeting the requirements of subparagraph (B).

''(B) REQUIREMENTS OF PROVISION.—The nonforfeiture provision required under subparagraph (A) shall meet the following requirements:

''(i) The nonforfeiture provision shall be appropriately captioned.

''(ii) The nonforfeiture provision shall provide for a benefit available in the event of a default in the payment of any premiums and the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying policies approved by the Secretary for the same policy form.

''(iii) The nonforfeiture provision shall provide at least one of the following:

''(I) Reduced paid-up insurance.

''(II) Extended term insurance.

''(III) Shortened benefit period.

''(IV) Other similar offerings approved by the Secretary.

''(5) LONG-TERM CARE INSURANCE POLICY DEFINED.—For purposes of this subsection, the term

'long-term care insurance policy' has the meaning given such term by section 4980C(e).''.

SEC. 326. REQUIREMENTS FOR ISSUERS OF LONG-TERM CARE INSURANCE POLICIES.

(a) IN GENERAL.—Chapter 43 is amended by adding at the end the following new section:

''SEC. 4980C. REQUIREMENTS FOR ISSUERS OF LONG-TERM CARE INSURANCE POLICIES.

''(a) GENERAL RULE.—There is hereby imposed on any person failing to meet the requirements of subsection (c) or (d) a tax in the amount determined under subsection (b).

''(b) AMOUNT.—

''(1) IN GENERAL.—The amount of the tax imposed by subsection (a) shall be $100 per policy for each day any requirements of subsection (c) or (d) are not met with respect to each long-term care insurance policy.

''(2) WAIVER.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that payment of the tax would be excessive relative to the failure involved.

''(c) RESPONSIBILITIES.—The requirements of this subsection are as follows:

''(1) REQUIREMENTS OF MODEL PROVISIONS.—

''(A) MODEL REGULATION.—The following requirements of the model regulation must be met:

''(i) Section 13 (relating to application forms and replacement coverage).

''(ii) Section 14 (relating to reporting requirements), except that the issuer shall also report at least annually the number of claims denied during the reporting period for each class of business (expressed as a percentage of claims denied), other than claims denied for failure to meet the waiting period or because of any applicable preexisting condition.

''(iii) Section 20 (relating to filing requirements for marketing).

''(iv) Section 21 (relating to standards for marketing), including inaccurate completion of medical histories, other than sections 21C(1) and 21C(6) thereof, except that—

''(I) in addition to such requirements, no person shall, in selling or offering to sell a long-term care insurance policy, misrepresent a material fact; and

''(II) no such requirements shall include a requirement to inquire or identify whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance.

''(v) Section 22 (relating to appropriateness of recommended purchase).

''(vi) Section 24 (relating to standard format outline of coverage).

''(vii) Section 25 (relating to requirement to deliver shopper's guide).

''(B) MODEL ACT.—The following requirements of the model Act must be met:

''(i) Section 6F (relating to right to return), except that such section shall also apply to denials of applications and any refund shall be made within 30 days of the return or denial.

"(ii) Section 6G (relating to outline of coverage).

"(iii) Section 6H (relating to requirements for certificates under group plans).

"(iv) Section 6I (relating to policy summary).

"(v) Section 6J (relating to monthly reports on accelerated death benefits).

"(vi) Section 7 (relating to incontestability period).

"(C) DEFINITIONS.—For purposes of this paragraph, the terms 'model regulation' and 'model Act' have the meanings given such terms by section 7702B(f)(2)(B).

"(2) DELIVERY OF POLICY.—If an application for a long-term care insurance policy (or for a certificate under a group long-term care insurance policy) is approved, the issuer shall deliver to the applicant (or policyholder or certificateholder) the policy (or certificate) of insurance not later than 30 days after the date of the approval.

"(3) INFORMATION ON DENIALS OF CLAIMS.—If a claim under a long-term care insurance policy is denied, the issuer shall, within 60 days of the date

of a written request by the policyholder or certificateholder (or representative)—

''(A) provide a written explanation of the reasons for the denial, and

''(B) make available all information directly relating to such denial.

''(d) DISCLOSURE.—The requirements of this subsection are met if the issuer of a long-term care insurance policy discloses in such policy and in the outline of coverage required under subsection (c)(1)(B)(ii) that the policy is intended to be a qualified long-term care insurance contract under section 7702B(b).

''(e) LONG-TERM CARE INSURANCE POLICY DEFINED.—For purposes of this section, the term 'long-term care insurance policy' means any product which is advertised, marketed, or offered as long-term care insurance.''.

(b) CONFORMING AMENDMENT.—The table of sections for chapter 43 is amended by adding at the end the following new item:

''Sec. 4980C. Requirements for issuers of long-term care insurance policies.''.

SEC. 327. COORDINATION WITH STATE REQUIREMENTS.

Nothing in this part shall prevent a State from establishing, implementing, or continuing in effect standards related to the protection of policyholders of long-term care insurance policies (as defined in section 4980C(e) of the

Internal Revenue Code of 1986), if such standards are not in conflict with or inconsistent with the standards established under such Code.

SEC. 328. EFFECTIVE DATES.

(a) IN GENERAL.—The provisions of, and amendments made by, this part shall apply to contracts issued after December 31, 1996. The provisions of section 321(g) (relating to transition rule) shall apply to such contracts.

(b) ISSUERS.—The amendments made by section 326 shall apply to actions taken after December 31, 1996.

Subtitle D—Treatment of Accelerated Death Benefits

SEC. 331. TREATMENT OF ACCELERATED DEATH BENEFITS BY RECIPIENT.

(a) IN GENERAL.—Section 101 (relating to certain death benefits) is amended by adding at the end the following new subsection:

"(g) TREATMENT OF CERTAIN ACCELERATED DEATH BENEFITS.—

"(1) IN GENERAL.—For purposes of this section, the following amounts shall be treated as an amount paid by reason of the death of an insured:

"(A) Any amount received under a life insurance contract on the life of an insured who is a terminally ill individual.

"(B) Any amount received under a life insurance contract on the life of an insured who is a chronically ill individual (as defined in section 7702B(c)(2)) but only if such amount is received under a rider or other provision of such contract which is treated as a qualified long-term care insurance contract under section 7702B and such amount is treated under section 7702B (after the application of subsection (d) thereof) as a payment for qualified long-term care services (as defined in such section).

"(2) TREATMENT OF VIATICAL SETTLEMENTS.—

"(A) IN GENERAL.—In the case of a life insurance contract on the life of an insured described in paragraph (1), if—

"(i) any portion of such contract is sold to any viatical settlement provider, or

"(ii) any portion of the death benefit is assigned to such a provider,

the amount paid for such sale or assignment shall be treated as an amount paid under the life insurance contract by reason of the death of such insured.

"(B) VIATICAL SETTLEMENT PROVIDER.—The term 'viatical settlement provider' means any person regularly engaged in the trade or business of purchasing, or taking assignments of, life insurance contracts on the lives of insureds described in paragraph (1) if—

"(i) such person is licensed for such purposes in the State in which the insured resides, or

"(ii) in the case of an insured who resides in a State not requiring the licensing of such persons for such purposes—

"(I) such person meets the requirements of sections 8 and 9 of the Viatical Settlements Model Act of the National Association of Insurance Commissioners, and

"(II) meets the requirements of the Model Regulations of the National Association of Insurance Commissioners (relating to standards for evaluation of reasonable payments) in determining amounts paid by such person in connection with such purchases or assignments.

''(3) DEFINITIONS.—For purposes of this subsection—

''(A) TERMINALLY ILL INDIVIDUAL.—The term 'terminally ill individual' means an individual who has been certified by a physician as having an illness or physical condition which can reasonably be expected to result in death in 24 months or less after the date of the certification.

''(B) PHYSICIAN.—The term 'physician' has the meaning given to such term by section 1861(r)(1) of the Social Security Act (42 U.S.C. 1395x(r)(1)).

''(4) EXCEPTION FOR BUSINESS-RELATED POLICIES.—This subsection shall not apply in the case of any amount paid to any taxpayer other than the insured if such taxpayer has an insurable interest with respect to the life of the insured by reason of the insured being a director, officer, or employee of the taxpayer or by reason of the insured being financially interested in any trade or business carried on by the taxpayer.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to amounts received after December 31, 1996.

SEC. 332. TAX TREATMENT OF COMPANIES ISSUING QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.

(a) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—Section 818 (relating to other definitions and special rules) is amended by adding at the end the following new subsection:

''(g) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—For purposes of this part—

''(1) IN GENERAL.—Any reference to a life insurance contract shall be treated as including a reference to a qualified accelerated death benefit rider on such contract.

''(2) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.—For purposes of this subsection, the term 'qualified accelerated death benefit rider' means any rider on a life insurance contract if the only payments under the rider are payments meeting the requirements of section 101(g).

''(3) EXCEPTION FOR LONG-TERM CARE RIDERS.—Paragraph (1) shall not apply to any rider which is treated as a long-term care insurance contract under section 7702B.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by this section shall take effect on January 1, 1997.

(2) ISSUANCE OF RIDER NOT TREATED AS MATERIAL CHANGE.—For purposes of applying sections 101(f), 7702, and 7702A of the Internal Revenue Code of 1986 to any contract—

(A) the issuance of a qualified accelerated death benefit rider (as defined in section 818(g) of such Code (as added by this Act)), and

(B) the addition of any provision required to conform an accelerated death benefit rider to the requirements of such section 818(g),

shall not be treated as a modification or material change of such contract.

Subtitle E—High-Risk Pools

SEC. 341. EXEMPTION FROM INCOME TAX FOR STATE-SPONSORED ORGANIZATIONS PROVIDING HEALTH COVERAGE FOR HIGH-RISK INDIVIDUALS.

(a) IN GENERAL.—Subsection (c) of section 501 (relating to list of exempt organizations) is amended by adding at the end the following new paragraph:

''(26) Any membership organization if—

''(A) such organization is established by a State exclusively to provide coverage for medical care (as defined in section 213(d)) on a not-for-

profit basis to individuals described in subparagraph (B) through—

"(i) insurance issued by the organization, or

"(ii) a health maintenance organization under an arrangement with the organization,

"(B) the only individuals receiving such coverage through the organization are individuals—

"(i) who are residents of such State, and

"(ii) who, by reason of the existence or history of a medical condition, are unable to acquire medical care coverage for such condition through insurance or from a health maintenance organization or are able to acquire such coverage only at a rate which is substantially in excess of the rate for such coverage through the membership organization,

"(C) the composition of the membership in such organization is specified by such State, and

''(D) no part of the net earnings of the organization inures to the benefit of any private shareholder or individual.''.

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

Subtitle F—Organizations Subject to Section 833

SEC. 351. ORGANIZATIONS SUBJECT TO SECTION 833.

(a) IN GENERAL.—Section 833(c) (relating to organization to which section applies) is amended by adding at the end the following new paragraph:

''(4) TREATMENT AS EXISTING BLUE CROSS OR BLUE SHIELD ORGANIZATION.—

''(A) IN GENERAL.—Paragraph (2) shall be applied to an organization described in subparagraph (B) as if it were a Blue Cross or Blue Shield organization.

''(B) APPLICABLE ORGANIZATION.—An organization is described in this subparagraph if it—

''(i) is organized under, and governed by, State laws which are specifically and exclusively applicable to not-for-profit

health insurance or health service type organizations, and

"(ii) is not a Blue Cross or Blue Shield organization or health maintenance organization.".

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

TITLE IV—REVENUE OFFSETS

SEC. 400. AMENDMENT OF 1986 CODE.

Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

Subtitle A—Repeal of Bad Debt Reserve Method for Thrift Savings Associations

SEC. 401. REPEAL OF BAD DEBT RESERVE METHOD FOR THRIFT SAVINGS ASSOCIATIONS.

(a) IN GENERAL.—Section 593 (relating to reserves for losses on loans) is amended by adding at the end the following new subsections:

''(f) TERMINATION OF RESERVE METHOD.—Subsections (a), (b), (c), and (d) shall not apply to any taxable year beginning after December 31, 1995.

''(g) 6-YEAR SPREAD OF ADJUSTMENTS.—

''(1) IN GENERAL.—In the case of any taxpayer who is required by reason of subsection (f) to change its method of computing reserves for bad debts—

''(A) such change shall be treated as a change in a method of accounting,

''(B) such change shall be treated as initiated by the taxpayer and as having been made with the consent of the Secretary, and

''(C) the net amount of the adjustments required to be taken into account by the taxpayer under section 481(a)—

''(i) shall be determined by taking into account only applicable excess reserves, and

''(ii) as so determined, shall be taken into account ratably over the 6-taxable year period beginning with the first taxable year beginning after December 31, 1995.

''(2) APPLICABLE EXCESS RESERVES.—

"(A) IN GENERAL.—For purposes of paragraph (1), the term 'applicable excess reserves' means the excess (if any) of—

"(i) the balance of the reserves described in subsection (c)(1) (other than the supplemental reserve) as of the close of the taxpayer's last taxable year beginning before December 31, 1995, over

"(ii) the lesser of—

"(I) the balance of such reserves as of the close of the taxpayer's last taxable year beginning before January 1, 1988, or

"(II) the balance of the reserves described in subclause (I), reduced in the same manner as under section 585(b)(2)(B)(ii) on the basis of the taxable years described in clause (i) and this clause.

"(B) SPECIAL RULE FOR THRIFTS WHICH BECOME SMALL BANKS.—In the case of a bank (as defined in section 581) which was not a large bank (as defined in section 585(c)(2)) for its first taxable year beginning after December 31, 1995—

"(i) the balance taken into account under subparagraph (A)(ii) shall not be less than the amount which would be the balance of such reserves as of the close of its last taxable year beginning before such date if the additions to such reserves for all taxable years had been determined under section 585(b)(2)(A), and

"(ii) the opening balance of the reserve for bad debts as of the beginning of such first taxable year shall be the balance taken into account under subparagraph (A)(ii) (determined after the application of clause (i) of this subparagraph).

The preceding sentence shall not apply for purposes of paragraphs (5) and (6) or subsection (e)(1).

"(3) RECAPTURE OF PRE-1988 RESERVES WHERE TAXPAYER CEASES TO BE BANK.—If, during any taxable year beginning after December 31, 1995, a taxpayer to which paragraph (1) applied is not a bank (as defined in section 581), paragraph (1) shall apply to the reserves described in paragraph (2)(A)(ii) and the supplemental reserve; except that such reserves shall be taken into account

ratably over the 6-taxable year period beginning with such taxable year.

''(4) SUSPENSION OF RECAPTURE IF RESIDENTIAL LOAN REQUIREMENT MET.—

''(A) IN GENERAL.—In the case of a bank which meets the residential loan requirement of subparagraph (B) for the first taxable year beginning after December 31, 1995, or for the following taxable year—

''(i) no adjustment shall be taken into account under paragraph (1) for such taxable year, and

''(ii) such taxable year shall be disregarded in determining—

''(I) whether any other taxable year is a taxable year for which an adjustment is required to be taken into account under paragraph (1), and

''(II) the amount of such adjustment.

''(B) RESIDENTIAL LOAN REQUIREMENT.—A taxpayer meets the residential loan requirement of this subparagraph for any taxable year if the principal amount of the residential loans made by the taxpayer during such

year is not less than the base amount for such year.

"(C) RESIDENTIAL LOAN.—For purposes of this paragraph, the term 'residential loan' means any loan described in clause (v) of section 7701(a)(19)(C) but only if such loan is incurred in acquiring, constructing, or improving the property described in such clause.

"(D) BASE AMOUNT.—For purposes of subparagraph (B), the base amount is the average of the principal amounts of the residential loans made by the taxpayer during the 6 most recent taxable years beginning on or before December 31, 1995. At the election of the taxpayer who made such loans during each of such 6 taxable years, the preceding sentence shall be applied without regard to the taxable year in which such principal amount was the highest and the taxable year in such principal amount was the lowest. Such an election may be made only for the first taxable year beginning after such date, and, if made for such taxable year, shall apply to the succeeding taxable year unless revoked with the consent of the Secretary.

"(E) CONTROLLED GROUPS.—In the case of a taxpayer which is a member of any controlled group of corporations described in section 1563(a)(1), subparagraph (B) shall be applied with respect to such group.

"(5) CONTINUED APPLICATION OF FRESH START UNDER SECTION 585 TRANSITIONAL RULES.—In the case of a taxpayer to which paragraph (1) applied and which was not a large bank (as defined in section 585(c)(2)) for its first taxable year beginning after December 31, 1995:

"(A) IN GENERAL.—For purposes of determining the net amount of adjustments referred to in section 585(c)(3)(A)(iii), there shall be taken into account only the excess (if any) of the reserve for bad debts as of the close of the last taxable year before the disqualification year over the balance taken into account by such taxpayer under paragraph (2)(A)(ii) of this subsection.

"(B) TREATMENT UNDER ELECTIVE CUTOFF METHOD.—For purposes of applying section 585(c)(4)—

"(i) the balance of the reserve taken into account under subparagraph (B)

thereof shall be reduced by the balance taken into account by such taxpayer under paragraph (2)(A)(ii) of this subsection, and

"(ii) no amount shall be includible in gross income by reason of such reduction.

"(6) SUSPENDED RESERVE INCLUDED AS SECTION 381(c) ITEMS.—The balance taken into account by a taxpayer under paragraph (2)(A)(ii) of this subsection and the supplemental reserve shall be treated as items described in section 381(c).

"(7) CONVERSIONS TO CREDIT UNIONS.—In the case of a taxpayer to which paragraph (1) applied which becomes a credit union described in section 501(c) and exempt from taxation under section 501(a)—

"(A) any amount required to be included in the gross income of the credit union by reason of this subsection shall be treated as derived from an unrelated trade or business (as defined in section 513), and

"(B) for purposes of paragraph (3), the credit union shall not be treated as if it were a bank.

''(8) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out this subsection and subsection (e), including regulations providing for the application of such subsections in the case of acquisitions, mergers, spinoffs, and other reorganizations.''.

(b) CONFORMING AMENDMENTS.—

(1) Subsection (d) of section 50 is amended by adding at the end the following new sentence: ''Paragraphs (1)(A), (2)(A), and (4) of the section 46(e) referred to in paragraph (1) of this subsection shall not apply to any taxable year beginning after December 31, 1995.''

(2) Subsection (e) of section 52 is amended by striking paragraph (1) and by redesignating paragraphs (2) and (3) as paragraphs (1) and (2), respectively.

(3) Subsection (a) of section 57 is amended by striking paragraph (4).

(4) Section 246 is amended by striking subsection (f).

(5) Clause (i) of section 291(e)(1)(B) is amended by striking ''or to which section 593 applies''.

(6) Subparagraph (A) of section 585(a)(2) is amended by striking ''other than an organization to which section 593 applies''.

(7)(A) The material preceding subparagraph (A) of section 593(e)(1) is amended by striking ''by a domestic building and loan association or an institution that is treated as a mutual savings bank under section 591(b)'' and inserting ''by a taxpayer having a balance described in subsection (g)(2)(A)(ii)''.

(B) Subparagraph (B) of section 593(e)(1) is amended to read as follows:

''(B) then out of the balance taken into account under subsection (g)(2)(A)(ii) (properly adjusted for amounts charged against such reserves for taxable years beginning after December 31, 1987),''.

(C) Paragraph (1) of section 593(e) is amended by adding at the end the following new sentence: ''This paragraph shall not apply to any distribution of all of the stock of a bank (as defined in section 581) to another corporation if, immediately after the distribution, such bank and such other corporation are members of the same affiliated group (as defined in section 1504) and the provisions of section 5(e)

of the Federal Deposit Insurance Act (as in effect on December 31, 1995) or similar provisions are in effect.''

(8) Section 595 is hereby repealed.

(9) Section 596 is hereby repealed.

(10) Subsection (a) of section 860E is amended—

(A) by striking ''Except as provided in paragraph (2), the'' in paragraph (1) and inserting ''The'',

(B) by striking paragraphs (2) and (4) and redesignating paragraphs (3) and (5) as paragraphs (2) and (3), respectively, and

(C) by striking in paragraph (2) (as so redesignated) all that follows ''subsection'' and inserting a period.

(11) Paragraph (3) of section 992(d) is amended by striking ''or 593''.

(12) Section 1038 is amended by striking subsection (f).

(13) Clause (ii) of section 1042(c)(4)(B) is amended by striking ''or 593''.

(14) Subsection (c) of section 1277 is amended by striking ''or to which section 593 applies''.

(15) Subparagraph (B) of section 1361(b)(2) is amended by striking ''or to which section 593 applies''.

(16) The table of sections for part II of subchapter H of chapter 1 is amended by striking the items relating to sections 595 and 596.

(c) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall apply to taxable years beginning after December 31, 1995.

(2) SUBSECTION (b)(7).—The amendments made by subsection (b)(7) shall not apply to any distribution with respect to preferred stock if—

(A) such stock is outstanding at all times after October 31, 1995, and before the distribution, and

(B) such distribution is made before the date which is 1 year after the date of the enactment of this Act (or, in the case of stock which may be redeemed, if later, the date which is 30 days after the earliest date that such stock may be redeemed).

(3) SUBSECTION (b)(8).—The amendment made by subsection (b)(8) shall apply to property

acquired in taxable years beginning after December 31, 1995.

(4) SUBSECTION (b)(10).—The amendments made by subsection (b)(10) shall not apply to any residual interest held by a taxpayer if such interest has been held by such taxpayer at all times after October 31, 1995.

Subtitle B—Reform of the Earned Income Credit

SEC. 411. EARNED INCOME CREDIT DENIED TO INDIVIDUALS NOT AUTHORIZED TO BE EMPLOYED IN THE UNITED STATES.

(a) IN GENERAL.—Section 32(c)(1) (relating to individuals eligible to claim the earned income credit) is amended by adding at the end the following new subparagraph:

"(F) IDENTIFICATION NUMBER REQUIREMENT.—The term 'eligible individual' does not include any individual who does not include on the return of tax for the taxable year—

"(i) such individual's taxpayer identification number, and

"(ii) if the individual is married (within the meaning of section 7703), the tax-

payer identification number of such individual's spouse.''.

(b) SPECIAL IDENTIFICATION NUMBER.—Section 32 is amended by adding at the end the following new subsection:

''(l) IDENTIFICATION NUMBERS.—Solely for purposes of subsections (c)(1)(F) and (c)(3)(D), a taxpayer identification number means a social security number issued to an individual by the Social Security Administration (other than a social security number issued pursuant to clause (II) (or that portion of clause (III) that relates to clause (II)) of section 205(c)(2)(B)(i) of the Social Security Act).''.

(c) EXTENSION OF PROCEDURES APPLICABLE TO MATHEMATICAL OR CLERICAL ERRORS.—Section 6213(g)(2) (relating to the definition of mathematical or clerical errors) is amended by striking ''and'' at the end of subparagraph (D), by striking the period at the end of subparagraph (E) and inserting a comma, and by inserting after subparagraph (E) the following new subparagraphs:

''(F) an omission of a correct taxpayer identification number required under section 32 (relating to the earned income credit) to be included on a return, and

''(G) an entry on a return claiming the credit under section 32 with respect to net earnings from self-employment described in section 32(c)(2)(A) to the extent the tax imposed by section 1401 (relating to self-employment tax) on such net earnings has not been paid.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

Subtitle C—Treatment of Individuals Who Lose United States Citizenship

SEC. 421. REVISION OF INCOME, ESTATE, AND GIFT TAXES ON INDIVIDUALS WHO LOSE UNITED STATES CITIZENSHIP.

(a) IN GENERAL.—Subsection (a) of section 877 is amended to read as follows:

''(a) TREATMENT OF EXPATRIATES.—

''(1) IN GENERAL.—Every nonresident alien individual who, within the 10-year period immediately preceding the close of the taxable year, lost United States citizenship, unless such loss did not have for 1 of its principal purposes the avoidance of taxes under this subtitle or subtitle B, shall be taxable for such taxable year in the manner provided in sub-

section (b) if the tax imposed pursuant to such subsection exceeds the tax which, without regard to this section, is imposed pursuant to section 871.

''(2) CERTAIN INDIVIDUALS TREATED AS HAVING TAX AVOIDANCE PURPOSE.—For purposes of paragraph (1), an individual shall be treated as having a principal purpose to avoid such taxes if—

''(A) the average annual net income tax (as defined in section 38(c)(1)) of such individual for the period of 5 taxable years ending before the date of the loss of United States citizenship is greater than $100,000, or

''(B) the net worth of the individual as of such date is $500,000 or more.

In the case of the loss of United States citizenship in any calendar year after 1996, such $100,000 and $500,000 amounts shall be increased by an amount equal to such dollar amount multiplied by the cost-of-living adjustment determined under section 1(f)(3) for such calendar year by substituting '1994' for '1992' in subparagraph (B) thereof. Any increase under the preceding sentence shall be rounded to the nearest multiple of $1,000.''.

(b) EXCEPTIONS.—

(1) IN GENERAL.—Section 877 is amended by striking subsection (d), by redesignating subsection (c) as subsection (d), and by inserting after subsection (b) the following new subsection:

"(c) TAX AVOIDANCE NOT PRESUMED IN CERTAIN CASES.—

"(1) IN GENERAL.—Subsection (a)(2) shall not apply to an individual if—

"(A) such individual is described in a subparagraph of paragraph (2) of this subsection, and

"(B) within the 1-year period beginning on the date of the loss of United States citizenship, such individual submits a ruling request for the Secretary's determination as to whether such loss has for 1 of its principal purposes the avoidance of taxes under this subtitle or subtitle B.

"(2) INDIVIDUALS DESCRIBED.—

"(A) DUAL CITIZENSHIP, ETC.—An individual is described in this subparagraph if—

"(i) the individual became at birth a citizen of the United States and a citizen of another country and continues to be a citizen of such other country, or

"(ii) the individual becomes (not later than the close of a reasonable period after loss of United States citizenship) a citizen of the country in which—

"(I) such individual was born,

"(II) if such individual is married, such individual's spouse was born, or

"(III) either of such individual's parents were born.

"(B) LONG-TERM FOREIGN RESIDENTS.—An individual is described in this subparagraph if, for each year in the 10-year period ending on the date of loss of United States citizenship, the individual was present in the United States for 30 days or less. The rule of section 7701(b)(3)(D)(ii) shall apply for purposes of this subparagraph.

"(C) RENUNCIATION UPON REACHING AGE OF MAJORITY.—An individual is described in this subparagraph if the individual's loss of United States citizenship occurs before such individual attains age 18½.

"(D) INDIVIDUALS SPECIFIED IN REGULATIONS.—An individual is described in this sub-

paragraph if the individual is described in a category of individuals prescribed by regulation by the Secretary.''

(2) TECHNICAL AMENDMENT.—Paragraph (1) of section 877(b) of such Code is amended by striking ''subsection (c)'' and inserting ''subsection (d)''.

(c) TREATMENT OF PROPERTY DISPOSED OF IN NONRECOGNITION TRANSACTIONS; TREATMENT OF DISTRIBUTIONS FROM CERTAIN CONTROLLED FOREIGN CORPORATIONS.—Subsection (d) of section 877, as redesignated by subsection (b), is amended to read as follows:

''(d) SPECIAL RULES FOR SOURCE, ETC.—For purposes of subsection (b)—

''(1) SOURCE RULES.—The following items of gross income shall be treated as income from sources within the United States:

''(A) SALE OF PROPERTY.—Gains on the sale or exchange of property (other than stock or debt obligations) located in the United States.

''(B) STOCK OR DEBT OBLIGATIONS.—Gains on the sale or exchange of stock issued by a domestic corporation or debt obligations of United States persons or of the United States,

a State or political subdivision thereof, or the District of Columbia.

''(C) INCOME OR GAIN DERIVED FROM CONTROLLED FOREIGN CORPORATION.—Any income or gain derived from stock in a foreign corporation but only—

''(i) if the individual losing United States citizenship owned (within the meaning of section 958(a)), or is considered as owning (by applying the ownership rules of section 958(b)), at any time during the 2-year period ending on the date of the loss of United States citizenship, more than 50 percent of—

''(I) the total combined voting power of all classes of stock entitled to vote of such corporation, or

''(II) the total value of the stock of such corporation, and

''(ii) to the extent such income or gain does not exceed the earnings and profits attributable to such stock which were earned or accumulated before the loss of citizenship and during periods that the

ownership requirements of clause (i) are met.

"(2) GAIN RECOGNITION ON CERTAIN EXCHANGES.—

"(A) IN GENERAL.—In the case of any exchange of property to which this paragraph applies, notwithstanding any other provision of this title, such property shall be treated as sold for its fair market value on the date of such exchange, and any gain shall be recognized for the taxable year which includes such date.

"(B) EXCHANGES TO WHICH PARAGRAPH APPLIES.—This paragraph shall apply to any exchange during the 10-year period described in subsection (a) if—

"(i) gain would not (but for this paragraph) be recognized on such exchange in whole or in part for purposes of this subtitle,

"(ii) income derived from such property was from sources within the United States (or, if no income was so derived, would have been from such sources), and

"(iii) income derived from the property acquired in the exchange would be from sources outside the United States.

"(C) EXCEPTION.—Subparagraph (A) shall not apply if the individual enters into an agreement with the Secretary which specifies that any income or gain derived from the property acquired in the exchange (or any other property which has a basis determined in whole or part by reference to such property) during such 10-year period shall be treated as from sources within the United States. If the property transferred in the exchange is disposed of by the person acquiring such property, such agreement shall terminate and any gain which was not recognized by reason of such agreement shall be recognized as of the date of such disposition.

"(D) SECRETARY MAY EXTEND PERIOD.—To the extent provided in regulations prescribed by the Secretary, subparagraph (B) shall be applied by substituting the 15-year period beginning 5 years before the loss of United States citizenship for the 10-year period referred to therein.

''(E) SECRETARY MAY REQUIRE RECOGNITION OF GAIN IN CERTAIN CASES.—To the extent provided in regulations prescribed by the Secretary—

''(i) the removal of appreciated tangible personal property from the United States, and

''(ii) any other occurrence which (without recognition of gain) results in a change in the source of the income or gain from property from sources within the United States to sources outside the United States,

shall be treated as an exchange to which this paragraph applies.

''(3) SUBSTANTIAL DIMINISHING OF RISKS OF OWNERSHIP.—For purposes of determining whether this section applies to any gain on the sale or exchange of any property, the running of the 10-year period described in subsection (a) shall be suspended for any period during which the individual's risk of loss with respect to the property is substantially diminished by—

''(A) the holding of a put with respect to such property (or similar property),

''(B) the holding by another person of a right to acquire the property, or

''(C) a short sale or any other transaction.''.

(d) CREDIT FOR FOREIGN TAXES IMPOSED ON UNITED STATES SOURCE INCOME.—

(1) Subsection (b) of section 877 is amended by adding at the end the following new sentence: ''The tax imposed solely by reason of this section shall be reduced (but not below zero) by the amount of any income, war profits, and excess profits taxes (within the meaning of section 903) paid to any foreign country or possession of the United States on any income of the taxpayer on which tax is imposed solely by reason of this section.''

(2) Subsection (a) of section 877, as amended by subsection (a), is amended by inserting ''(after any reduction in such tax under the last sentence of such subsection)'' after ''such subsection''.

(e) COMPARABLE ESTATE AND GIFT TAX TREATMENT.—

(1) ESTATE TAX.—

(A) IN GENERAL.—Subsection (a) of section 2107 is amended to read as follows:

''(a) TREATMENT OF EXPATRIATES.—

''(1) RATE OF TAX.—A tax computed in accordance with the table contained in section 2001 is hereby imposed on the transfer of the taxable estate, determined as provided in section 2106, of every decedent nonresident not a citizen of the United States if, within the 10-year period ending with the date of death, such decedent lost United States citizenship, unless such loss did not have for 1 of its principal purposes the avoidance of taxes under this subtitle or subtitle A.

''(2) CERTAIN INDIVIDUALS TREATED AS HAVING TAX AVOIDANCE PURPOSE.—

''(A) IN GENERAL.—For purposes of paragraph (1), an individual shall be treated as having a principal purpose to avoid such taxes if such individual is so treated under section 877(a)(2).

''(B) EXCEPTION.—Subparagraph (A) shall not apply to a decedent meeting the requirements of section 877(c)(1).''.

(B) CREDIT FOR FOREIGN DEATH TAXES.—Subsection (c) of section 2107 is amended by redesignating paragraph (2) as paragraph (3) and by inserting after paragraph (1) the following new paragraph:

''(2) CREDIT FOR FOREIGN DEATH TAXES.—

''(A) IN GENERAL.—The tax imposed by subsection (a) shall be credited with the amount of any estate, inheritance, legacy, or succession taxes actually paid to any foreign country in respect of any property which is included in the gross estate solely by reason of subsection (b).

''(B) LIMITATION ON CREDIT.—The credit allowed by subparagraph (A) for such taxes paid to a foreign country shall not exceed the lesser of—

''(i) the amount which bears the same ratio to the amount of such taxes actually paid to such foreign country in respect of property included in the gross estate as the value of the property included in the gross estate solely by reason of subsection (b) bears to the value of all property subjected to such taxes by such foreign country, or

''(ii) such property's proportionate share of the excess of—

''(I) the tax imposed by subsection (a), over

''(II) the tax which would be imposed by section 2101 but for this section.

''(C) PROPORTIONATE SHARE.—For purposes of subparagraph (B), a property's proportionate share is the percentage of the value of the property which is included in the gross estate solely by reason of subsection (b) bears to the total value of the gross estate.''.

(C) EXPANSION OF INCLUSION IN GROSS ESTATE OF STOCK OF FOREIGN CORPORATIONS.—Paragraph (2) of section 2107(b) is amended by striking ''more than 50 percent of'' and all that follows and inserting ''more than 50 percent of—

''(A) the total combined voting power of all classes of stock entitled to vote of such corporation, or

''(B) the total value of the stock of such corporation,''.

(2) GIFT TAX.—

(A) IN GENERAL.—Paragraph (3) of section 2501(a) is amended to read as follows:

''(3) EXCEPTION.—

''(A) CERTAIN INDIVIDUALS.—Paragraph (2) shall not apply in the case of a donor who, within the 10-year period ending with the date of transfer, lost United States citizenship, unless such loss did not have for 1 of its principal purposes the avoidance of taxes under this subtitle or subtitle A.

''(B) CERTAIN INDIVIDUALS TREATED AS HAVING TAX AVOIDANCE PURPOSE.—For purposes of subparagraph (A), an individual shall be treated as having a principal purpose to avoid such taxes if such individual is so treated under section 877(a)(2).

''(C) EXCEPTION FOR CERTAIN INDIVIDUALS.—Subparagraph (B) shall not apply to a decedent meeting the requirements of section 877(c)(1).

''(D) CREDIT FOR FOREIGN GIFT TAXES.—The tax imposed by this section solely by reason of this paragraph shall be credited with the amount of any gift tax actually paid to any foreign country in respect of any gift which is taxable under this section solely by reason of this paragraph.''.

(f) COMPARABLE TREATMENT OF LAWFUL PERMANENT RESIDENTS WHO CEASE TO BE TAXED AS RESIDENTS.—

(1) IN GENERAL.—Section 877 is amended by redesignating subsection (e) as subsection (f) and by inserting after subsection (d) the following new subsection:

''(e) COMPARABLE TREATMENT OF LAWFUL PERMANENT RESIDENTS WHO CEASE TO BE TAXED AS RESIDENTS.—

''(1) IN GENERAL.—Any long-term resident of the United States who—

''(A) ceases to be a lawful permanent resident of the United States (within the meaning of section 7701(b)(6)), or

''(B) commences to be treated as a resident of a foreign country under the provisions of a tax treaty between the United States and the foreign country and who does not waive the benefits of such treaty applicable to residents of the foreign country,

shall be treated for purposes of this section and sections 2107, 2501, and 6039F in the same manner as if such resident were a citizen of the United

States who lost United States citizenship on the date of such cessation or commencement.

''(2) LONG-TERM RESIDENT.—For purposes of this subsection, the term 'long-term resident' means any individual (other than a citizen of the United States) who is a lawful permanent resident of the United States in at least 8 taxable years during the period of 15 taxable years ending with the taxable year during which the event described in subparagraph (A) or (B) of paragraph (1) occurs. For purposes of the preceding sentence, an individual shall not be treated as a lawful permanent resident for any taxable year if such individual is treated as a resident of a foreign country for the taxable year under the provisions of a tax treaty between the United States and the foreign country and does not waive the benefits of such treaty applicable to residents of the foreign country.

''(3) SPECIAL RULES.—

''(A) EXCEPTIONS NOT TO APPLY.—Subsection (c) shall not apply to an individual who is treated as provided in paragraph (1).

''(B) STEP-UP IN BASIS.—Solely for purposes of determining any tax imposed by reason of this subsection, property which was held by

the long-term resident on the date the individual first became a resident of the United States shall be treated as having a basis on such date of not less than the fair market value of such property on such date. The preceding sentence shall not apply if the individual elects not to have such sentence apply. Such an election, once made, shall be irrevocable.

''(4) AUTHORITY TO EXEMPT INDIVIDUALS.—This subsection shall not apply to an individual who is described in a category of individuals prescribed by regulation by the Secretary.

''(5) REGULATIONS.—The Secretary shall prescribe such regulations as may be appropriate to carry out this subsection, including regulations providing for the application of this subsection in cases where an alien individual becomes a resident of the United States during the 10-year period after being treated as provided in paragraph (1).''.

(2) CONFORMING AMENDMENTS.—

(A) Section 2107 is amended by striking subsection (d), by redesignating subsection (e) as subsection (d), and by inserting after subsection (d) (as so redesignated) the following new subsection:

''(e) CROSS REFERENCE.—

"For comparable treatment of long-term lawful permanent residents who ceased to be taxed as residents, see section 877(e).".

(B) Paragraph (3) of section 2501(a) (as amended by subsection (e)) is amended by adding at the end the following new subparagraph:

''(E) CROSS REFERENCE.—

"For comparable treatment of long-term lawful permanent residents who ceased to be taxed as residents, see section 877(e).".

(g) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to—

(A) individuals losing United States citizenship (within the meaning of section 877 of the Internal Revenue Code of 1986) on or after February 6, 1995, and

(B) long-term residents of the United States with respect to whom an event described in subparagraph (A) or (B) of section 877(e)(1) of such Code occurs on or after February 6, 1995.

(2) SPECIAL RULE.—

(A) IN GENERAL.—In the case of an individual who performed an act of expatriation specified in paragraph (1), (2), (3), or (4) of section 349(a) of the Immigration and Nation-

ality Act (8 U.S.C. 1481(a)(1)–(4)) before February 6, 1995, but who did not, on or before such date, furnish to the United States Department of State a signed statement of voluntary relinquishment of United States nationality confirming the performance of such act, the amendments made by this section and section 11349 shall apply to such individual except that—

(i) the 10-year period described in section 877(a) of such Code shall not expire before the end of the 10-year period beginning on the date such statement is so furnished, and

(ii) the 1-year period referred to in section 877(c) of such Code, as amended by this section, shall not expire before the date which is 1 year after the date of the enactment of this Act.

(B) EXCEPTION.—Subparagraph (A) shall not apply if the individual establishes to the satisfaction of the Secretary of the Treasury that such loss of United States citizenship occurred before February 6, 1994.

SEC. 422. INFORMATION ON INDIVIDUALS LOSING UNITED STATES CITIZENSHIP.

(a) IN GENERAL.—Subpart A of part III of subchapter A of chapter 61 is amended by inserting after section 6039E the following new section:

"SEC. 6039F. INFORMATION ON INDIVIDUALS LOSING UNITED STATES CITIZENSHIP.

''(a) IN GENERAL.—Notwithstanding any other provision of law, any individual who loses United States citizenship (within the meaning of section 877(a)) shall provide a statement which includes the information described in subsection (b). Such statement shall be—

''(1) provided not later than the earliest date of any act referred to in subsection (c), and

''(2) provided to the person or court referred to in subsection (c) with respect to such act.

''(b) INFORMATION TO BE PROVIDED.—Information required under subsection (a) shall include—

''(1) the taxpayer's TIN,

''(2) the mailing address of such individual's principal foreign residence,

''(3) the foreign country in which such individual is residing,

''(4) the foreign country of which such individual is a citizen,

''(5) in the case of an individual having a net worth of at least the dollar amount applicable under section 877(a)(2)(B), information detailing the assets and liabilities of such individual, and

''(6) such other information as the Secretary may prescribe.

''(c) ACTS DESCRIBED.—For purposes of this section, the acts referred to in this subsection are—

''(1) the individual's renunciation of his United States nationality before a diplomatic or consular officer of the United States pursuant to paragraph (5) of section 349(a) of the Immigration and Nationality Act (8 U.S.C. 1481(a)(5)),

''(2) the individual's furnishing to the United States Department of State a signed statement of voluntary relinquishment of United States nationality confirming the performance of an act of expatriation specified in paragraph (1), (2), (3), or (4) of section 349(a) of the Immigration and Nationality Act (8 U.S.C. 1481(a)(1)–(4)),

''(3) the issuance by the United States Department of State of a certificate of loss of nationality to the individual, or

''(4) the cancellation by a court of the United States of a naturalized citizen's certificate of naturalization.

''(d) PENALTY.—Any individual failing to provide a statement required under subsection (a) shall be subject to a penalty for each year (of the 10-year period beginning on the date of loss of United States citizenship) during any portion of which such failure continues in an amount equal to the greater of—

''(1) 5 percent of the tax required to be paid under section 877 for the taxable year ending during such year, or

''(2) $1,000,

unless it is shown that such failure is due to reasonable cause and not to willful neglect.

''(e) INFORMATION TO BE PROVIDED TO SECRETARY.—Notwithstanding any other provision of law—

''(1) any Federal agency or court which collects (or is required to collect) the statement under subsection (a) shall provide to the Secretary—

''(A) a copy of any such statement, and

''(B) the name (and any other identifying information) of any individual refusing to comply with the provisions of subsection (a),

''(2) the Secretary of State shall provide to the Secretary a copy of each certificate as to the loss of American nationality under section 358 of the Immigration and Nationality Act which is approved by the Secretary of State, and

''(3) the Federal agency primarily responsible for administering the immigration laws shall provide to the Secretary the name of each lawful permanent resident of the United States (within the meaning of section 7701(b)(6)) whose status as such has been revoked or has been administratively or judicially determined to have been abandoned.

Notwithstanding any other provision of law, not later than 30 days after the close of each calendar quarter, the Secretary shall publish in the Federal Register the name of each individual losing United States citizenship (within the meaning of section 877(a)) with respect to whom the Secretary receives information under the preceding sentence during such quarter.

''(f) REPORTING BY LONG-TERM LAWFUL PERMANENT RESIDENTS WHO CEASE TO BE TAXED AS RESIDENTS.—In lieu of applying the last sentence of subsection (a), any individual who is required to provide a statement under this section by reason of section 877(e)(1) shall provide such statement with the return of

tax imposed by chapter 1 for the taxable year during which the event described in such section occurs.

''(g) EXEMPTION.—The Secretary may by regulations exempt any class of individuals from the requirements of this section if he determines that applying this section to such individuals is not necessary to carry out the purposes of this section.''.

(b) CLERICAL AMENDMENT.—The table of sections for such subpart A is amended by inserting after the item relating to section 6039E the following new item:

''Sec. 6039F. Information on individuals losing United States citizenship.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to—

(1) individuals losing United States citizenship (within the meaning of section 877 of the Internal Revenue Code of 1986) on or after February 6, 1995, and

(2) long-term residents of the United States with respect to whom an event described in subparagraph (A) or (B) of section 877(e)(1) of such Code occurs on or after such date.

In no event shall any statement required by such amendments be due before the 90th day after the date of the enactment of this Act.

SEC. 423. REPORT ON TAX COMPLIANCE BY UNITED STATES CITIZENS AND RESIDENTS LIVING ABROAD.

Not later than 90 days after the date of the enactment of this Act, the Secretary of the Treasury shall prepare and submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report—

(1) describing the compliance with subtitle A of the Internal Revenue Code of 1986 by citizens and lawful permanent residents of the United States (within the meaning of section 7701(b)(6) of such Code) residing outside the United States, and

(2) recommending measures to improve such compliance (including improved coordination between executive branch agencies).

Passed the House of Representatives March 28, 1996.

Attest:

Clerk.