I

104TH CONGRESS
2D SESSION

H. R. 3125

To provide for improvements in financial security for senior citizens.

IN THE HOUSE OF REPRESENTATIVES

MARCH 20, 1996

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

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A BILL

To provide for improvements in financial security for senior citizens.

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

SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.

This Act may be cited as the ''Senior Citizens Bill of Rights Act of 1996''.

TITLE I—LONG-TERM CARE

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

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

"SEC. 7702B. TREATMENT OF LONG-TERM CARE INSURANCE.

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

"(1) a 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 long-term care insurance contract shall be treated as amounts received for personal injuries and sickness and shall be treated as reimbursement for expenses actually incurred for medical care (as defined in section 213(d)),

''(3) any plan of an employer providing coverage under a 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 (d)(3), amounts paid for a 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 long-term care insurance contract shall be treated as a guaranteed renewable contract subject to the rules of section 816(e).

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

''(1) IN GENERAL.—The term '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), and

"(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.

"(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 long-term care insurance contract on the basis that the contract coordinates its benefits with those provided under such title.

"(C) REFUNDS OF PREMIUMS.—Paragraph (1)(E) shall not apply to any refund on the death of the insured, or on a complete surrender or cancellation of the contract, which cannot exceed the aggregate premiums paid under the contract. Any refund on a complete surrender or cancellation of the contract shall be includible in gross income to the extent that any deduction or exclusion was allowable with respect to the premiums.

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

''(1) IN GENERAL.—The term 'qualified long-term care services' means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, which—

''(A) are required by a chronically ill individual, and

''(B) are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

''(2) CHRONICALLY ILL INDIVIDUAL.—

''(A) IN GENERAL.—The term 'chronically ill individual' means any individual who has been certified by a licensed health care practitioner as—

''(i) being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living for a period of at least 90 days due to a loss of functional capacity or to cognitive impairment, or

''(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).

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) 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 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 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 long-term care insurance contract."

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

''(other than a long-term care insurance contract, as defined in section 7702B(b))'' after ''insurance contract''.

(c) LONG-TERM CARE INSURANCE NOT PERMITTED UNDER CAFETERIA PLANS OR FLEXIBLE SPENDING ARRANGEMENTS.—

(1) CAFETERIA PLANS.—Section 125(f) of such Code 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 7702B(b)).''

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

''(a) GENERAL RULE.—Except as provided in subsection (b), gross income of an employee does not include employer-provided coverage under an accident or health plan.

''(b) INCLUSION OF LONG-TERM CARE BENEFITS PROVIDED THROUGH FLEXIBLE SPENDING ARRANGEMENTS.—

''(1) IN GENERAL.—Effective on and after January 1, 1996, 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.''

(d) CONTINUATION COVERAGE EXCISE TAX NOT TO APPLY.—Subsection (f) of section 4980B of such Code 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 long-term care insurance contract (as defined in section 7702B(b)).''

(e) AMOUNTS PAID TO RELATIVES TREATED AS NOT PAID FOR MEDICAL CARE.—Section 213(d) of such Code is amended by adding at the end the following new paragraph:

''(10) 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 a relative (directly or through a partnership, corporation, or other entity) unless the relative is a licensed professional with respect to such services, 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.''

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

"Sec. 7702B. Treatment of long-term care insurance.".

(g) 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 issued at the time the contract was issued—

(A) such contract shall be treated for purposes of the Internal Revenue Code of 1986 as a 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, 1997, a contract providing for long-term care insurance coverage is exchanged solely for a long-term care insurance contract (as defined in sec-

tion 7702B(b) of such Code), no gain or loss shall be recognized on the exchange. If, in addition to a 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 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 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. 102. QUALIFIED LONG-TERM CARE SERVICES TREATED AS MEDICAL CARE.

(a) GENERAL RULE.—Paragraph (1) of section 213(d) of the Internal Revenue Code of 1986 (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) of such Code (as redesignated by subsection (a)) is amended by striking ''subparagraphs (A) and (B)'' and inserting ''subparagraphs (A), (B), and (C)''.

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

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

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

''(11) 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 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 1996, 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 1995.

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.''

(3) Paragraph (6) of section 213(d) of such Code 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) of such Code is amended by striking ''subparagraphs (A) and (B)'' and inserting ''subparagraphs (A), (B), and (C)''.

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

SEC. 103. CERTAIN EXCHANGES OF LIFE INSURANCE CONTRACTS FOR LONG-TERM CARE INSURANCE CONTRACTS NOT TAXABLE.

(a) IN GENERAL.—Subsection (a) of section 1035 of the Internal Revenue Code of 1986 (relating to certain exchanges of insurance contracts) is amended by striking the period at the end of paragraph (3) and inserting ''; or'', and by adding at the end the following new paragraph:

''(4) a contract of life insurance or an endowment or annuity contract for a long-term care insurance contract (as defined in section 7702B(b)).''

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

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

(a) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to items specifically excluded from gross income) is amended by redesignating section 137 as section 138 and by inserting after section 136 the following new section:

"SEC. 137. DISTRIBUTIONS FROM CERTAIN RETIREMENT PLANS FOR LONG-TERM CARE INSURANCE.

''(a) GENERAL RULE.—The amount which would (but for this section) be includible in the gross income of an individual for the taxable year by reason of eligible distributions during the taxable year shall be reduced (but not below zero) by the aggregate premiums paid by such individual during such taxable year for any long-term care insurance contract (as defined in section 7702B(b)) for coverage of such individual or the spouse of such individual.

''(b) ELIGIBLE DISTRIBUTION.—For purposes of this section, the term 'eligible distribution' means any distribution or payment to an individual from—

''(1) an individual retirement plan of such individual,

''(2) amounts attributable to employer contributions made pursuant to elective deferrals described

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

''(3) amounts deferred under section 457(a).''

(b) CONFORMING AMENDMENTS.—

(1) Section 401(k)(2)(B)(i) of such Code is amended by striking ''or'' at the end of subclause (III), by striking ''and'' at the end of subclause (IV) and inserting ''or'', and by inserting after subclause (IV) the following new subclause:

''(V) the date distributions for premiums for a long-term care insurance contract (as defined in section 7702B(b)) for coverage of such individual or the spouse of such individual are made, and''.

(2) Section 403(b)(11) of such Code is amended by striking ''or'' at the end of subparagraph (A), by striking the period at the end of subparagraph (B) and inserting '', or'', and by inserting after subparagraph (B) the following new subparagraph:

''(C) for the payment of premiums for a long-term care insurance contract (as defined in section 7702B(b)) for coverage of the employee or the spouse of the employee.''

(3) Subparagraph (A) of section 457(d)(1) of such Code is amended by striking ''or'' at the end of clause (ii), by striking ''and'' at the end of clause (iii) and inserting ''or'', and by inserting after clause (iii) the following new clause:

''(iv) the date distributions for premiums for a long-term care insurance contract (as defined in section 7702B(b)) for coverage of such individual or the spouse of such individual are made, and''.

(4) The table of sections for part III of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following new items:

''Sec. 137. Distributions from certain retirement plans for long-term care insurance.
''Sec. 138. Cross references to other Acts.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payments and distributions after December 31, 1996.

SEC. 105. CREDIT FOR TAXPAYERS WITH CERTAIN PERSONS REQUIRING CUSTODIAL CARE IN THEIR HOUSEHOLDS.

(a) IN GENERAL.—Subpart A of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 25A the following new section:

"SEC. 25B. CREDIT FOR TAXPAYERS WITH CERTAIN PERSONS REQUIRING CUSTODIAL CARE IN THEIR HOUSEHOLDS.

''(a) ALLOWANCE OF CREDIT.—In the case of an individual who maintains a household which includes as a member one or more qualified persons, there shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to $1,000 for each such person.

''(b) QUALIFIED PERSON.—For purposes of this section, the term 'qualified person' means any individual—

''(1) who is a father or mother of the taxpayer, his spouse, or his former spouse or who is an ancestor of such a father or mother,

''(2) who is physically or mentally incapable of caring for himself,

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

''(4) whose name and TIN are included on the taxpayer's return for the taxable year.

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

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

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

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

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

TITLE II—SOCIAL SECURITY BENEFITS

SEC. 201. INCREASES IN MONTHLY EXEMPT AMOUNT FOR PURPOSES OF THE SOCIAL SECURITY EARNINGS LIMIT.

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

"(D) Notwithstanding any other provision of this subsection, the exempt amount which is applicable to an individual who has attained retirement age (as defined in section 216(l)) before the close of the taxable year involved shall be—

"(i) for each month of any taxable year ending after 1996 and before 1998, $1,466.66⅔,

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

"(iii) for each month of any taxable year ending after 1998 and before 2000, $2,333.33⅓,

"(iv) for each month of any taxable year ending after 1999 and before 2001, $2,791.66⅔,

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

"(vi) for each month of any taxable year ending after 2001 and before 2003, $3,708.33⅓, and

"(vii) for each month of any taxable year ending after 2002 and before 2004, $4,166.66⅔.".

(b) CONFORMING AMENDMENTS.—

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

(A) by striking "the taxable year ending after 1993 and before 1995" and inserting "the taxable year ending after 2002 and before 2004 (with respect to individuals described in subparagraph (D)) or the taxable year ending after

1993 and before 1995 (with respect to other individuals)''; and

(B) in subclause (II), by striking ''for 1992'' and inserting ''for 2001 (with respect to individuals described in subparagraph (D)) or 1992 (with respect to other individuals)''.

(2) The second sentence of section 223(d)(4)(A) of such Act (42 U.S.C. 423(d)(4)(A)) is amended by striking ''the exempt amount under section 203(f)(8) which is applicable to individuals described in subparagraph (D) thereof'' and inserting the following: ''an amount equal to the exempt amount which would be applicable under section 203(f)(8), to individuals described in subparagraph (D) thereof, if section 201 of the Senior Citizens Bill of Rights Act of 1996 had not been enacted''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to taxable years ending after 1996.

SEC. 202. REVOCATION BY MEMBERS OF THE CLERGY OF EXEMPTION FROM SOCIAL SECURITY COVERAGE.

(a) IN GENERAL.—Notwithstanding section 1402(e)(4) of the Internal Revenue Code of 1986, any exemption which has been received under section 1402(e)(1)

of such Code by a duly ordained, commissioned, or licensed minister of a church, a member of a religious order, or a Christian Science practitioner, and which is effective for the taxable year in which this Act is enacted, may be revoked by filing an application therefor (in such form and manner, and with such official, as may be prescribed in regulations made under chapter 2 of such Code), if such application is filed no later than the due date of the Federal income tax return (including any extension thereof) for the applicant's second taxable year beginning after December 31, 1996. Any such revocation shall be effective (for purposes of chapter 2 of the Internal Revenue Code of 1986 and title II of the Social Security Act), as specified in the application, either with respect to the applicant's first taxable year beginning after December 31, 1996, or with respect to the applicant's second taxable year beginning after such date, and for all succeeding taxable years; and the applicant for any such revocation may not thereafter again file application for an exemption under such section 1402(e)(1). If the application is filed after the due date of the applicant's Federal income tax return for a taxable year and is effective with respect to that taxable year, it shall include or be accompanied by payment in full of an amount equal to the total of the taxes that would have been imposed by section 1401 of

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

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

TITLE III—INDEPENDENT COMMISSION ON MEDICARE

SEC. 301. ESTABLISHMENT OF COMMISSION.

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

(b) MEMBERSHIP.—

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

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

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

(c) TERMS.—

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

(2) TERMS OF INITIAL APPOINTMENT.—As designated by the President at the time of appointment, of the members first appointed—

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

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

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

filled in the manner in which the original appointment was made.

(4) EXCLUSIVE EMPLOYMENT.—During the term of appointment, members shall serve as employees of the Federal Government and shall hold no other employment.

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

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

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

(e) STAFF.—

(1) IN GENERAL.—The Commission shall appoint a Director, who shall be paid at a rate the

Commission considers appropriate. The Director may appoint and fix the pay of such additional personnel as the Director (with the approval of the Chair of the Commission) considers appropriate, without regard to provisions of title 5, United States Code, governing appointments in the competitive service.

(2) EXPERTS AND CONSULTANTS.—The Commission may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

(3) STAFF OF FEDERAL AGENCIES.—Upon request of the Director, the head of any Federal department or agency may detail, on a reimbursable basis, any of the personnel of that department or agency to the Commission to assist it in carrying out its duties under this title.

(f) POWERS.—

(1) HEARINGS AND SESSIONS.—The Commission may, for the purpose of carrying out its duties under this title, hold hearings, sit and act at times and places, take testimony, and receive evidence as the Commission considers appropriate. The Commission may administer oaths or affirmations to witnesses appearing before it.

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

(3) OBTAINING OFFICIAL DATA.—The Commission may secure directly from any department or agency of the United States information necessary to enable it to carry out this title. Upon request of the Chair of the Commission, the head of that department or agency shall furnish that information to the Commission.

(4) GIFTS, BEQUESTS, AND DEVISES.—The Commission may accept, use, and dispose of gifts, bequests, or devises of services or property, both real and personal, for the purpose of aiding or facilitating the work of the Commission. Gifts, bequests, or devises of money and proceeds from sales of other property received as gifts, bequests, or devises shall be deposited in the Treasury and shall be available for disbursement upon order of the Chair of the Commission.

(5) MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as other departments and agencies of the United States.

(6) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Commission, the Administrator of General Services shall provide to the Commission, on a reimbursable basis, the administrative support services necessary for the Commission to carry out its duties under this title.

SEC. 302. DUTIES OF THE COMMISSION.

(a) IN GENERAL.—The Commission shall—

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

(2) transmit to Congress during July of each year (beginning with 1997) a report containing specific recommendations on the matters specified in subsection (c).

(b) ASPECTS OF MEDICARE.—

(1) IN GENERAL.—The report transmitted pursuant to subsection (a)(1) during December of a year shall include information on the following:

(A) The total outlays made under the medicare program for each of the 10 most recently completed fiscal years.

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

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

(C) Projections of the actuarial value of the package of benefits provided to medicare beneficiaries for each of the fiscal years specified in subparagraph (B), on an aggregate and a per capita basis.

(D) A comparison of each of the projections made under subparagraph (B) for a fiscal year with the projections made for the year under subparagraph (C).

(E) The health status of medicare beneficiaries, the access of beneficiaries to health services covered under the medicare program, and the utilization of such services by beneficiaries.

(F) Methods to improve the methodologies used to determine the payments made under the medicare program to or on behalf of medicare beneficiaries (including the use of risk adjustment in the determination of the amount of such payments) and methods to encourage efficiency and cost-effectiveness in the delivery of health care services.

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

(2) ACTUARIAL VALUE DEFINED.—For purposes of projecting the actuarial value of the package of benefits provided to medicare beneficiaries under paragraph (1)(C), the Commission shall determine actuarial value by measuring the costs of resources used to provide health care services covered under the medicare program and adjusting such costs to take into account—

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

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

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

(D) scientific and technological advances;

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

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

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

(c) RECOMMENDATIONS ON CONTROLLING OUTLAYS.—The report transmitted to Congress pursuant to subsection (a)(2) during July of a year shall include specific recommendations on changes in the medicare program, including changes in eligibility, benefits (including the mode of delivery of such benefits), cost-sharing, or payments made to or on behalf of beneficiaries, sufficient to ensure that total outlays for the program for the fiscal year beginning on the following October 1 do not exceed the limit established for that fiscal year under section 305, except that such recommendations may not include changes relating to the payment of payroll taxes for financing the program.

SEC. 303. EXPEDITED CONGRESSIONAL CONSIDERATION OF RECOMMENDATIONS.

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

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

olution which is introduced within the 10-day period beginning on the date on which the Commission submits recommendations under section 302(c) and—

(1) which does not have a preamble;

(2) the matter after the resolving clause of which is as follows: ''That Congress approves the recommendations of the Independent Commission on Medicare concerning methods to control outlays under the medicare program for fiscal year _____, as submitted by the Commission on _____.'', the first blank space being filled in with the appropriate fiscal year and the second blank space being filled in with the appropriate date; and

(3) the title of which is as follows: ''Joint resolution approving recommendations of the Independent Commission on Medicare concerning methods to control outlays under the medicare program for fiscal year _____, as submitted by the Commission on _____.'', the first blank space being filled in with the appropriate fiscal year and the second blank space being filled in with the appropriate date.

(c) PROCEDURES FOR CONSIDERATION OF RESOLUTION OF APPROVAL.—Subject to subsection (d), the provi-

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

(d) SPECIAL RULES.—For purposes of applying subsection (c) with respect to such provisions—

(1) any reference to the Committee on Armed Services of the House of Representatives shall be deemed a reference to an appropriate committee of the House of Representatives (specified by the Speaker of the House of Representatives at the time of submission of recommendations under subsection (c)) and any reference to the Committee on Armed Services of the Senate shall be deemed a reference to an appropriate committee of the Senate (specified by the majority leader of the Senate at the time of submission of recommendations by the Commission under section 302(c)); and

(2) any reference to the date on which the President transmits a report shall be deemed a reference to the date on which the Commission submits recommendations under section 302(c).

SEC. 304. NO TERMINATION OF COMMISSION.

Section 14(a)(2)(B) of the Federal Advisory Committee Act (5 U.S.C. App.; relating to the termination of advisory committees) shall not apply to the Commission.

SEC. 305. ESTABLISHMENT OF ANNUAL LIMITS ON OUTLAYS.

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

SEC. 306. ENFORCEMENT OF LIMITS THROUGH SEQUESTRATION.

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

"SEC. 252A. SEQUESTRATION WITH RESPECT TO MEDICARE.

"(a) SEQUESTRATION.—If, with respect to a fiscal year (beginning with fiscal year 1998), Congress has not enacted a joint resolution under section 303(b) of the Senior Citizens Bill of Rights Act of 1996 before the first day of the fiscal year, there shall be a sequestration to eliminate any budgetary excess in the medicare program as described in subsection (b).

"(b) ELIMINATING A BUDGETARY EXCESS.—

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

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

''(A) reduce payments made under the medicare program by a uniform percentage sufficient to reduce 50 percent of the amount described in paragraph (1); and

''(B) increase premiums, deductibles, copayments, and coinsurance required to be paid under the program by a uniform percentage sufficient to reduce 50 percent of the amount described in paragraph (1).

''(c) PART-YEAR APPROPRIATIONS AND OMB ESTIMATES.—Paragraphs (4) and (7) of section 251(a) shall apply to sequestration of amounts under this section in the same manner as those paragraphs apply to discretionary appropriations and sequestrations under that section.

''(d) COORDINATION WITH OTHER SEQUESTRATION.—

''(1) IN GENERAL.—Reductions under subsection (b) for a fiscal year shall supersede any reduction otherwise made under section 252 or 253.

''(2) REPORTS.—On the dates specified in section 254(a), OMB and CBO shall issue preview, update, and final reports on medicare sequestration under this section. Such reports shall specify—

''(A) the estimated amount described in subsection (b)(1) for the fiscal year;

''(B) the estimated uniform percentage described in subsection (b)(2)(A) of the fiscal year; and

''(C) the estimated uniform percentage described in subsection (b)(2)(B) of the fiscal year.

''(3) RULES FOR APPLICATION OF REDUCTIONS.—The provisions of section 256(d) shall apply to reductions under this section.''.

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

''Sec. 252A. Sequestration with respect to medicare.''.

TITLE IV—HEALTH CARE FRAUD PREVENTION

Subtitle A—All-Payer Fraud and Abuse Control Program

SEC. 401. ALL-PAYER FRAUD AND ABUSE CONTROL PROGRAM.

(a) ESTABLISHMENT OF PROGRAM.—

(1) IN GENERAL.—Not later than January 1, 1997, the Secretary of Health and Human Services (in this title referred to as 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 the delivery of and payment for health care in the United States,

(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 of the Social Security Act and other statutes applicable to health care fraud and abuse, and

(D) to provide for the modification and establishment of safe harbors and to issue interpretative rulings and special fraud alerts pursuant to section 403.

(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) REGULATIONS.—

(A) IN GENERAL.—The Secretary and the Attorney General shall by regulation establish standards to carry out the program under paragraph (1).

(B) INFORMATION STANDARDS.—

(i) IN GENERAL.—Such standards shall include standards 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 standards shall include procedures to assure that such information is provided and uti-

lized 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) of the Social Security Act (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.

(C) DISCLOSURE OF OWNERSHIP INFORMATION.—

(i) IN GENERAL.—Such standards shall include standards relating to the disclosure of ownership information described in clause (ii) by any entity providing health care services and items.

(ii) OWNERSHIP INFORMATION DESCRIBED.—The ownership information described in this clause includes—

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

(II) the names and unique physician identification numbers of all physicians with a financial relationship (as defined in section 1877(a)(2) of the Social Security Act) with such entity;

(III) the names of all other individuals with such an ownership or investment interest in such entity; and

(IV) any other ownership and related information required to be disclosed by such entity under section 1124 or section 1124A of the Social Security Act, except that the Secretary shall establish procedures under which the information required to be submitted under this subclause will be reduced with respect to health care provider entities that the Secretary determines will be unduly burdened if such entities are required to comply fully with this subclause.

(4) AUTHORIZATION OF APPROPRIATIONS FOR INVESTIGATORS AND OTHER PERSONNEL.—In addition to any other amounts authorized to be appro-

priated to the Secretary, the Attorney General, the Director of the Federal Bureau of Investigation, and the Inspectors General of the Departments of Defense, Labor, and Veterans Affairs and of the Office of Personnel Management, for health care anti-fraud and abuse activities for a fiscal year, there are authorized to be appropriated additional amounts, from the Health Care Fraud and Abuse Account described in subsection (b) of this section, as may be necessary to enable the Secretary, the Attorney General, and such Inspectors General to conduct investigations and audits of allegations of health care fraud and abuse and otherwise carry out the program established under paragraph (1) in a fiscal year.

(5) ENSURING ACCESS TO DOCUMENTATION.—The Inspector General of the Department of Health and Human Services is authorized to exercise the authority described in paragraphs (4) and (5) of section 6 of the Inspector General Act of 1978 (relating to subpoenas and administration of oaths) with respect to the activities under the all-payer fraud and abuse control program established under this subsection to the same extent as such Inspector General

may exercise such authorities to perform the functions assigned by such Act.

(6) 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.

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

(b) HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—There is hereby established an account to be known as the ''Health Care Fraud and Abuse Control Account'' (in this section referred to as the ''Anti-Fraud Account''). The Anti-Fraud Account shall consist of—

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

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

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

(iii) such amounts as are transferred to the Anti-Fraud Account under subparagraph (C).

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

(C) TRANSFER OF AMOUNTS.—The Secretary of the Treasury shall transfer to the Anti-Fraud Account an amount equal to the sum of the following:

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

(ii) Administrative penalties and assessments imposed under titles XI, XVIII, and XIX of the Social Security Act (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 imposed under the False Claims Act (31 U.S.C. 3729 et seq.), in cases involving claims related to the provision of health care items and services (other than funds awarded to a relator or for restitution).

(2) USE OF FUNDS.—

(A) IN GENERAL.—Amounts in the Anti-Fraud Account shall be available to carry out the health care fraud and abuse control program established under subsection (a) (including the administration of the program), and may be used to cover costs incurred in operating the program, including costs (including equipment, salaries and benefits, and travel and training) 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 this title.

(B) FUNDS USED TO SUPPLEMENT AGENCY APPROPRIATIONS.—It is intended that disbursements made from the Anti-Fraud Account to any Federal agency be used to increase and not supplant the recipient agency's appropriated operating budget.

(3) 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 by the Anti-Fraud Account in each fiscal year.

(4) USE OF FUNDS BY INSPECTOR GENERAL.—

(A) REIMBURSEMENTS FOR INVESTIGATIONS.—The Inspector General is authorized to receive and retain for current use reimbursement for the costs of conducting investigations, when such restitution is ordered by a court, voluntarily agreed to by the payer, or otherwise.

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

the Departments of Defense, Labor, and Veterans Affairs and of the Office of Personnel Management, 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 their deposit.

SEC. 402. APPLICATION OF CERTAIN FEDERAL HEALTH ANTI-FRAUD AND ABUSE SANCTIONS TO FRAUD AND ABUSE AGAINST ANY HEALTH PLAN.

(a) CRIMES.—

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

(A) In the heading, by adding at the end the following: ''OR HEALTH PLANS''.

(B) In subsection (a)(1)—

(i) by striking ''title XVIII or'' and inserting ''title XVIII,'', and

(ii) by adding at the end the following: ''or a health plan (as defined in section 1128(i)),''.

(C) In subsection (a)(5), by striking ''title XVIII or a State health care program'' and inserting ''title XVIII, a State health care program, or a health plan''.

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

(i) by inserting after ''title XIX'' the following: ''or a health plan'', and

(ii) by inserting after ''the State'' the following: ''or the plan''.

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

''(f) The Secretary may—

''(1) in consultation with State and local health care officials, identify opportunities for the satisfaction of community service obligations that a court may impose upon the conviction of an offense under this section, and

''(2) make information concerning such opportunities available to Federal and State law enforcement officers and State and local health care officials.''.

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

''(i) HEALTH PLAN DEFINED.—For purposes of sections 1128A and 1128B, the term 'health plan' means a plan that provides health benefits, whether through directly, through insurance, or otherwise, and includes a policy of health insurance, a contract of a service benefit organization, or a membership agreement with a health maintenance organization or other prepaid health plan, and also includes an employee welfare benefit plan or a multiple employer welfare plan (as such terms are defined in section 3 of the Employee Retirement Income Security Act of 1974).''.

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

SEC. 403. HEALTH CARE FRAUD AND ABUSE GUIDANCE.

(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) of the Social Security Act the (42 U.S.C. 1320a–7b(b)) and shall not serve as the basis for an exclusion under section 1128(b)(7) of such Act (42 U.S.C. 1320a–7(b)(7));

(iii) interpretive rulings 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 At-

torney 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 (hereafter 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 Government health care programs.

(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 Government health care programs.

(b) INTERPRETIVE RULINGS.—

(1) IN GENERAL.—

(A) REQUEST FOR INTERPRETIVE RULING.—Any person may present, at any time, a request to the Inspector General for a statement of the Inspector General's current interpretation of the meaning of a specific aspect of the application of sections 1128A and 1128B of the Social Security Act (hereafter in this section referred to as an ''interpretive ruling'').

(B) ISSUANCE AND EFFECT OF INTERPRETIVE RULING.—

(i) IN GENERAL.—If appropriate, the Inspector General shall in consultation with the Attorney General, issue an interpretive ruling in response to a request described in subparagraph (A). Interpretive

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

(ii) REASONS FOR DENIAL.—If the Inspector General does not issue an interpretive ruling in response to a request described in subparagraph (A), the Inspector General shall notify the requesting party of such decision and shall identify the reasons for such decision.

(2) CRITERIA FOR INTERPRETIVE RULINGS.—

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

(i) whether and to what extent the request identifies an ambiguity within the language of the statute, the existing safe harbors, or previous interpretive rulings; and

(ii) whether the subject of the requested interpretive ruling can be adequately addressed by interpretation of the language of the statute, the existing safe harbor rules, or previous interpretive rulings, or whether the request would require a substantive ruling not authorized under this subsection.

(B) NO RULINGS ON FACTUAL ISSUES.—The Inspector General shall not give an interpretive ruling on any factual issue, including the intent of the parties or the fair market value of particular leased space or equipment.

(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 section 1128B(b) of the Social Security Act (42 U.S.C. 1320a–7b(b)) (hereafter 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 in consultation with the Attorney General, 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.

SEC. 404. REPORTING OF FRAUDULENT ACTIONS UNDER MEDICARE.

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

Subtitle B—Revisions to Current Sanctions for Fraud and Abuse

SEC. 411. MANDATORY EXCLUSION FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS.

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

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

''(3) FELONY CONVICTION RELATING TO FRAUD.—Any individual or entity that has been convicted after the date of the enactment of the Senior Citizens Bill of Rights 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 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.—Section 1128(b)(1) of such Act (42 U.S.C. 1320a–7(b)(1)) 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''.

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

(1) IN GENERAL.—Section 1128(a) of the Social Security Act (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 enact-

ment of the Senior Citizens Bill of Rights 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) of such Act (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. 412. 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) of the Social Security Act (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. 413. PERMISSIVE EXCLUSION OF INDIVIDUALS WITH OWNERSHIP OR CONTROL INTEREST IN SANCTIONED ENTITIES.

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

''(15) INDIVIDUALS CONTROLLING A SANCTIONED ENTITY.—Any individual who has a direct or indirect ownership or control interest of 5 percent or more, or an ownership or control interest (as defined in section 1124(a)(3)) in, or who is an officer,

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

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

"(B) against which a civil monetary penalty has been assessed under section 1128A; or

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

SEC. 414. 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) of the Social Security Act (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) of such Act (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) of the Social Security Act (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. 415. INTERMEDIATE SANCTIONS FOR MEDICARE HEALTH MAINTENANCE ORGANIZATIONS.

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

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

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

''(B) is carrying out the contract in a manner 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) of such Act (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) of such Act (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 provides the organization with the opportunity to develop and implement a corrective action plan to correct the deficiencies that

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

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

''(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) of such Act (42 U.S.C. 1395mm(i)(6)(B)) is amended by striking the second sentence.

(b) AGREEMENTS WITH PEER REVIEW ORGANIZATIONS.—

(1) REQUIREMENT FOR WRITTEN AGREEMENT.—Section 1876(i)(7)(A) of the Social Security Act (42 U.S.C. 1395mm(i)(7)(A)) is amended by

striking ''an agreement'' and inserting ''a written agreement''.

(2) DEVELOPMENT OF MODEL AGREEMENT.—Not later than July 1, 1996, the Secretary shall develop a model of the agreement that an eligible organization with a risk-sharing contract under section 1876 of the Social Security Act must enter into with an entity providing peer review services with respect to services provided by the organization under section 1876(i)(7)(A) of such Act.

(3) REPORT BY GAO.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study of the costs incurred by eligible organizations with risk-sharing contracts under section 1876(b) of such Act of complying with the requirement of entering into a written agreement with an entity providing peer review services with respect to services provided by the organization, together with an analysis of how information generated by such entities is used by the Secretary to assess the quality of services provided by such eligible organizations.

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

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

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to contract years beginning on or after January 1, 1997.

SEC. 416. EFFECTIVE DATE.

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

Subtitle C—Administrative and Miscellaneous Provisions

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

(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 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.

(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. The amount of such a fee may not exceed the costs of processing the requests for disclosure and of providing such information. 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) The term ''final adverse action'' includes:

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

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

(C) 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 of the provider, supplier, or practitioner, by operation of law, or

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

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

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

(2) 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) The term ''health care provider'' means a provider of services as defined in section 1861(u) of the Social Security Act, and any entity, including a health maintenance organization, group medical practice, or any other entity listed by the Secretary in regulation, that provides health care services.

(4) The term ''supplier'' means a supplier of health care items and services described in section 1819 (a) and (b), and section 1861 of the Social Security Act.

(5) 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 and abuse units.

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

(6) The term ''health plan'' has the meaning given to such term by section 1128(i) of the Social Security Act.

(7) For purposes of paragraph (2), the existence of a conviction shall be determined under paragraph (4) of section 1128(j) of the Social Security Act.

(g) CONFORMING AMENDMENT.—Section 1921(d) of the Social Security Act is amended by inserting ''and section 421 of the Senior Citizens Bill of Rights Act of 1996''

after ''section 422 of the Health Care Quality Improvement Act of 1986''.

Subtitle D—Civil Monetary Penalties

SEC. 431. CIVIL MONETARY PENALTIES.

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

(1) In subsection (a)(1), by inserting ''or of any health plan (as defined in section 1128(i)),'' after ''subsection (i)(1)),''.

(2) In subsection (f)—

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

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

''(3) With respect to amounts recovered arising out of a claim under a health plan, the portion of such amounts as is determined to have been paid by the plan shall be repaid to the plan, and the portion of such amounts attributable to the amounts recovered under this section by reason of the amendments made by title IV of the Senior Citizens Bill of Rights Act of 1996 (as estimated by the Secretary) shall be deposited into the Health Care Fraud and Abuse

Control Account established under section 101(b) of such Act.''.

(3) In subsection (i)—

(A) in paragraph (2), by inserting ''or under a health plan'' before the period at the end, and

(B) in paragraph (5), by inserting ''or under a health plan'' after ''or XX''.

(b) EXCLUDED INDIVIDUAL RETAINING OWNERSHIP OR CONTROL INTEREST IN PARTICIPATING ENTITY.—Section 1128A(a) of the Social Security Act (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, retains a direct or indirect ownership or control interest of 5 percent or more, or an ownership or control interest (as defined in section 1124(a)(3)) in, or who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of, an entity that is participating in a program under title XVIII or a State health care program;''.

(c) MODIFICATIONS OF AMOUNTS OF PENALTIES AND ASSESSMENTS.—Section 1128A(a) of the Social Security Act (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) of the Social Security Act (42 U.S.C. 1320a–7a(a)(1)) is amended—

(1) in subparagraph (A) by striking ''claimed,'' and inserting the following: ''claimed, including any person who repeatedly presents or causes to be presented a claim for an item or service that is based on a code that the person knows or should know will result in a greater payment to the person than the code the person knows or should know is applicable to the item or service actually provided,'';

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

(3) in subparagraph (D), by striking ''; or'' and inserting '', or''; and

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

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

(e) PERMITTING SECRETARY TO IMPOSE CIVIL MONETARY PENALTY.—Section 1128A(b) of the Social Security Act (42 U.S.C. 1320a–7a(a)) is amended by adding the following new paragraph:

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

title shall be subject to a civil monetary penalty of not more than $10,000 for each such violation. In addition, such person shall be subject to an assessment of not more than twice the total amount of the remuneration offered, paid, solicited, or received in violation of section 1128B(b). The total amount of remuneration subject to an assessment shall be calculated without regard to whether some portion thereof also may have been intended to serve a purpose other than one proscribed by section 1128B(b).''.

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

(g) PROCEDURAL PROVISIONS.—Section 1876(i)(6) of such Act (42 U.S.C. 1395mm(i)(6)) is further 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 (A) or (B) in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).''.

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

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

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

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

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

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

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

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

(2) REMUNERATION DEFINED.—Section 1128A(i) of such Act (42 U.S.C. 1320a–7a(i)) is amended by adding 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 third party payors to whom claims are presented and as long as the differentials meet the standards as defined in regulations promulgated by the Secretary; or

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

Subtitle E—Amendments to Criminal Law

SEC. 441. HEALTH CARE FRAUD.

(a) IN GENERAL.—

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

''§ 1347. Health care fraud

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

''(1) to defraud any health plan or other person, in connection with the delivery of or payment for health care benefits, items, or services; 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 plan, or person 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(g)(3) of this title), such person shall be imprisoned for any term of years.

''(b) For purposes of this section, the term 'health plan' has the same meaning given such term in section 1128(i) of the Social Security Act.''.

(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 THE HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.—The Secretary of the Treasury shall deposit into the Health Care Fraud and Abuse Control Account established under section 401(b) an amount equal to the criminal fines imposed

under section 1347 of title 18, United States Code (relating to health care fraud).

SEC. 442. 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)(A) 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—

''(i) is used in the commission of the offense if the offense results in a financial loss or gain of $50,000 or more; or

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

''(B) For purposes of this paragraph, the term 'Federal health care offense' means a violation of, or a criminal conspiracy to violate—

''(i) section 1347 of this title;

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

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

''(iv) section 501 or 511 of the Employee Retirement Income Security Act of 1974, if the violation or conspiracy relates to health care fraud.''.

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

SEC. 443. INJUNCTIVE RELIEF RELATING TO FEDERAL 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 (as defined in section 982(a)(6)(B) of this title);''.

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

a Federal health care offense (as defined in section 982(a)(6)(B))'' after ''title)''.

SEC. 444. GRAND JURY DISCLOSURE.

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

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

(2) by inserting after subsection (b) the following:

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

''(1) received in the course of duty as an attorney for the Government; or

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

may disclose that information to an attorney for the Government to use in any investigation or civil proceeding relating to health care fraud.''.

SEC. 445. FALSE STATEMENTS.

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

''§ 1033. False statements relating to health care matters

''Whoever, in any matter involving a health plan, knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact, or 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, shall be fined under this title or imprisoned not more than 5 years, or both.''.

(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:

''1033. False statements relating to health care matters.''.

SEC. 446. VOLUNTARY DISCLOSURE PROGRAM.

In consultation with the Attorney General of the United States, the Secretary of Health and Human Services shall publish proposed regulations not later than 9 months after the date of enactment of this Act, and final regulations not later than 18 months after such date of enactment, establishing a program of voluntary disclosure that would facilitate the enforcement of sections 1128A and 1128B of the Social Security Act (42 U.S.C. 1320a–7a and 1320a–7b) and other relevant provisions of Federal law relating to health care fraud and abuse. Such program should promote and provide incentives for disclo-

sures of potential violations of such sections and provisions by providing that, under certain circumstances, the voluntary disclosure of wrongdoing would result in the imposition of penalties and punishments less substantial than those that would be assessed for the same wrongdoing if voluntary disclosure did not occur.

SEC. 447. OBSTRUCTION OF CRIMINAL INVESTIGATIONS OF FEDERAL HEALTH CARE OFFENSES.

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

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

''(a) IN GENERAL.—Whoever willfully prevents, obstructs, misleads, delays or attempts to prevent, obstruct, mislead, or delay the communication of information or records relating to 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) FEDERAL HEALTH CARE OFFENSE.—As used in this section the term 'Federal health care offense' has the same meaning given such term in section 982(a)(6)(B) of this title.

''(c) CRIMINAL INVESTIGATOR.—As used in this section the term 'criminal investigator' means any individual

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

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

''1518. Obstruction of criminal investigations of Federal health care offenses.''.

SEC. 448. THEFT OR EMBEZZLEMENT.

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

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

''(a) IN GENERAL.—Whoever willfully embezzles, steals, or otherwise without authority willfully and unlawfully converts to the use of any person other than the rightful owner, or intentionally misapplies any of the moneys, funds, securities, premiums, credits, property, or other assets of a health care benefit program, shall be fined under this title or imprisoned not more than 10 years, or both.

''(b) FEDERAL HEALTH CARE OFFENSE.—As used in this section the term 'Federal health care offense' has the same meaning given such term in section 982(a)(6)(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. 449. LAUNDERING OF MONETARY INSTRUMENTS.

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

''(F) Any act or activity constituting an offense involving a Federal health care offense as that term is defined in section 982(a)(6)(B) of this title.''.

Subtitle F—Payments for State Health Care Fraud Control Units

SEC. 451. ESTABLISHMENT OF STATE FRAUD UNITS.

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

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

SEC. 452. REQUIREMENTS FOR STATE FRAUD UNITS.

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

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

(2) be separate and distinct from any State agency with principal responsibility for the administration of any Federally-funded or mandated health care program;

(3) meet the other requirements of this section.

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

(1) be a Unit of the office of the State Attorney General or of another department of State government which possesses statewide authority to prosecute individuals for criminal violations;

(2) if it is in a State the constitution of which does not provide for the criminal prosecution of individuals by a statewide authority and has formal procedures, (A) assure its referral of suspected criminal violations to the appropriate authority or authorities in the State for prosecution, and (B) assure its assistance of, and coordination with, such authority or authorities in such prosecutions; or

(3) have a formal working relationship with the office of the State Attorney General or the appropriate authority or authorities for prosecution and

have formal procedures (including procedures for its referral of suspected criminal violations to such office) which provide effective coordination of activities between the Fraud Unit and such office with respect to the detection, investigation, and prosecution of suspected criminal violations relating to any Federally-funded or mandated health care programs.

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

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

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

(d) COOPERATIVE AGREEMENTS; MEMORANDA OF UNDERSTANDING.—The State Fraud Unit shall have cooperative agreements with—

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

(2) similar Fraud Units in other States, as exemplified through membership and participation in the National Association of Medicaid Fraud Control Units or its successor; and

(3) the Secretary.

(e) REPORTS.—The State Fraud Unit shall submit to the Secretary an application and an annual report containing such information as the Secretary determines to be necessary to determine whether the State Fraud Unit meets the requirements of this section.

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

SEC. 453. SCOPE AND PURPOSE.

The State Fraud Unit shall carry out the following activities:

(1) The State Fraud Unit shall conduct a statewide program for the investigation and prosecution (or referring for prosecution) of violations of all applicable state laws regarding any and all aspects of fraud in connection with any aspect of the administration and provision of health care services and activities of providers of such services under any Federally-funded or mandated health care programs;

(2) The State Fraud Unit shall have procedures for reviewing complaints of the abuse or neglect of patients of facilities (including patients in residential facilities and home health care programs) that receive payments under any Federally-funded or mandated health care programs, and, where appropriate, to investigate and prosecute such complaints under the criminal laws of the State or for referring the complaints to other State agencies for action.

(3) The State Fraud Unit shall provide for the collection, or referral for collection to the appropriate agency, of overpayments that are made under any Federally-funded or mandated health care program and that are discovered by the State Fraud Unit in carrying out its activities.

SEC. 454. PAYMENTS TO STATES.

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

(b) APPLICABLE PERCENTAGE DEFINED.—

(1) IN GENERAL.—In subsection (a), the ''applicable percentage'' with respect to a State for a fiscal year is—

(A) 90 percent, for quarters occurring during the first 3 years for which the State Fraud Unit is in operation; or

(B) 75 percent, for any other quarters.

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

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

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