

104TH CONGRESS
1ST SESSION

S. 294

To increase the availability and affordability of health care coverage for individuals and their families, to reduce paperwork and simplify the administration of health care claims, to increase access to care in rural and underserved areas, to improve quality and protect consumers from health care fraud and abuse, to promote preventive care, to make long-term care more affordable, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JANUARY 30, 1995

Mr. COHEN introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To increase the availability and affordability of health care coverage for individuals and their families, to reduce paperwork and simplify the administration of health care claims, to increase access to care in rural and underserved areas, to improve quality and protect consumers from health care fraud and abuse, to promote preventive care, to make long-term care more affordable, and for other purposes.

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

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

2 (a) SHORT TITLE.—This Act may be cited as the
3 “Access to Affordable Health Care Act”.

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

Sec. 1. Short title and table of contents.

TITLE I—HEALTH INSURANCE MARKET REFORM

Subtitle A—Insurance Market Standards

- Sec. 1001. Nondiscrimination based on health status.
- Sec. 1002. Guaranteed issue and renewal.
- Sec. 1003. Rating limitations.
- Sec. 1004. Delivery system quality standards.
- Sec. 1005. Risk adjustment.
- Sec. 1006. Effective dates.

Subtitle B—Establishment and Application of Standards

- Sec. 1011. General rules.
- Sec. 1012. Encouragement of State reforms.
- Sec. 1013. Enforcement of standards.

Subtitle C—Definitions

- Sec. 1021. Definitions.

TITLE II—GRANTS TO STATES FOR SMALL GROUP HEALTH
INSURANCE PURCHASING ARRANGEMENTS

- Sec. 2001. Grants to States for small group health insurance purchasing ar-
rangements.

TITLE III—TAX INCENTIVES TO ENCOURAGE THE PURCHASE OF
HEALTH INSURANCE

- Sec. 3001. Permanent extension and increase of deduction for health insurance
costs of self-employed individuals.
- Sec. 3002. Credit for health insurance expenses.

TITLE IV—INCENTIVES TO INCREASE THE ACCESS OF RURAL
AND UNDERSERVED AREAS TO HEALTH CARE

- Sec. 4001. Nonrefundable credit for certain primary health services providers.
- Sec. 4002. Expensing of medical equipment.
- Sec. 4003. Expanded services for medically underserved individuals.
- Sec. 4004. Increase in National Health Service Corps and area health edu-
cation center funding.
- Sec. 4005. Assistant Secretary for Rural Health.
- Sec. 4006. Study on transitional measures to ensure access.

TITLE V—QUALITY AND CONSUMER PROTECTION

Subtitle A—Quality Improvement Foundations

Sec. 5001. Quality improvement foundations.

Subtitle B—Administrative Simplification

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Sec. 5162. Health information continuity.

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Sec. 5201. Definitions.

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Sec. 5206. General rules regarding disclosure.

Sec. 5207. Authorizations for disclosure of protected health information.

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- Sec. 5322. Establishment of minimum period of exclusion for certain individuals and entities subject to permissive exclusion from medicare and State health care programs.
- Sec. 5323. Permissive exclusion of individuals with ownership or control interest in sanctioned entities.
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- Sec. 5352. Forfeitures for Federal health care offenses.
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- Sec. 8001. Short title.
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Subtitle A—Tax Treatment of Long-Term Care Insurance

- Sec. 8101. Qualified long-term care services treated as medical care.
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Subtitle B—Standards For Long-Term Care Insurance

- Sec. 8201. National Long-Term Care Insurance Advisory Council.
- Sec. 8202. Additional requirements for issuers of long-term care insurance policies.
- Sec. 8203. Coordination with State requirements.
- Sec. 8204. Uniform language and definitions.

Subtitle C—Incentives to Encourage the Purchase of Private Insurance

- Sec. 8301. Assets or resources disregarded under the medicaid program.

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TITLE IX—BUDGET NEUTRALITY

Sec. 9001. Assurance of budget neutrality.

1 **TITLE I—HEALTH INSURANCE**
 2 **MARKET REFORM**
 3 **Subtitle A—Insurance Market**
 4 **Standards**

5 **SEC. 1001. NONDISCRIMINATION BASED ON HEALTH STA-**
 6 **TUS.**

7 (a) IN GENERAL.—Except as provided in subsection
 8 (b) and section 1003(d), a health plan may not deny, limit,
 9 or condition the coverage under (or benefits of) the plan,
 10 or vary the premium, for an individual based on the health
 11 status, medical condition, claims experience, receipt of
 12 health care, medical history, anticipated need for health
 13 care services, disability, or lack of evidence of insurability.

14 (b) TREATMENT OF PREEXISTING CONDITION EX-
 15 CLUSIONS FOR ALL SERVICES.—

16 (1) IN GENERAL.—A health plan may impose a
 17 limitation or exclusion of benefits relating to treat-
 18 ment of a condition based on the fact that the condi-
 19 tion preexisted the effective date of the plan with re-
 20 spect to an individual only if—

1 (A) the condition was diagnosed or treated
2 during the 3-month period ending on the day
3 before the date of enrollment under the plan;

4 (B) the limitation or exclusion extends for
5 a period not more than 6 months after the date
6 of enrollment under the plan;

7 (C) the limitation or exclusion does not
8 apply to an individual who, as of the date of
9 birth, was covered under the plan; or

10 (D) the limitation or exclusion does not
11 apply to pregnancy.

12 (2) CREDITING OF PREVIOUS COVERAGE.—A
13 health plan shall provide that if an individual under
14 such plan is in a period of continuous coverage as
15 of the date of enrollment under such plan, any pe-
16 riod of exclusion of coverage with respect to a pre-
17 existing condition shall be reduced by 1 month for
18 each month in the period of continuous coverage.

19 (3) DEFINITIONS.—For purposes of this sub-
20 section:

21 (A) PERIOD OF CONTINUOUS COVERAGE.—

22 (i) IN GENERAL.—The term “period
23 of continuous coverage” means the period
24 beginning on the date an individual is en-
25 rolled under a health plan or an equivalent

1 health care program and ends on the date
2 the individual is not so enrolled for a con-
3 tinuous period of more than 3 months.

4 (ii) EQUIVALENT HEALTH CARE PRO-
5 GRAM.—The term “equivalent health care
6 program” means—

7 (I) part A or part B of the medi-
8 care program under title XVIII of the
9 Social Security Act (42 U.S.C. 1395
10 et seq.),

11 (II) the medicaid program under
12 title XIX of the Social Security Act
13 (42 U.S.C. 1396 et seq.),

14 (III) the health care program for
15 active military personnel under title
16 10, United States Code,

17 (IV) the veterans health care pro-
18 gram under chapter 17 of title 38,
19 United States Code,

20 (V) the Civilian Health and Med-
21 ical Program of the Uniformed Serv-
22 ices (CHAMPUS), as defined in sec-
23 tion 1073(4) of title 10, United States
24 Code, and

1 (VI) the Indian health service
2 program under the Indian Health
3 Care Improvement Act (25 U.S.C.
4 1601 et seq.).

5 (B) PREEXISTING CONDITION.—The term
6 “preexisting condition” means, with respect to
7 coverage under a health plan, a condition which
8 was diagnosed, or which was treated, within the
9 3-month period ending on the day before the
10 date of enrollment (without regard to any wait-
11 ing period).

12 (c) LIMITATIONS PROHIBITED.—

13 (1) IN GENERAL.—A health plan may not im-
14 pose a lifetime limitation on the provision of benefits
15 under the plan.

16 (2) RULE OF CONSTRUCTION.—The prohibition
17 contained in paragraph (1) shall not be construed as
18 prohibiting limitations on the scope or duration of
19 particular items or services covered by a health plan.

20 **SEC. 1002. GUARANTEED ISSUE AND RENEWAL.**

21 (a) SMALL GROUP MARKET.—Each health plan of-
22 fering coverage in the small group market shall guarantee
23 each individual purchaser and small employer (and each
24 eligible employee of such small employer) applying for cov-
25 erage in such market the opportunity to enroll in the plan.

1 (b) LARGE EMPLOYER MARKET.—Each health plan
2 offering coverage in the large employer market shall guar-
3 antee any individual eligible for coverage under the plan
4 the opportunity to enroll in such plan.

5 (c) CAPACITY LIMITS.—Notwithstanding this section,
6 a health plan may apply a capacity limit based on limited
7 financial or provider capacity if the plan enrolls individ-
8 uals in a manner that provides prospective enrollees with
9 a fair chance of enrollment regardless of the method by
10 which the individual seeks enrollment.

11 (d) RENEWAL OF POLICY.—

12 (1) SMALL GROUP MARKET.—A health plan is-
13 sued to a small employer or an individual purchaser
14 in the small group market shall be renewed at the
15 option of the employer or individual, if such em-
16 ployer or individual purchaser remains eligible for
17 coverage under the plan.

18 (2) LARGE EMPLOYER MARKET.—A health plan
19 issued to an individual eligible for coverage under a
20 large employer plan shall be renewed at the option
21 of the individual, if such individual remains eligible
22 for coverage under the plan.

23 (e) GROUNDS FOR REFUSAL TO RENEW.—A health
24 plan may refuse to renew a policy only in the case of—

25 (1) the nonpayment of premiums;

1 (2) fraud on the part of the employer or indi-
2 vidual relating to such plan; or

3 (3) the misrepresentation by the employer or in-
4 dividual of material facts relating to an application
5 for coverage of a claim or benefit.

6 (f) NOTIFICATION OF AVAILABILITY.—Each health
7 plan sponsor shall publicly disclose the availability of each
8 health plan that such sponsor provides or offers in a small
9 group market. Such disclosure shall be accompanied by
10 information describing the method by which eligible em-
11 ployers and individuals may enroll in such plans.

12 **SEC. 1003. RATING LIMITATIONS.**

13 (a) IN GENERAL.—A health plan offering coverage
14 in the small group market shall comply with the standards
15 developed under this section.

16 (b) ROLE OF NAIC.—The Secretary shall request
17 that the NAIC—

18 (1) develop specific standards in the form of a
19 model Act and model regulations that provide for
20 the implementation of the rating limitations de-
21 scribed in subsection (d); and

22 (2) report to the Secretary concerning such
23 standards within 6 months after the date of enact-
24 ment of this Act.

1 (c) ROLE OF THE SECRETARY.—The Secretary, upon
2 review of the report received under subsection (b)(2), shall
3 not later than January 1, 1997, promulgate final stand-
4 ards implementing this section. Such standards shall be
5 the applicable health plan standards under this section.

6 (d) RATING STANDARDS.—The standards described
7 in this section shall provide for the following:

8 (1) A determination of factors that health plans
9 may use to vary the premium rates of such plans.
10 Such factors—

11 (A) shall be applied in a uniform fashion
12 to all enrollees covered by a plan;

13 (B) shall include age (as specified in para-
14 graph (3)), family type, and geography; and

15 (C) except as provided in paragraph
16 (2)(A), shall not include gender, health status,
17 or health expenditures.

18 (2)(A) Factors prohibited under paragraph
19 (1)(C) shall be phased out over a period not to ex-
20 ceed 3 years after the effective date of this section.

21 (B) Other rating factors (other than age) may
22 be phased out to the extent necessary to minimize
23 market disruption and maximize coverage rates.

24 (3) Uniform age categories and age adjustment
25 factors that reflect the relative actuarial costs of

1 benefit packages among enrollees. By the end of the
2 3-year period beginning on the effective date of this
3 section, for individuals who have attained age 18 but
4 not age 65, the highest age adjustment factor may
5 not exceed 3 times the lowest age adjustment factor.

6 (e) DISCOUNTS.—Standards developed under this
7 section shall permit health plans to provide premium dis-
8 counts based on workplace health promoting activities.

9 **SEC. 1004. DELIVERY SYSTEM QUALITY STANDARDS.**

10 (a) IN GENERAL.—Each health plan shall comply
11 with the standards developed under this section.

12 (b) ROLE OF THE SECRETARY.—Not later than 9
13 months after the date of enactment of this Act, the Sec-
14 retary, in consultation with the NAIC and other organiza-
15 tions with expertise in the areas of quality assurance (in-
16 cluding the Joint Commission on Accreditation of Health
17 Care Organizations, the National Committee for Quality
18 Assurance, and peer review organizations), shall establish
19 minimum guidelines specified in subsection (c) for the is-
20 suance by each State of delivery system quality standards.
21 Such standards shall be the applicable health plan stand-
22 ards under this section.

23 (c) MINIMUM GUIDELINES.—The minimum guide-
24 lines specified in this subsection are as follows:

1 (1) Establishing and maintaining health plan
2 quality assurance, including—

3 (A) quality management;

4 (B) credentialing;

5 (C) utilization management;

6 (D) health care provider selection and due
7 process in selection; and

8 (E) practice guidelines and protocols.

9 (2) Providing consumer protection for health
10 plan enrollees, including—

11 (A) comparative standardized consumer in-
12 formation with respect to health plan premiums
13 and quality measures, including health care re-
14 port cards;

15 (B) nondiscrimination in plan enrollment,
16 disenrollment, and service provision;

17 (C) continuation of treatment with respect
18 to health plans that become insolvent; and

19 (D) grievance procedures.

20 (3) Ensuring reasonable access to health care
21 services, including access for vulnerable populations
22 in underserved areas.

23 **SEC. 1005. RISK ADJUSTMENT.**

24 Each health plan offering coverage in the small group
25 market in a State shall participate in a risk adjustment

1 program developed by such State under standards estab-
2 lished by the Secretary.

3 **SEC. 1006. EFFECTIVE DATES.**

4 (a) IN GENERAL.—Except as provided in subsection
5 (b), this title shall take effect on January 1, 1996.

6 (b) RATING LIMITATIONS AND RISK ADJUST-
7 MENTS.—The standards promulgated under sections 1003
8 and 1005 shall apply to plans that are issued or renewed
9 after December 31, 1996.

10 **Subtitle B—Establishment and**
11 **Application of Standards**

12 **SEC. 1011. GENERAL RULES.**

13 (a) CONSTRUCTION.—

14 (1) IN GENERAL.—A requirement or standard
15 imposed on a health plan under this Act shall be
16 deemed to be a requirement or standard imposed on
17 the insurer or sponsor of such plan.

18 (2) PREEMPTION OF STATE LAW.—

19 (A) IN GENERAL.—No requirement of this
20 title shall be construed as preempting any State
21 law unless such State law directly conflicts with
22 such requirement. The provision of additional
23 consumer protections under State law as de-
24 scribed in subparagraph (B) shall not be con-

1 sidered to directly conflict with any such re-
2 quirement.

3 (B) CONSUMER PROTECTION LAWS.—State
4 laws referred to in subparagraph (A) that are
5 not preempted by this title include—

6 (i) laws that limit the exclusions or
7 limitations for preexisting medical condi-
8 tions to periods that are less than those
9 provided for under section 1001;

10 (ii) laws that limit variations in pre-
11 mium rates beyond the variations per-
12 mitted under section 1003; and

13 (iii) laws that would expand the small
14 group market in excess of that provided for
15 under this title.

16 (C) LIMITED PREEMPTION OF STATE MAN-
17 DATED BENEFITS.—No State law or regulation
18 in effect in a State that requires health plans
19 offered to small employers in the State to in-
20 clude specified items and services other than
21 those described in section 1005(b)(2)(B) shall
22 apply with respect to a health plan offered by
23 an insurer to a small employer.

24 (b) REGULATIONS.—The Secretary, in consultation
25 with NAIC, and the Secretary of Labor are each author-

1 ized to issue regulations as are necessary to implement
2 this Act.

3 **SEC. 1012. ENCOURAGEMENT OF STATE REFORMS.**

4 Nothing in this Act shall be construed as prohibiting
5 States from enacting health care reform measures that ex-
6 ceed the measures established under this Act, including
7 reforms that expand access to health care services, control
8 health care costs, and enhance quality of care.

9 **SEC. 1013. ENFORCEMENT OF STANDARDS.**

10 (a) IN GENERAL.—Except as provided in subsection
11 (b), each State shall require that each health plan issued,
12 sold, offered for sale, or operated in such State meets the
13 insurance reform standards established under this title
14 pursuant to an enforcement plan filed by the State with,
15 and approved by, the Secretary. If the State does not file
16 an acceptable plan, the Secretary shall enforce such stand-
17 ards until a plan is filed and approved.

18 (b) SECRETARY OF LABOR.—With respect to any
19 health plan for which the application of State insurance
20 laws are preempted under section 514 of Employee Retire-
21 ment Income Security Act of 1974 (29 U.S.C. 1144), the
22 enforcement of the insurance reform standards established
23 under this title shall be by the Secretary of Labor.

1 **Subtitle C—Definitions**

2 **SEC. 1021. DEFINITIONS.**

3 (a) HEALTH PLAN.—For purposes of this title and
4 title II, the term “health plan” means a plan that pro-
5 vides, or pays the cost of, health benefits. Such term does
6 not include the following, or any combination thereof:

7 (1) Coverage only for accidental death, dis-
8 memberment, dental, or vision.

9 (2) Coverage providing wages or payments in
10 lieu of wages for any period during which the em-
11 ployee is absent from work on account of sickness or
12 injury.

13 (3) A medicare supplemental policy (as defined
14 in section 1882(g)(1) of the Social Security Act (42
15 U.S.C. 1395ss(g)(1)).

16 (4) Coverage issued as a supplement to liability
17 insurance.

18 (5) Worker’s compensation or similar insurance.

19 (6) Automobile medical-payment insurance.

20 (7) A long-term care insurance policy, including
21 a nursing home fixed indemnity policy (unless the
22 Secretary determines that such a policy provides suf-
23 ficiently comprehensive coverage of a benefit so that
24 it should be treated as a health plan).

1 (8) Any plan or arrangement not described in
2 any preceding subparagraph which provides for ben-
3 efit payments, on a periodic basis, for a specified
4 disease or illness or period of hospitalization without
5 regard to the costs incurred or services rendered
6 during the period to which the payments relate.

7 (9) Such other plan or arrangement as the Sec-
8 retary determines is not a health plan.

9 (b) TERMS AND RULES RELATING TO THE SMALL
10 GROUP AND LARGE EMPLOYER MARKETS.—For purposes
11 of this title and title II:

12 (1) SMALL GROUP MARKET.—The term “small
13 group market” means the market for health plans
14 which is composed of small employers and individual
15 purchasers.

16 (2) SMALL EMPLOYER.—The term “small em-
17 ployer” means, with respect to any calendar year,
18 any employer if, on each of 20 days during the pre-
19 ceding calendar year (each day being in a different
20 week), such employer (or any predecessor) employed
21 less than 51 employees for some portion of the day.

22 (3) INDIVIDUAL PURCHASER.—The term “indi-
23 vidual purchaser” means an individual who is not el-
24 igible to enroll in a health plan sponsored by a large
25 or small employer.

1 (4) LARGE EMPLOYER MARKET.—The term
2 “large employer market” means the market for
3 health plans which is composed of large employers.

4 (5) LARGE EMPLOYER.—The term “large em-
5 ployer”—

6 (A) means an employer that is not a small
7 employer; and

8 (B) includes a multiemployer plan as de-
9 fined in section 3(37) of the Employment Re-
10 tirement Income Security Act of 1974 (29
11 U.S.C. 1002(37)) and a plan which is main-
12 tained by a rural electric cooperative or a rural
13 telephone cooperative association (within the
14 meaning of section 3(40) of such Act (29
15 U.S.C. 1002(40)).

16 (c) ADDITIONAL DEFINITIONS.—For purposes of this
17 title and title II:

18 (1) NAIC.—The term “NAIC” means the Na-
19 tional Association of Insurance Commissioners.

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

1 **TITLE II—GRANTS TO STATES**
2 **FOR SMALL GROUP HEALTH**
3 **INSURANCE PURCHASING AR-**
4 **RANGEMENTS**

5 **SEC. 2001. GRANTS TO STATES FOR SMALL GROUP HEALTH**
6 **INSURANCE PURCHASING ARRANGEMENTS.**

7 (a) IN GENERAL.—The Secretary shall make grants
8 to States that submit applications meeting the require-
9 ments of this section for the establishment and operation
10 of small group health insurance purchasing arrangements.

11 (b) USE OF FUNDS.—Grant funds awarded under
12 this section to a State may be used to finance administra-
13 tive costs associated with developing and operating a small
14 group health insurance purchasing arrangement, including
15 the costs associated with—

16 (1) engaging in marketing and outreach efforts
17 to inform individuals and small employers about the
18 small group health insurance purchasing arrange-
19 ment, which may include the payment of sales com-
20 missions;

21 (2) negotiating with insurers to provide health
22 insurance through the small group health insurance
23 purchasing arrangement; or

1 (3) providing administrative functions, such as
2 eligibility screening, claims administration, and cus-
3 tomer service.

4 (c) APPLICATION REQUIREMENTS.—An application
5 submitted by a State to the Secretary shall describe—

6 (1) whether the program will be operated di-
7 rectly by the State or through 1 or more State-spon-
8 sored private organizations and the details of such
9 operation;

10 (2) program goals for reducing the cost of
11 health insurance for, and increasing insurance cov-
12 erage in, the small group market;

13 (3) the approaches proposed for enlisting par-
14 ticipation by insurers and small employers, including
15 any plans to use State funds to subsidize the cost
16 of insurance for participating individuals and em-
17 ployers; and

18 (4) the methods proposed for evaluating the ef-
19 fectiveness of the program in reducing the number
20 of uninsured in the State and on lowering the cost
21 of health insurance for the small group market in
22 the State.

23 (d) GRANT CRITERIA.—In awarding grants, the Sec-
24 retary shall consider the potential impact of the State's
25 proposal on the cost of health insurance for the small

1 group market and on the number of uninsured, and the
2 need for regional variation in the awarding of grants. To
3 the extent the Secretary deems appropriate, grants shall
4 be awarded to fund programs employing a variety of ap-
5 proaches for establishing small group health insurance
6 purchasing arrangements.

7 (e) PROHIBITION ON GRANTS.—No grant funds shall
8 be paid to States that do not meet the requirements of
9 this title with respect to small group health plans, or to
10 States with group purchasing programs involving small
11 group health plans that do not meet the requirements of
12 this title.

13 (f) ANNUAL REPORT BY STATES.—States receiving
14 grants under this section shall report to the Secretary an-
15 nually on the numbers and rates of participation by eligi-
16 ble insurers and small employers, on the estimated impact
17 of the program on reducing the number of uninsured, and
18 on the cost of insurance available to the small group mar-
19 ket in the State.

20 (g) AUTHORIZATION OF APPROPRIATIONS.—There
21 are authorized to be appropriated for each of the fiscal
22 years 1996, 1997, and 1998, such sums as may be nec-
23 essary to carry out this section.

24 (h) SECRETARIAL REPORT.—The Secretary shall re-
25 port to Congress by not later than January 1, 1997, on

1 the number and amount of grants awarded under this sec-
 2 tion, and include with such report an evaluation of the
 3 impact of the grant program on the number of uninsured
 4 and cost of health insurance to small group markets in
 5 participating States.

6 **TITLE III—TAX INCENTIVES TO**
 7 **ENCOURAGE THE PURCHASE**
 8 **OF HEALTH INSURANCE**

9 **SEC. 3001. PERMANENT EXTENSION AND INCREASE OF DE-**
 10 **DUCTION FOR HEALTH INSURANCE COSTS OF**
 11 **SELF-EMPLOYED INDIVIDUALS.**

12 (a) DEDUCTION MADE PERMANENT.—Section 162(l)
 13 of the Internal Revenue Code of 1986 (relating to special
 14 rules for health insurance costs of self-employed individ-
 15 uals) is amended by striking paragraph (6).

16 (b) INCREASE IN DEDUCTION.—Section 162(l) of
 17 such Code, as amended by subsection (a), is amended—

18 (1) by striking “25 percent” in paragraph (1)
 19 and inserting “the applicable percentage”, and

20 (2) by adding at the end the following new
 21 paragraph:

22 “(6) APPLICABLE PERCENTAGE.—For purposes
 23 of paragraph (1), the applicable percentage shall be
 24 determined as follows:

For taxable years beginning	The applicable percentage is:
in:	
1994, 1995 and 1996	25

**For taxable years beginning The applicable percentage is:
in:**

1997	50
1998 and 1999	75
2000 and thereafter	100.”

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to taxable years beginning after
3 December 31, 1993.

4 **SEC. 3002. CREDIT FOR HEALTH INSURANCE EXPENSES.**

5 (a) IN GENERAL.—Subpart C of part IV of sub-
6 chapter A of chapter 1 of the Internal Revenue Code of
7 1986 (relating to refundable personal credits) is amended
8 by inserting after section 34 the following new section:

9 **“SEC. 34A. HEALTH INSURANCE EXPENSES.**

10 “(a) ALLOWANCE OF CREDIT.—

11 “(1) IN GENERAL.—In the case of an eligible
12 individual, there shall be allowed as a credit against
13 the tax imposed by this subtitle for the taxable year
14 an amount equal to the applicable percentage of the
15 qualified health insurance expenses paid by such in-
16 dividual during the taxable year.

17 “(2) APPLICABLE PERCENTAGE.—For purposes
18 of paragraph (1), the term ‘applicable percentage’
19 means 60 percent reduced (but not below zero) by
20 10 percentage points for each \$1,000 (or fraction
21 thereof) by which the taxpayer’s adjusted gross in-
22 come for the taxable year exceeds the applicable dol-
23 lar amount.

1 “(3) APPLICABLE DOLLAR AMOUNT.—For pur-
2 poses of this subsection, the term ‘applicable dollar
3 amount’ means—

4 “(A) in the case of a taxpayer filing a joint
5 return, \$28,000,

6 “(B) in the case of any other taxpayer
7 (other than a married individual filing a sepa-
8 rate return), \$18,000, and

9 “(C) in the case of a married individual fil-
10 ing a separate return, zero.

11 For purposes of this subsection, the rule of section
12 219(g)(4) shall apply.

13 “(b) QUALIFIED HEALTH INSURANCE EXPENSES.—
14 For purposes of this section—

15 “(1) IN GENERAL.—The term ‘qualified health
16 insurance expenses’ means amounts paid during the
17 taxable year for insurance which constitutes medical
18 care (within the meaning of section 213(d)(1)(C)).

19 For purposes of the preceding sentence, the rules of
20 section 213(d)(6) shall apply.

21 “(2) DOLLAR LIMIT ON QUALIFIED HEALTH IN-
22 SURANCE EXPENSES.—The amount of the qualified
23 health insurance expenses paid during any taxable
24 year which may be taken into account under sub-

1 section (a)(1) shall not exceed \$1,200 (\$2,400 in the
2 case of a taxpayer filing a joint return).

3 “(3) ELECTION NOT TO TAKE CREDIT.—A tax-
4 payer may elect for any taxable year to have
5 amounts described in paragraph (1) not treated as
6 qualified health insurance expenses.

7 “(c) ELIGIBLE INDIVIDUAL.—For purposes of this
8 section, the term ‘eligible individual’ means, with respect
9 to any period, an individual who is not covered during such
10 period by a health plan maintained by an employer of such
11 individual or such individual’s spouse.

12 “(d) SPECIAL RULES.—For purposes of this sec-
13 tion—

14 “(1) COORDINATION WITH ADVANCE PAYMENT
15 AND MINIMUM TAX.—Rules similar to the rules of
16 subsections (g) and (h) of section 32 shall apply to
17 any credit to which this section applies.

18 “(2) MEDICARE-ELIGIBLE INDIVIDUALS.—No
19 expense shall be treated as a qualified health insur-
20 ance expense if it is an amount paid for insurance
21 for an individual for any period with respect to
22 which such individual is entitled (or, on application
23 without the payment of an additional premium,
24 would be entitled to) benefits under part A of title
25 XVIII of the Social Security Act.

1 “(3) SUBSIDIZED EXPENSES.—No expense shall
2 be treated as a qualified health insurance expense to
3 the extent—

4 “(A) such expense is paid, reimbursed, or
5 subsidized (whether by being disregarded for
6 purposes of another program or otherwise) by
7 the Federal Government, a State or local gov-
8 ernment, or any agency or instrumentality
9 thereof, and

10 “(B) the payment, reimbursement, or sub-
11 sidy of such expense is not includible in the
12 gross income of the recipient.

13 “(e) REGULATIONS.—The Secretary shall prescribe
14 such regulations as may be necessary to carry out the pur-
15 poses of this section.”.

16 (b) ADVANCE PAYMENT OF CREDIT.—

17 (1) IN GENERAL.—Chapter 25 of the Internal
18 Revenue Code of 1986 is amended by inserting after
19 section 3507 the following new section:

20 **“SEC. 3507A. ADVANCE PAYMENT OF HEALTH INSURANCE**
21 **EXPENSES CREDIT.**

22 “(a) GENERAL RULE.—Except as otherwise provided
23 in this section, every employer making payment of wages
24 with respect to whom a health insurance expenses eligi-
25 bility certificate is in effect shall, at the time of paying

1 such wages, make an additional payment equal to such
2 employee's dependent care advance amount.

3 “(b) HEALTH INSURANCE EXPENSES ELIGIBILITY
4 CERTIFICATE.—For purposes of this title, a health insur-
5 ance expenses eligibility certificate is a statement fur-
6 nished by an employee to the employer which—

7 “(1) certifies that the employee will be eligible
8 to receive the credit provided by section 34A for the
9 taxable year,

10 “(2) certifies that the employee does not have
11 a health insurance expenses eligibility certificate in
12 effect for the calendar year with respect to the pay-
13 ment of wages by another employer,

14 “(3) states whether or not the employee's
15 spouse has a health insurance expenses eligibility
16 certificate in effect, and

17 “(4) estimates the amount of qualified health
18 insurance expenses (as defined in section 34A(b))
19 for the calendar year.

20 For purposes of this section, a certificate shall be treated
21 as being in effect with respect to a spouse if such a certifi-
22 cate will be in effect on the first status determination date
23 following the date on which the employee furnishes the
24 statement in question.

1 “(c) HEALTH INSURANCE EXPENSES ADVANCE
2 AMOUNT.—

3 “(1) IN GENERAL.—For purposes of this title,
4 the term ‘health insurance expenses advance
5 amount’ means, with respect to any payroll period,
6 the amount determined—

7 “(A) on the basis of the employee’s wages
8 from the employer for such period,

9 “(B) on the basis of the employee’s esti-
10 mated qualified health insurance expenses in-
11 cluded in the health insurance expenses eligi-
12 bility certificate, and

13 “(C) in accordance with tables provided by
14 the Secretary.

15 “(2) ADVANCE AMOUNT TABLES.—The tables
16 referred to in paragraph (1)(C) shall be similar in
17 form to the tables prescribed under section 3402(a)
18 and, to the maximum extent feasible, shall be coordi-
19 nated with such tables and the tables prescribed
20 under section 3507(c).

21 “(d) OTHER RULES.—For purposes of this section,
22 rules similar to the rules of subsections (d) and (e) of sec-
23 tion 3507 shall apply.

1 “(e) REGULATIONS.—The Secretary shall prescribe
2 such regulations as may be necessary to carry out the pur-
3 poses of this section.”.

4 (2) CONFORMING AMENDMENT.—The table of
5 sections for chapter 25 of such Code is amended by
6 adding after the item relating to section 3507 the
7 following new item:

 “Sec. 3507A. Advance payment of health insurance expenses cred-
 it.”.

8 (c) COORDINATION WITH DEDUCTIONS FOR HEALTH
9 INSURANCE EXPENSES.—

10 (1) SELF-EMPLOYED INDIVIDUALS.—Section
11 162(l) of the Internal Revenue Code of 1986, as
12 amended by section 8001, is further amended by
13 adding after paragraph (6) the following new para-
14 graph:

15 “(7) COORDINATION WITH HEALTH INSURANCE
16 PREMIUM CREDIT.—Paragraph (1) shall not apply to
17 any amount taken into account in computing the
18 amount of the credit allowed under section 34A.”.

19 (2) MEDICAL, DENTAL, ETC., EXPENSES.—Sub-
20 section (e) of section 213 of such Code is amended
21 by inserting “or section 34A” after “section 21”.

22 (d) CLERICAL AMENDMENT.—The table of sections
23 for subpart A of part IV of subchapter A of chapter 1
24 of the Internal Revenue Code of 1986 is amended by in-

1 inserting after the item relating to section 34 the following
2 new item:

“Sec. 34A. Health insurance expenses.”.

3 (e) EFFECTIVE DATE.—The amendments made by
4 this section shall apply to taxable years beginning after
5 December 31, 1995.

6 **TITLE IV—INCENTIVES TO IN-**
7 **CREASE THE ACCESS OF**
8 **RURAL AND UNDERSERVED**
9 **AREAS TO HEALTH CARE**

10 **SEC. 4001. NONREFUNDABLE CREDIT FOR CERTAIN PRI-**
11 **MARY HEALTH SERVICES PROVIDERS.**

12 (a) IN GENERAL.—Subpart A of part IV of sub-
13 chapter A of chapter 1 of the Internal Revenue Code of
14 1986 (relating to nonrefundable personal credits) is
15 amended by inserting after section 22 the following new
16 section:

17 **“SEC. 23. PRIMARY HEALTH SERVICES PROVIDERS.**

18 “(a) ALLOWANCE OF CREDIT.—There shall be al-
19 lowed as a credit against the tax imposed by this chapter
20 for the taxable year an amount equal to the product of—

21 “(1) the number of months during such taxable
22 year—

23 “(A) during which the taxpayer is a quali-
24 fied primary health services provider, and

1 “(B) which are within the taxpayer’s man-
2 datory service period, and

3 “(2) \$1,000 (\$500 in the case of a qualified
4 practitioner who is not a physician).

5 “(b) QUALIFIED PRIMARY HEALTH SERVICES PRO-
6 VIDER.—For purposes of this section, the term ‘qualified
7 primary health services provider’ means, with respect to
8 any month, any qualified practitioner who—

9 “(1) has in effect a certification by the Bureau
10 as a provider of primary health services and such
11 certification is, when issued, for a health profes-
12 sional shortage area in which the qualified practi-
13 tioner is commencing the providing of primary
14 health services,

15 “(2) is providing primary health services full
16 time in the health professional shortage area identi-
17 fied in such certification, and

18 “(3) has not received a scholarship under the
19 National Health Service Corps Scholarship Program
20 or any loan repayments under the National Health
21 Service Corps Loan Repayment Program.

22 For purposes of paragraph (2) and subsection (e)(3), a
23 provider shall be treated as providing services in a health
24 professional shortage area when such area ceases to be

1 such an area if it was such an area when the provider
2 commenced providing services in the area.

3 “(c) MANDATORY SERVICE PERIOD.—For purposes
4 of this section, the term ‘mandatory service period’ means
5 the period of 60 consecutive calendar months beginning
6 with the first month the taxpayer is a qualified primary
7 health services provider. A taxpayer shall not have more
8 than 1 mandatory service period.

9 “(d) DEFINITIONS AND SPECIAL RULES.—For pur-
10 poses of this section—

11 “(1) BUREAU.—The term ‘Bureau’ means the
12 Bureau of Primary Health Care, Health Resources
13 and Services Administration of the United States
14 Public Health Service.

15 “(2) QUALIFIED PRACTITIONER.—The term
16 ‘qualified practitioner’ means a physician, a physi-
17 cian assistant, a nurse practitioner, or a certified
18 nurse-midwife.

19 “(3) PHYSICIAN.—The term ‘physician’ has the
20 meaning given to such term by section 1861(r) of
21 the Social Security Act.

22 “(4) PHYSICIAN ASSISTANT; NURSE PRACTI-
23 TIONER.—The terms ‘physician assistant’ and ‘nurse
24 practitioner’ have the meanings given to such terms
25 by section 1861(aa)(5) of the Social Security Act.

1 “(5) CERTIFIED NURSE-MIDWIFE.—The term
2 ‘certified nurse-midwife’ has the meaning given to
3 such term by section 1861(gg)(2) of the Social Secu-
4 rity Act.

5 “(6) PRIMARY HEALTH SERVICES.—The term
6 ‘primary health services’ has the meaning given such
7 term by section 330(b)(1) of the Public Health Serv-
8 ice Act.

9 “(7) HEALTH PROFESSIONAL SHORTAGE
10 AREA.—The term ‘health professional shortage area’
11 has the meaning given such term by section
12 332(a)(1)(A) of the Public Health Service Act.

13 “(e) RECAPTURE OF CREDIT.—

14 “(1) IN GENERAL.—If there is a recapture
15 event during any taxable year, then—

16 “(A) no credit shall be allowed under sub-
17 section (a) for such taxable year and any suc-
18 ceeding taxable year, and

19 “(B) the tax of the taxpayer under this
20 chapter for such taxable year shall be increased
21 by an amount equal to the product of—

22 “(i) the applicable percentage, and

23 “(ii) the aggregate unrecaptured cred-
24 its allowed to such taxpayer under this sec-
25 tion for all prior taxable years.

1 “(2) APPLICABLE RECAPTURE PERCENTAGE.—

2 “(A) IN GENERAL.—For purposes of this
 3 subsection, the applicable recapture percentage
 4 shall be determined from the following table:

“If the recapture event occurs during:	The applicable recap- true percentage is:
Months 1-24	100
Months 25-36	75
Months 37-48	50
Months 49-60	25
Month 61 or thereafter	0.

5 “(B) TIMING.—For purposes of subpara-
 6 graph (A), month 1 shall begin on the first day
 7 of the mandatory service period.

8 “(3) RECAPTURE EVENT DEFINED.—

9 “(A) IN GENERAL.—For purposes of this
 10 subsection, the term ‘recapture event’ means
 11 the failure of the taxpayer to be a qualified pri-
 12 mary health services provider for any month
 13 during the taxpayer’s mandatory service period.

14 “(B) SECRETARIAL WAIVER.—The Sec-
 15 retary, in consultation with the Secretary of
 16 Health and Human Services, may waive any re-
 17 capture event caused by extraordinary cir-
 18 cumstances.

19 “(4) NO CREDITS AGAINST TAX; MINIMUM
 20 TAX.—Any increase in tax under this subsection
 21 shall not be treated as a tax imposed by this chapter
 22 for purposes of determining the amount of any cred-

1 it under subpart A, B, or D of this part or for pur-
2 poses of section 55.”

3 (b) CLERICAL AMENDMENT.—The table of sections
4 for subpart A of part IV of subchapter A of chapter 1
5 of such Code is amended by inserting after the item relat-
6 ing to section 22 the following new item:

“Sec. 23. Primary health services providers.”

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

10 **SEC. 4002. EXPENSING OF MEDICAL EQUIPMENT.**

11 (a) IN GENERAL.—Paragraph (1) of section 179(b)
12 of the Internal Revenue Code of 1986 (relating to dollar
13 limitation on expensing of certain depreciable business as-
14 sets) is amended to read as follows:

15 “(1) DOLLAR LIMITATION.—

16 “(A) GENERAL RULE.—The aggregate cost
17 which may be taken into account under sub-
18 section (a) for any taxable year shall not exceed
19 \$17,500.

20 “(B) HEALTH CARE PROPERTY.—The ag-
21 gregate cost which may be taken into account
22 under subsection (a) shall be increased by the
23 lesser of—

1 “(i) the cost of section 179 property
2 which is health care property placed in
3 service during the taxable year, or

4 “(ii) \$10,000.”

5 (b) DEFINITION.—Section 179(d) of such Code (re-
6 lating to definitions) is amended by adding at the end the
7 following new paragraph:

8 “(11) HEALTH CARE PROPERTY.—For purposes
9 of this section, the term ‘health care property’
10 means section 179 property—

11 “(A) which is medical equipment used in
12 the screening, monitoring, observation, diag-
13 nosis, or treatment of patients in a laboratory,
14 medical, or hospital environment,

15 “(B) which is owned (directly or indirectly)
16 and used by a physician (as defined in section
17 1861(r) of the Social Security Act) in the active
18 conduct of such physician’s full-time trade or
19 business of providing primary health services
20 (as defined in section 330(b)(1) of the Public
21 Health Service Act) in a health professional
22 shortage area (as defined in section
23 332(a)(1)(A) of the Public Health Service Act),
24 and

1 “(C) substantially all the use of which is in
2 such area.”

3 (c) RECAPTURE.—Paragraph (10) of section 179(d)
4 of such Code is amended by inserting before the period
5 “and with respect to any health care property which ceases
6 (other than by an area failing to be treated as a health
7 professional shortage area) to be health care property at
8 any time”.

9 (d) EFFECTIVE DATE.—The amendments made by
10 this section shall apply to property placed in service in
11 taxable years beginning after December 31, 1994.

12 **SEC. 4003. EXPANDED SERVICES FOR MEDICALLY UNDER-**
13 **SERVED INDIVIDUALS.**

14 (a) IN GENERAL.—Subpart I of part D of title III
15 of the Public Health Service Act (42 U.S.C. 254b et seq.)
16 (as amended by section 313) is amended by adding at the
17 end the following new section:

18 **“SEC. 330B. EXPANDED SERVICES FOR MEDICALLY UNDER-**
19 **SERVED INDIVIDUALS.**

20 “(a) ESTABLISHMENT OF HEALTH SERVICES AC-
21 CESS PROGRAM.—From amounts appropriated under this
22 section, the Secretary shall, acting through the Bureau of
23 Health Care Delivery Assistance, award grants under this
24 section to federally qualified health centers (hereinafter re-
25 ferred to in this section as ‘FQHC’s’) and other entities

1 and organizations submitting applications under this sec-
2 tion (as described in subsection (c)) for the purpose of
3 providing access to services for medically underserved pop-
4 ulations (as defined in section 330(b)(3)) or in high im-
5 pact areas (as defined in section 329(a)(5)) not currently
6 being served by a FQHC.

7 “(b) ELIGIBILITY FOR GRANTS.—

8 “(1) IN GENERAL.—The Secretary shall award
9 grants under this section to entities or organizations
10 described in this paragraph and paragraph (2) which
11 have submitted a proposal to the Secretary to ex-
12 pand such entities or organizations operations (in-
13 cluding expansions to new sites (as determined nec-
14 essary by the Secretary)) to serve medically under-
15 served populations or high impact areas not cur-
16 rently served by a FQHC and which—

17 “(A) have as of January 1, 1991, been cer-
18 tified by the Secretary as a FQHC under sec-
19 tion 1905(l)(2)(B) of the Social Security Act;
20 or

21 “(B) have submitted applications to the
22 Secretary to qualify as FQHC’s under such sec-
23 tion 1905(l)(2)(B); or

24 “(C) have submitted a plan to the Sec-
25 retary which provides that the entity will meet

1 the requirements to qualify as a FQHC when
2 operational.

3 “(2) NON FQHC ENTITIES.—

4 “(A) ELIGIBILITY.—The Secretary shall
5 also make grants under this section to public or
6 private nonprofit agencies, health care entities
7 or organizations which meet the requirements
8 necessary to qualify as a FQHC except, the re-
9 quirement that such entity have a consumer
10 majority governing board and which have sub-
11 mitted a proposal to the Secretary to provide
12 those services provided by a FQHC as defined
13 in section 1905(l)(2)(B) of the Social Security
14 Act and which are designed to promote access
15 to primary care services or to reduce reliance on
16 hospital emergency rooms or other high cost
17 providers of primary health care services, pro-
18 vided such proposal is developed by the entity
19 or organizations (or such entities or organiza-
20 tions acting in a consortium in a community)
21 with the review and approval of the Governor of
22 the State in which such entity or organization
23 is located.

24 “(B) LIMITATION.—The Secretary shall
25 provide in making grants to entities or organi-

1 zations described in this paragraph that no
2 more than 10 percent of the funds provided for
3 grants under this section shall be made avail-
4 able for grants to such entities or organizations.

5 “(c) APPLICATION REQUIREMENTS.—

6 “(1) IN GENERAL.—In order to be eligible to
7 receive a grant under this section, a FQHC or other
8 entity or organization must submit an application in
9 such form and at such time as the Secretary shall
10 prescribe and which meets the requirements of this
11 subsection.

12 “(2) REQUIREMENTS.—An application submit-
13 ted under this section must provide—

14 “(A)(i) for a schedule of fees or payments
15 for the provision of the services provided by the
16 entity designed to cover its reasonable costs of
17 operations; and

18 “(ii) for a corresponding schedule of dis-
19 counts to be applied to such fees or payments,
20 based upon the patient’s ability to pay (deter-
21 mined by using a sliding scale formula based on
22 the income of the patient);

23 “(B) assurances that the entity or organi-
24 zation provides services to persons who are eli-
25 gible for benefits under title XVIII of the Social

1 Security Act, for medical assistance under title
2 XIX of such Act or for assistance for medical
3 expenses under any other public assistance pro-
4 gram or private health insurance program; and

5 “(C) assurances that the entity or organi-
6 zation has made and will continue to make
7 every reasonable effort to collect reimbursement
8 for services—

9 “(i) from persons eligible for assist-
10 ance under any of the programs described
11 in subparagraph (B); and

12 “(ii) from patients not entitled to ben-
13 efits under any such programs.

14 “(d) LIMITATIONS ON USE OF FUNDS.—

15 “(1) IN GENERAL.—From the amounts award-
16 ed to an entity or organization under this section,
17 funds may be used for purposes of planning but may
18 only be expended for the costs of—

19 “(A) assessing the needs of the populations
20 or proposed areas to be served;

21 “(B) preparing a description of how the
22 needs identified will be met; and

23 “(C) development of an implementation
24 plan that addresses—

1 “(i) recruitment and training of per-
2 sonnel; and

3 “(ii) activities necessary to achieve
4 operational status in order to meet FQHC
5 requirements under 1905(l)(2)(B) of the
6 Social Security Act.

7 “(2) RECRUITING, TRAINING AND COMPENSA-
8 TION OF STAFF.—From the amounts awarded to an
9 entity or organization under this section, funds may
10 be used for the purposes of paying for the costs of
11 recruiting, training and compensating staff (clinical
12 and associated administrative personnel (to the ex-
13 tent such costs are not already reimbursed under
14 title XIX of the Social Security Act or any other
15 State or Federal program)) to the extent necessary
16 to allow the entity to operate at new or expanded ex-
17 isting sites.

18 “(3) FACILITIES AND EQUIPMENT.—From the
19 amounts awarded to an entity or organization under
20 this section, funds may be expended for the purposes
21 of acquiring facilities and equipment but only for the
22 cost of—

23 “(A) construction of new buildings (to the
24 extent that new construction is found to be the
25 most cost-efficient approach by the Secretary);

1 “(B) acquiring, expanding, and moderniz-
2 ing of existing facilities;

3 “(C) purchasing essential (as determined
4 by the Secretary) equipment; and

5 “(D) amortization of principal and pay-
6 ment of interest on loans obtained for purposes
7 of site construction, acquisition, modernization,
8 or expansion, as well as necessary equipment.

9 “(4) SERVICES.—From the amounts awarded
10 to an entity or organization under this section, funds
11 may be expended for the payment of services but
12 only for the costs of—

13 “(A) providing or arranging for the provi-
14 sion of all services through the entity necessary
15 to qualify such entity as a FQHC under section
16 1905(l)(2)(B) of the Social Security Act;

17 “(B) providing or arranging for any other
18 service that a FQHC may provide and be reim-
19 bursed for under title XIX of such Act; and

20 “(C) providing any unreimbursed costs of
21 providing services as described in section 330(a)
22 to patients.

23 “(e) PRIORITIES IN THE AWARDING OF GRANTS.—

24 “(1) CERTIFIED FQHC’S.—The Secretary shall
25 give priority in awarding grants under this section

1 to entities which have, as of January 1, 1991, been
2 certified as a FQHC under section 1905(l)(2)(B) of
3 the Social Security Act and which have submitted
4 a proposal to the Secretary to expand their oper-
5 ations (including expansion to new sites) to serve
6 medically underserved populations for high impact
7 areas not currently served by a FQHC. The Sec-
8 retary shall give first priority in awarding grants
9 under this section to those FQHCs or other entities
10 which propose to serve populations with the highest
11 degree of unmet need, and which can demonstrate
12 the ability to expand their operations in the most
13 efficient manner.

14 “(2) QUALIFIED FQHC’S.—The Secretary shall
15 give second priority in awarding grants to entities
16 which have submitted applications to the Secretary
17 which demonstrate that the entity will qualify as a
18 FQHC under section 1905(l)(2)(B) of the Social Se-
19 curity Act before it provides or arranges for the pro-
20 vision of services supported by funds awarded under
21 this section, and which are serving or proposing to
22 serve medically underserved populations or high im-
23 pact areas which are not currently served (or pro-
24 posed to be served) by a FQHC.

1 “(3) EXPANDED SERVICES AND PROJECTS.—

2 The Secretary shall give third priority in awarding
3 grants in subsequent years to those FQHCs or other
4 entities which have provided for expanded services
5 and project and are able to demonstrate that such
6 entity will incur significant unreimbursed costs in
7 providing such expanded services.

8 “(f) RETURN OF FUNDS TO SECRETARY FOR COSTS

9 REIMBURSED FROM OTHER SOURCES.—To the extent
10 that an entity or organization receiving funds under this
11 section is reimbursed from another source for the provi-
12 sion of services to an individual, and does not use such
13 increased reimbursement to expand services furnished,
14 areas served, to compensate for costs of unreimbursed
15 services provided to patients, or to promote recruitment,
16 training, or retention of personnel, such excess revenues
17 shall be returned to the Secretary.

18 “(g) TERMINATION OF GRANTS.—

19 “(1) FAILURE TO MEET FQHC REQUIRE-
20 MENTS.—

21 “(A) IN GENERAL.—With respect to any
22 entity that is receiving funds awarded under
23 this section and which subsequently fails to
24 meet the requirements to qualify as a FQHC
25 under section 1905(l)(2)(B) or is an entity that

1 is not required to meet the requirements to
2 qualify as a FQHC under section 1905(l)(2)(B)
3 of the Social Security Act but fails to meet the
4 requirements of this section, the Secretary shall
5 terminate the award of funds under this section
6 to such entity.

7 “(B) NOTICE.—Prior to any termination
8 of funds under this section to an entity, the en-
9 tities shall be entitled to 60 days prior notice of
10 termination and, as provided by the Secretary
11 in regulations, an opportunity to correct any de-
12 ficiencies in order to allow the entity to con-
13 tinue to receive funds under this section.

14 “(2) REQUIREMENTS.—Upon any termination
15 of funding under this section, the Secretary may (to
16 the extent practicable)—

17 “(A) sell any property (including equip-
18 ment) acquired or constructed by the entity
19 using funds made available under this section
20 or transfer such property to another FQHC,
21 provided, that the Secretary shall reimburse
22 any costs which were incurred by the entity in
23 acquiring or constructing such property (includ-
24 ing equipment) which were not supported by
25 grants under this section; and

1 “(B) recoup any funds provided to an en-
2 tity terminated under this section.

3 “(h) AUTHORIZATION OF APPROPRIATIONS.—There
4 are authorized to be appropriated such sums as may be
5 necessary for each of the fiscal years 1996 through 1999
6 to carry out this section.”.

7 (b) EFFECTIVE DATE.—The amendment made by
8 subsection (a) shall become effective with respect to serv-
9 ices furnished by a federally qualified health center or
10 other qualifying entity described in this section beginning
11 on or after October 1, 1996.

12 **SEC. 4004. INCREASE IN NATIONAL HEALTH SERVICE**
13 **CORPS AND AREA HEALTH EDUCATION CEN-**
14 **TER FUNDING.**

15 (a) NATIONAL HEALTH SERVICE CORPS.—Section
16 338H(b)(1) of the Public Health Service Act (42 U.S.C.
17 254q(b)(1)) is amended—

18 (1) by striking “1991, and” and inserting
19 “1991,”; and

20 (2) by striking “through 2000” and inserting “,
21 1994, and 1995, and \$20,000,000 for each of the
22 fiscal years 1996 through 2000”.

23 (b) AREA HEALTH EDUCATION CENTERS.—Section
24 746(i)(1) of such Act (42 U.S.C. 293j(i)(1)) is amended—

1 (1) in subparagraph (A), by striking “1995”
2 and inserting “1995, and \$20,000,000 for each of
3 the fiscal years 1996 through 2000”; and

4 (2) in subparagraph (C), by striking “and
5 1995” and inserting “1995, and \$20,000,000 for
6 each of the fiscal years 1996 through 2000”.

7 **SEC. 4005. ASSISTANT SECRETARY FOR RURAL HEALTH.**

8 (a) APPOINTMENT OF ASSISTANT SECRETARY.—

9 (1) IN GENERAL.—Section 711(a) of the Social
10 Security Act (42 U.S.C. 912(a)) is amended—

11 (A) by striking “by a Director, who shall
12 advise the Secretary” and inserting “by an As-
13 sistant Secretary for Rural Health (in this sec-
14 tion referred to as the ‘Assistant Secretary’),
15 who shall report directly to the Secretary”; and

16 (B) by adding at the end the following new
17 sentence: “The Office shall not be a component
18 of any other office, service, or component of the
19 Department.”.

20 (2) CONFORMING AMENDMENTS.—(A) Section
21 711(b) of the Social Security Act (42 U.S.C. 912(b))
22 is amended by striking “the Director” and inserting
23 “the Assistant Secretary”.

24 (B) Section 338J(a) of the Public Health Serv-
25 ice Act (42 U.S.C. 254r(a)) is amended by striking

1 “Director of the Office of Rural Health Policy” and
2 inserting “Assistant Secretary for Rural Health”.

3 (C) Section 464T(b) of the Public Health Serv-
4 ice Act (42 U.S.C. 285p-2(b)) is amended in the
5 matter preceding paragraph (1) by striking “Direc-
6 tor of the Office of Rural Health Policy” and insert-
7 ing “Assistant Secretary for Rural Health”.

8 (D) Section 6213 of the Omnibus Budget Rec-
9 onciliation Act of 1989 (42 U.S.C. 1395x note) is
10 amended in subsection (e)(1) by striking “Director
11 of the Office of Rural Health Policy” and inserting
12 “Assistant Secretary for Rural Health”.

13 (E) Section 403 of the Ryan White Comprehen-
14 sive AIDS Resources Emergency Act of 1990 (42
15 U.S.C. 300ff-11 note) is amended in the matter pre-
16 ceding paragraph (1) of subsection (a) by striking
17 “Director of the Office of Rural Health Policy” and
18 inserting “Assistant Secretary for Rural Health”.

19 (3) AMENDMENT TO THE EXECUTIVE SCHED-
20 ULE.—Section 5315 of title 5, United States Code,
21 is amended by striking “Assistant Secretaries of
22 Health and Human Services (5)” and inserting “As-
23 sistant Secretaries of Health and Human Services
24 (6)”.

1 (b) EXPANSION OF DUTIES.—Section 711(a) of the
2 Social Security Act (42 U.S.C. 912(a)) is amended by
3 striking “and access to (and the quality of) health care
4 in rural areas” and inserting “access to, and quality of,
5 health care in rural areas, and reforms to the health care
6 system and the implications of such reforms for rural
7 areas”.

8 (c) EFFECTIVE DATE.—The amendments made by
9 this section shall take effect on January 1, 1996.

10 **SEC. 4006. STUDY ON TRANSITIONAL MEASURES TO EN-**
11 **SURE ACCESS.**

12 (a) IN GENERAL.—The Prospective Payment Assess-
13 ment Commission shall conduct a study concerning the
14 need for legislation or regulations to ensure that vulner-
15 able populations have adequate access to health plans and
16 health care providers and services.

17 (b) REPORT.—Not later than 1 year after the date
18 of enactment of this Act, the Prospective Payment Assess-
19 ment Commission shall prepare and submit to Congress
20 a report concerning the findings and recommendations of
21 the Commission based on the study conducted under sub-
22 section (a).

1 **TITLE V—QUALITY AND**
2 **CONSUMER PROTECTION**
3 **Subtitle A—Quality Improvement**
4 **Foundations**

5 **SEC. 5001. QUALITY IMPROVEMENT FOUNDATIONS.**

6 (a) ESTABLISHMENT.—

7 (1) GRANT PROCESS.—The Secretary shall,
8 through a competitive grantmaking process, award
9 demonstration grants for the establishment and op-
10 eration of quality improvement foundations. In
11 awarding such grants the Secretary shall consider
12 geographic diversity, regional economics of scale,
13 population density, regional needs and other regional
14 differences.

15 (2) ELIGIBLE APPLICANTS.—To be eligible to
16 receive a grant for the establishment of a quality im-
17 provement foundation under paragraph (1), and ap-
18 plicant entity shall—

19 (A) be a not-for-profit entity; and

20 (B) have a board that includes health care
21 providers, representatives from relevant institu-
22 tions of higher education in the region, consum-
23 ers, purchasers of health care, and other inter-
24 ested parties.

25 (b) DUTIES.—

1 (1) IN GENERAL.—Each quality improvement
2 foundation shall carry out the duties described in
3 paragraph (2). The foundation shall establish a pro-
4 gram of activities incorporating such duties and
5 shall be able to demonstrate the involvement of a
6 broad cross-section of the providers and health care
7 institutions throughout the State or region.

8 (2) DUTIES DESCRIBED.—The duties described
9 in this paragraph include the following:

10 (A) Collaboration with and technical assist-
11 ance to providers and health plans in ongoing
12 efforts to improve the quality of health care
13 provided to individuals in the State.

14 (B) Population-based monitoring of prac-
15 tice patterns and patient outcomes, on an other
16 than a case-by-case basis.

17 (C) Developing programs in lifetime learn-
18 ing for health professionals to improve the qual-
19 ity of health care by ensuring that health pro-
20 fessionals remain informed about new knowl-
21 edge, acquire new skills, and adopt new roles as
22 technology and societal demands change.

23 (D) Disseminating information about suc-
24 cessful quality improvement programs, practice
25 guidelines, and research findings, including in-

1 formation on innovative staffing of health pro-
2 fessionals.

3 (E) Assist in developing innovative patient
4 education systems that enhance patient involve-
5 ment in decisions relating to their health care,
6 including an emphasis on shared decisionmak-
7 ing between patients and health care providers.

8 (F) Issuing a report to the public regard-
9 ing the foundation's activities for the previous
10 year including areas of success during the pre-
11 vious year and areas for opportunities in im-
12 proving health outcomes for the community,
13 and the adoption of guidelines.

14 (c) RESTRICTIONS ON DISCLOSURE.—The restric-
15 tions on disclosure of information under section 1160 of
16 the Social Security Act shall apply to quality improvement
17 foundations under this section, except that—

18 (1) such foundations shall make data available
19 to qualified organizations and individuals for re-
20 search for public benefit under the terms set forth
21 in section 5218;

22 (2) individuals and qualified organizations shall
23 meet standards consistent with the Public Health
24 Service Act and policies regarding the conduct of
25 scientific research, including provisions related to

1 confidentiality, privacy, protection of humans and
2 shall pay reasonable costs for data; and

3 (3) such foundations may exchange information
4 with other quality improvement foundations.

5 (d) AUTHORIZATION OF APPROPRIATIONS.—For the
6 purpose of carrying out this section, there are authorized
7 to be appropriated such sums as may be necessary for
8 each of the fiscal years 1996 through 2000.

9 **Subtitle B—Administrative**
10 **Simplification**

11 **PART 1—PURPOSE AND DEFINITIONS**

12 **SEC. 5101. PURPOSE.**

13 It is the purpose of this subtitle to improve the effi-
14 ciency and effectiveness of the health care system, includ-
15 ing the medicare program under title XVIII of the Social
16 Security Act and the medicaid program under title XIX
17 of such Act, by encouraging the development of a health
18 information network through the establishment of stand-
19 ards and requirements for the electronic transmission of
20 certain health information.

21 **SEC. 5102. DEFINITIONS.**

22 For purposes of this subtitle:

23 (1) CERTIFIED.—The term “certified” means,
24 with respect to a health information network service,
25 that such service is certified under section 5141.

1 (2) CODE SET.—The term “code set” means
2 any set of codes used for encoding data elements,
3 such as tables of terms, medical concepts, medical
4 diagnostic codes, or medical procedure codes.

5 (3) COORDINATION OF BENEFITS.—The term
6 “coordination of benefits” means determining and
7 coordinating the financial obligations of health plans
8 when health care benefits are payable under two or
9 more health plans.

10 (4) HEALTH CARE PROVIDER.—The term
11 “health care provider” includes a provider of services
12 (as defined in section 1861(u) of the Social Security
13 Act), a provider of medical or other health services
14 (as defined in section 1861(s) of the Social Security
15 Act), and any other person furnishing health care
16 services or supplies.

17 (5) HEALTH INFORMATION.—The term “health
18 information” means any information, whether oral
19 or recorded in any form or medium that—

20 (A) is created or received by a health care
21 provider, health plan, health oversight agency
22 (as defined in section 5202), health researcher,
23 public health authority (as defined in section
24 5202), employer, life insurer, school or univer-

1 sity, or certified health information network
2 service; and

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

8 (6) HEALTH INFORMATION NETWORK.—The
9 term “health information network” means the health
10 information system that is formed through the appli-
11 cation of the requirements and standards established
12 under this subtitle.

13 (7) HEALTH INFORMATION PROTECTION ORGA-
14 NIZATION.—The term “health information protection
15 organization” means a private entity or an entity op-
16 erated by a State that accesses standard data ele-
17 ments of health information through the health in-
18 formation network and—

19 (A) processes such information into non-
20 identifiable health information and discloses
21 such information;

22 (B) if such information is protected health
23 information (as defined in section 5202), dis-
24 closes such information only in accordance with
25 subtitle C; and

1 (C) may store such information.

2 (8) HEALTH INFORMATION NETWORK SERV-
3 ICE.—The term “health information network serv-
4 ice”—

5 (A) means a private entity or an entity op-
6 erated by a State that enters into contracts
7 to—

8 (i) process or facilitate the processing
9 of nonstandard data elements of health in-
10 formation into standard data elements;

11 (ii) provide the means by which per-
12 sons are connected to the health informa-
13 tion network for purposes of meeting the
14 requirements of this subtitle, including the
15 holding of standard data elements of
16 health information;

17 (iii) provide authorized access to
18 health information through the health in-
19 formation network; or

20 (iv) provide specific information proc-
21 essing services, such as automated coordi-
22 nation of benefits and claims transaction
23 routing; and

24 (B) includes a health information protec-
25 tion organization.

1 (9) HEALTH PLAN.—The term “health plan”
2 has the meaning given such term in section 1021(a).

3 (10) NON-IDENTIFIABLE HEALTH INFORMA-
4 TION.—The term “non-identifiable health informa-
5 tion” means health information that is not protected
6 health information as defined in section 5202.

7 (11) PATIENT MEDICAL RECORD INFORMA-
8 TION.—The term “patient medical record informa-
9 tion” means health information derived from a clini-
10 cal encounter that relates to the physical or mental
11 condition of an individual.

12 (12) STANDARD.—The term “standard” when
13 referring to an information transaction or to data
14 elements of health information means the trans-
15 action or data elements meet any standard adopted
16 by the Secretary under part 2 that applies to such
17 information transaction or data elements.

18 **PART 2—STANDARDS FOR DATA ELEMENTS AND**
19 **INFORMATION TRANSACTIONS**

20 **SEC. 5111. GENERAL REQUIREMENTS ON SECRETARY.**

21 (a) IN GENERAL.—The Secretary shall adopt stand-
22 ards and modifications to standards under this subtitle
23 that are—

24 (1) consistent with the objective of reducing the
25 costs of providing and paying for health care;

1 (2) in use and generally accepted or developed
2 or modified by the standards setting organizations
3 accredited by the American National Standard Insti-
4 tute (ANSI); and

5 (3) consistent with the objective of protecting
6 the privacy of protected health information (as de-
7 fined in section 5202).

8 (b) INITIAL STANDARDS.—The Secretary may de-
9 velop an expedited process for the adoption of initial
10 standards under this subtitle.

11 (c) FAILSAFE.—If the Secretary is unable to adopt
12 standards or modified standards in accordance with sub-
13 section (a) that meet the requirements of this subtitle—

14 (1) the Secretary may develop or modify such
15 standards and, after providing public notice and an
16 adequate period for public comment, adopt such
17 standards; and

18 (2) if the Secretary adopts standards under
19 paragraph (1), the Secretary shall submit a report
20 to the appropriate committees of Congress on the
21 actions taken by the Secretary under this subsection.

22 (d) ASSISTANCE TO THE SECRETARY.—In complying
23 with the requirements of this subtitle, the Secretary shall
24 rely on recommendations of the Health Information Advi-

1 sory Committee established under section 5163 and shall
2 consult with appropriate Federal agencies.

3 **SEC. 5112. STANDARDS FOR TRANSACTIONS AND DATA ELE-**
4 **MENTS.**

5 (a) IN GENERAL.—The Secretary shall adopt stand-
6 ards for transactions and data elements to make uniform
7 and able to be exchanged electronically health information
8 that is—

9 (1) appropriate for the following financial and
10 administrative transactions: claims (including coordi-
11 nation of benefits) or equivalent encounter informa-
12 tion, claims attachments, enrollment and
13 disenrollment, eligibility, payment and remittance
14 advice, premium payments, first report of injury,
15 claims status, and referral certification and author-
16 ization;

17 (2) related to other transactions determined ap-
18 propriate by the Secretary consistent with the goals
19 of improving the health care system and reducing
20 administrative costs; and

21 (3) related to research inquiries by a health re-
22 searcher with respect to information standardized
23 under paragraph (1) or (2).

24 (b) UNIQUE HEALTH IDENTIFIERS.—The Secretary
25 shall adopt standards providing for a standard unique

1 health identifier for each individual, employer, health plan,
2 and health care provider for use in the health care system.

3 (c) CODE SETS.—

4 (1) IN GENERAL.—The Secretary, in consulta-
5 tion with experts from the private sector and Fed-
6 eral agencies, shall—

7 (A) select code sets for appropriate data
8 elements from among the code sets that have
9 been developed by private and public entities; or

10 (B) establish code sets for such data ele-
11 ments if no code sets for the data elements
12 have been developed.

13 (2) DISTRIBUTION.—The Secretary shall estab-
14 lish efficient and low-cost procedures for distribution
15 of code sets and modifications made to such code
16 sets under section 5113(b).

17 (d) ELECTRONIC SIGNATURE.—The Secretary, in co-
18 ordination with the Secretary of Commerce, shall promul-
19 gate regulations specifying procedures for the electronic
20 transmission and authentication of signatures, compliance
21 with which will be deemed to satisfy Federal and State
22 statutory requirements for written signatures with respect
23 to information transactions required by this subtitle and
24 written signatures on medical records and prescriptions.

25 (e) SPECIAL RULES—

1 (1) COORDINATION OF BENEFITS.—Any stand-
2 ards adopted under subsection (a) that relate to co-
3 ordination of benefits shall provide that a claim for
4 reimbursement for medical services furnished is test-
5 ed by an algorithm specified by the Secretary
6 against all records that are electronically available
7 through the health information network relating to
8 enrollment and eligibility for the individual who re-
9 ceived such services to determine any primary and
10 secondary obligors for payment.

11 (2) CLINICAL LABORATORY TESTS.—

12 (A) IN GENERAL.—Except as provided in
13 subparagraph (B), any standards adopted
14 under subsection (a) shall provide that claims
15 for clinical laboratory tests for which benefits
16 are payable by a plan sponsor shall be submit-
17 ted directly by the person or entity that per-
18 formed (or supervised the performance of) the
19 tests to the sponsor in a manner consistent with
20 (and subject to such exceptions as are provided
21 under) the requirement for direct submission of
22 such claims under the medicare program.

23 (B) EXCEPTION.—Payment for a clinical
24 laboratory test may be made—

1 (i) to a physician with whom the phy-
2 sician who performed or supervised the
3 test shares a practice; or

4 (ii) on a pre-paid, at-risk basis to the
5 person or entity who performs or super-
6 vises the test.

7 **SEC. 5113. TIMETABLES FOR ADOPTION OF STANDARDS.**

8 (a) INITIAL STANDARDS.—The Secretary shall adopt
9 standards relating to the data elements and transactions
10 for the information described in section 5112(a) not later
11 than 9 months after the date of the enactment of this sub-
12 title (except in the case of standards for claims attach-
13 ments which shall be adopted not later than 24 months
14 after the date of the enactment of this subtitle).

15 (b) ADDITIONS AND MODIFICATIONS TO STAND-
16 ARDS.—

17 (1) IN GENERAL.—Except as provided in para-
18 graph (2), the Secretary shall review the standards
19 adopted under this subtitle and shall adopt addi-
20 tional or modified standards as determined appro-
21 priate, but no more frequently than once every 6
22 months. Any addition or modification to standards
23 shall be completed in a manner which minimizes the
24 disruption and cost of compliance.

25 (2) SPECIAL RULES.—

1 (A) FIRST 12-MONTH PERIOD.—Except
2 with respect to additions and modifications to
3 code sets under subparagraph (B), the Sec-
4 retary shall not adopt any modifications to
5 standards adopted under this subtitle during
6 the 12-month period beginning on the date such
7 standards are adopted unless the Secretary de-
8 termines that a modification is necessary in
9 order to permit compliance with requirements
10 relating to the standards.

11 (B) ADDITIONS AND MODIFICATIONS TO
12 CODE SETS.—

13 (i) IN GENERAL.—The Secretary shall
14 ensure that procedures exist for the rou-
15 tine maintenance, testing, enhancement,
16 and expansion of code sets.

17 (ii) ADDITIONAL RULES.—If a code
18 set is modified under this subsection, the
19 modified code set shall include instructions
20 on how data elements that were encoded
21 prior to the modification are to be con-
22 verted or translated so as to preserve the
23 value of the data elements. Any modifica-
24 tion to a code set under this subsection
25 shall be implemented in a manner that

1 minimizes the disruption and cost of com-
2 plying with such modification.

3 (c) EVALUATION OF STANDARDS.—The Secretary
4 may establish a process to measure or verify the consist-
5 ency of standards adopted or modified under this subtitle.
6 Such process may include demonstration projects and
7 analysis of the cost of implementing such standards and
8 modifications.

9 **PART 3—REQUIREMENTS WITH RESPECT TO**
10 **CERTAIN TRANSACTIONS AND INFORMATION**

11 **SEC. 5121. REQUIREMENTS ON HEALTH PLANS.**

12 (a) IN GENERAL.—If a person desires to conduct any
13 of the transactions described in section 5112(a) with a
14 health plan as a standard transaction, the health plan
15 shall conduct such standard transaction in a timely man-
16 ner and the information transmitted or received in connec-
17 tion with such transaction shall be in the form of standard
18 data elements.

19 (b) SATISFACTION OF REQUIREMENTS.—A health
20 plan may satisfy the requirement imposed on such plan
21 under subsection (a) by directly transmitting standard
22 data elements or submitting nonstandard data elements
23 to a certified health information network service for proc-
24 essing into standard data elements and transmission.

1 **SEC. 5122. TIMETABLES FOR COMPLIANCE WITH REQUIRE-**
2 **MENTS.**

3 (a) INITIAL COMPLIANCE.—Not later than 12
4 months after the date on which standards are adopted
5 under part 2 with respect to any type of transaction or
6 data elements, a health plan shall comply with the require-
7 ments of this subtitle with respect to such transaction or
8 data elements.

9 (b) COMPLIANCE WITH MODIFIED STANDARDS.—

10 (1) IN GENERAL.—If the Secretary adopts a
11 modified standard under part 2, a health plan shall
12 be required to comply with the modified standard at
13 such time as the Secretary determines appropriate
14 taking into account the time needed to comply due
15 to the nature and extent of the modification.

16 (2) SPECIAL RULE.—In the case of modifica-
17 tions to standards that do not occur within the 12-
18 month period beginning on the date such standards
19 are adopted, the time determined appropriate by the
20 Secretary under paragraph (1) shall be no sooner
21 than the last day of the 90-day period beginning on
22 the date such modified standard is adopted and no
23 later than the last day of the 12 month period begin-
24 ning on the date such modified standard is adopted.

1 **PART 4—ACCESSING HEALTH INFORMATION**

2 **SEC. 5131. ACCESS FOR AUTHORIZED PURPOSES.**

3 (a) **IN GENERAL.**—The Secretary shall adopt tech-
4 nical standards for appropriate persons, including health
5 plans, health care providers, certified health information
6 network services, health researchers, and Federal and
7 State agencies, to locate and access the health information
8 that is available through the health information network
9 due to the requirements of this subtitle. Such technical
10 standards shall ensure that any request to locate or access
11 information shall be authorized under subtitle C.

12 (b) **GOVERNMENT AGENCIES.**—

13 (1) **IN GENERAL.**—Certified Health information
14 protection organizations shall make available to a
15 Federal or State agency pursuant to a Federal Ac-
16 quisition Regulation (or an equivalent State system),
17 any non-identifiable health information that is re-
18 quested by such agency.

19 (2) **CERTAIN INFORMATION AVAILABLE AT LOW**
20 **COST.**—If a health information protection organiza-
21 tion described in paragraph (1) needs information
22 from a health plan in order to comply with a request
23 of a Federal or State agency that is necessary to
24 comply with a requirement under this Act, such plan
25 shall make such information available to such orga-
26 nization for a charge that does not exceed the rea-

1 sonable cost of transmitting the information. An or-
2 ganization that receives information under the pre-
3 ceding sentence shall, upon request from any cer-
4 tified health information protection organization,
5 make such information available to such an organi-
6 zation for a charge that does not exceed the reason-
7 able cost of transmitting the information.

8 (c) **FUNCTIONAL SEPARATION.**—The standards
9 adopted by the Secretary under subsection (a) shall ensure
10 that any health information disclosed under such sub-
11 section shall not, after such disclosure, be used or released
12 for an administrative, regulatory, or law enforcement pur-
13 pose unless such disclosure was made for such purpose.

14 **SEC. 5132. RESPONDING TO ACCESS REQUESTS.**

15 (a) **IN GENERAL.**—The Secretary shall adopt, and
16 modify as appropriate, standards under which a health
17 plan shall respond to requests for access to health infor-
18 mation consistent with this subtitle and subtitle C.

19 (b) **STANDARDS DESCRIBED.**—The standards under
20 subsection (a) shall provide—

21 (1) for a standard format under which a plan
22 will respond to each request either by satisfying the
23 request or by responding with a negative response,
24 which may include an explanation of the failure to
25 satisfy the request; and

1 (1) such services have policies and security pro-
2 cedures that are consistent with the privacy require-
3 ments under subtitle C, including secure methods of
4 access to and transmission of data; and

5 (2) such services, if they are part of a larger or-
6 ganization, have policies and procedures in place
7 which isolate their activities with respect to process-
8 ing information in a manner that prevents unauthor-
9 ized access to such information by such larger orga-
10 nization.

11 (b) CERTIFICATION BY THE SECRETARY.—

12 (1) ESTABLISHMENT.—Not later than 12
13 months after the date of the enactment of this sub-
14 title, the Secretary shall establish a certification pro-
15 cedure for health information network services which
16 ensures that certified services are qualified to meet
17 the requirements of this subtitle.

18 (2) AUDITS AND REPORTS.—The procedure es-
19 tablished under paragraph (1) shall provide for au-
20 dits and reports as the Secretary determines appro-
21 priate in order to monitor such entity's compliance
22 with the requirements of this subtitle.

23 (c) LOSS OF CERTIFICATION.—

24 (1) MANDATORY TERMINATION.—If a health in-
25 formation network service violates a requirement im-

1 posed under subtitle C, its certification under this
2 section shall be terminated unless the Secretary de-
3 termines that appropriate corrective action has been
4 taken.

5 (2) DISCRETIONARY TERMINATION.—If a health
6 information network service violates a requirement
7 or standard imposed under this subtitle and a pen-
8 alty has been imposed under section 5151, the Sec-
9 retary shall review the certification of such service
10 and may terminate such certification.

11 (d) CERTIFICATION BY PRIVATE ENTITIES.—The
12 Secretary may designate private entities to conduct the
13 certification procedures established by the Secretary under
14 this section. A health information network service certified
15 by such an entity in accordance with such designation
16 shall be considered to be certified by the Secretary.

17 **SEC. 5142. ENSURING AVAILABILITY OF INFORMATION.**

18 The Secretary shall establish a procedure under
19 which a health plan which does not have the ability to
20 transmit standard data elements directly or does not have
21 access to a certified health information network service
22 shall be able to make health information available for dis-
23 closure as authorized by this subtitle.

PART 6—PENALTIES**SEC. 5151. GENERAL PENALTY FOR FAILURE TO COMPLY
WITH REQUIREMENTS AND STANDARDS.**

(a) IN GENERAL.—Except as provided in subsection (b), the Secretary shall impose on any person that violates a requirement or standard imposed under this subtitle a penalty of not more than \$1,000 for each violation. The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to the imposition of a civil money penalty under this subsection in the same manner as such provisions apply to the imposition of a penalty under section 1128A of the Social Security Act.

(b) LIMITATIONS.—

(1) NONCOMPLIANCE NOT DISCOVERED.—A penalty may not be imposed under subsection (a) if it is established to the satisfaction of the Secretary that the person liable for the penalty did not know, and by exercising reasonable diligence would not have known, that such person failed to comply with the requirement or standard described in subsection (a).

(2) FAILURES DUE TO REASONABLE CAUSE.—

(A) IN GENERAL.—Except as provided in subparagraph (B), a penalty may not be imposed under subsection (a) if—

1 (i) the failure to comply was due to
2 reasonable cause and not to willful neglect;
3 and

4 (ii) the failure to comply is corrected
5 during the 30-day period beginning on the
6 1st date the person liable for the penalty
7 knew, or by exercising reasonable diligence
8 would have known, that the failure to com-
9 ply occurred.

10 (B) EXTENSION OF PERIOD.—

11 (i) NO PENALTY.—The period re-
12 ferred to in subparagraph (A)(ii) may be
13 extended as determined appropriate by the
14 Secretary based on the nature and extent
15 of the failure to comply.

16 (ii) ASSISTANCE.—If the Secretary
17 determines that a health plan failed to
18 comply because such plan was unable to
19 comply, the Secretary may provide tech-
20 nical assistance to such plan during the pe-
21 riod described in clause (i). Such assist-
22 ance shall be provided in any manner de-
23 termined appropriate by the Secretary.

24 (3) REDUCTION.—In the case of a failure to
25 comply which is due to reasonable cause and not to

1 willful neglect, any penalty under subsection (a) that
2 is not entirely waived under paragraph (2) may be
3 waived to the extent that the payment of such pen-
4 alty would be excessive relative to the compliance
5 failure involved.

6 **PART 7—MISCELLANEOUS PROVISIONS**

7 **SEC. 5161. EFFECT ON STATE LAW.**

8 (a) IN GENERAL.—Except as provided in subsection
9 (b), a provision, requirement, or standard under this sub-
10 title shall supersede any contrary provision of State law,
11 including—

12 (1) a provision of State law that requires medi-
13 cal or health plan records (including billing informa-
14 tion) to be maintained or transmitted in written
15 rather than electronic form, and

16 (2) a provision of State law which provides for
17 requirements or standards that are more stringent
18 than the requirements or standards under this sub-
19 title;

20 except where the Secretary determines that the provision
21 is necessary to prevent fraud and abuse, with respect to
22 controlled substances, or for other purposes.

23 (b) PUBLIC HEALTH REPORTING.—Nothing in this
24 subtitle shall be construed to invalidate or limit the au-
25 thority, power, or procedures established under any law

1 providing for the reporting of disease or injury, child
2 abuse, birth, or death, public health surveillance, or public
3 health investigation or intervention.

4 **SEC. 5162. HEALTH INFORMATION CONTINUITY.**

5 (a) HEALTH PLANS.—If a health plan takes any ac-
6 tion that would threaten the continued availability of
7 standard data elements of health information held by such
8 plan, such data elements shall be transferred to a health
9 plan in accordance with procedures established by the Sec-
10 retary.

11 (b) HEALTH INFORMATION NETWORK SERVICES.—
12 If a certified health information network service loses its
13 certified status or takes any action that would threaten
14 the continued availability of the standard data elements
15 of health information held by such service, such data ele-
16 ments shall be transferred to another such service, as des-
17 ignated by the Secretary.

18 **SEC. 5163. HEALTH INFORMATION ADVISORY COMMITTEE.**

19 (a) ESTABLISHMENT.—There is established a com-
20 mittee to be known as the Health Information Advisory
21 Committee.

22 (b) DUTIES.—The committee shall—

23 (1) provide assistance to the Secretary in com-
24 plying with the requirements imposed on the Sec-
25 retary under this subtitle and subtitle C; and

1 (2) be generally responsible for advising the
2 Secretary and the Congress on the status and the
3 future of the health information network.

4 (c) MEMBERSHIP.—

5 (1) IN GENERAL.—The committee shall consist
6 of 15 members to be appointed by the President not
7 later than 60 days after the date of the enactment
8 of this subtitle. The President shall designate 1
9 member as the Chair.

10 (2) EXPERTISE.—The membership of the com-
11 mittee shall consist of individuals who are of recog-
12 nized standing and distinction in the areas of infor-
13 mation systems, consumer health, or privacy, and
14 who possess the demonstrated capacity to discharge
15 the duties imposed on the committee.

16 (3) TERMS.—Each member of the committee
17 shall be appointed for a term of 5 years, except that
18 the members first appointed shall serve staggered
19 terms such that the terms of no more than 3 mem-
20 bers expire at one time.

21 **SEC. 5164. AUTHORIZATION OF APPROPRIATIONS.**

22 There are authorized to be appropriated such sums
23 as may be necessary to carry out the purposes of this sub-
24 title.

1 **Subtitle C—Privacy of Health**
2 **Information**

3 **PART 1—DEFINITIONS**

4 **SEC. 5201. DEFINITIONS.**

5 For purposes of this subtitle:

6 (1) **PROTECTED HEALTH INFORMATION.**—The
7 term “protected health information” means any in-
8 formation, including demographic information col-
9 lected from an individual, whether oral or recorded
10 in any form or medium, that—

11 (A) is created or received by a health care
12 provider, health plan, health oversight agency,
13 health researcher, public health authority, em-
14 ployer, life insurer, school or university, or cer-
15 tified health information network service; and

16 (B) relates to the past, present, or future
17 physical or mental health or condition of an in-
18 dividual, the provision of health care to an indi-
19 vidual, or the past, present, or future payment
20 for the provision of health care to an individual,
21 and—

22 (i) identifies an individual; or

23 (ii) with respect to which there is a
24 reasonable basis to believe that the infor-

1 mation can be used to identify an individ-
2 ual.

3 (2) DISCLOSE.—The term “disclose”, when
4 used with respect to protected health information,
5 means to provide access to the information, but only
6 if such access is provided to a person other than the
7 individual who is the subject of the information.

8 (3) HEALTH INFORMATION TRUSTEE.—The
9 term “health information trustee” means—

10 (A) a health care provider, health plan,
11 health oversight agency, certified health infor-
12 mation network service, employer, life insurer,
13 or school or university insofar as it creates, re-
14 ceives, maintains, uses, or transmits protected
15 health information;

16 (B) any person who obtains protected
17 health information under section 5213, 5217,
18 5218, 5221, 5222, 5226, or 5231; and

19 (C) any employee or agent of a person cov-
20 ered under subparagraphs (A) or (B).

21 (4) HEALTH OVERSIGHT AGENCY.—The term
22 “health oversight agency” means a person who—

23 (A) performs or oversees the performance
24 of an assessment, evaluation, determination, or
25 investigation relating to the licensing, accredita-

1 tion, or certification of health care
2 providers; or

3 (B)(i) performs or oversees the perform-
4 ance of an assessment, evaluation, determina-
5 tion, investigation, or prosecution relating to
6 the effectiveness of, compliance with, or applica-
7 bility of legal, fiscal, medical, or scientific
8 standards or aspects of performance related to
9 the delivery of, or payment for health care,
10 health services, equipment, or research or relat-
11 ing to health care fraud or fraudulent claims
12 regarding health care, health services or equip-
13 ment, or related activities and items; and

14 (ii) is a public agency, acting on behalf of
15 a public agency, acting pursuant to a require-
16 ment of a public agency, or carrying out activi-
17 ties under a Federal or State law governing the
18 assessment, evaluation, determination, inves-
19 tigation, or prosecution described in clause (i).

20 (5) PUBLIC HEALTH AUTHORITY.—The term
21 “public health authority” means an authority or in-
22 strumentality of the United States, a State, or a po-
23 litical subdivision of a State that is (A) responsible
24 for public health matters; and (B) engaged in such
25 activities as injury reporting, public health surveil-

1 lance, and public health investigation or interven-
2 tion.

3 (6) INDIVIDUAL REPRESENTATIVE.—The term
4 “individual representative” means any individual le-
5 gally empowered to make decisions concerning the
6 provision of health care to an individual (where the
7 individual lacks the legal capacity under State law to
8 make such decisions) or the administrator or execu-
9 tor of the estate of a deceased individual.

10 (7) PERSON.—The term “person” includes an
11 authority of the United States, a State, or a political
12 subdivision of a State.

13 **PART 2—AUTHORIZED DISCLOSURES**

14 **Subpart A—General Provisions**

15 **SEC. 5206. GENERAL RULES REGARDING DISCLOSURE.**

16 (a) GENERAL RULE.—A health information trustee
17 may disclose protected health information only for a pur-
18 pose that is authorized under this subtitle.

19 (b) DISCLOSURE WITHIN A TRUSTEE.—A health in-
20 formation trustee may disclose protected health informa-
21 tion to an officer, employee, or agent of the trustee for
22 a purpose that is compatible with and related to the pur-
23 pose for which the information was collected or received
24 by that trustee.

1 (c) SCOPE OF DISCLOSURE.—Every disclosure of pro-
2 tected health information by a health information trustee
3 shall be limited to the minimum amount of information
4 necessary to accomplish the purpose for which the infor-
5 mation is disclosed.

6 (d) NO GENERAL REQUIREMENT TO DISCLOSE.—
7 Nothing in this subtitle that permits a disclosure of health
8 information shall be construed to require such disclosure.

9 (e) USE AND REDISCLOSURE OF INFORMATION.—
10 Protected health information about an individual that is
11 disclosed under this subtitle may not be used in, or dis-
12 closed to any person for use in, any administrative, civil,
13 or criminal action or investigation directed against the in-
14 dividual unless the action or investigation arises out of or
15 is directly related to the law enforcement inquiry for which
16 the information was obtained.

17 (f) IDENTIFICATION OF DISCLOSED INFORMATION AS
18 PROTECTED INFORMATION.—Except as provided in this
19 subtitle, a health information trustee may not disclose pro-
20 tected health information unless such information is clear-
21 ly identified as protected health information that is subject
22 to this subtitle.

23 (g) INFORMATION IN WHICH PROVIDERS ARE IDEN-
24 TIFIED.—The Secretary may issue regulations protecting

1 information identifying providers in order to promote the
2 availability of health care services.

3 **SEC. 5207. AUTHORIZATIONS FOR DISCLOSURE OF PRO-**
4 **TECTED HEALTH INFORMATION.**

5 A health information trustee may disclose protected
6 health information pursuant to an authorization executed
7 by the individual who is the subject of the information
8 pursuant to regulations issued by the Secretary with re-
9 gard to the form of such authorization, the information
10 that must be provided to the individual for authorization,
11 and the scope of the authorization.

12 **SEC. 5208. CERTIFIED HEALTH INFORMATION NETWORK**
13 **SERVICES.**

14 A health information trustee may disclose protected
15 health information to a certified health information pro-
16 tection organization for the purpose of creating non-identi-
17 fiable health information.

18 **Subpart B—Specific Disclosures Relating to Patient**

19 **SEC. 5211. DISCLOSURES FOR TREATMENT AND FINANCIAL**
20 **AND ADMINISTRATIVE TRANSACTIONS.**

21 (a) HEALTH CARE TREATMENT.—A health care pro-
22 vider, health plan, employer, or person who receives pro-
23 tected health information under section 5213, may dis-
24 close protected health information to a health care pro-
25 vider for the purpose of providing health care to an indi-

1 vidual if the individual who is the subject of the informa-
2 tion has been notified of the individual's right to object
3 and has not previously objected in writing to the disclo-
4 sure.

5 (b) DISCLOSURE FOR FINANCIAL AND ADMINISTRA-
6 TIVE PURPOSES.—A health care provider or employer may
7 disclose protected health information to a health care pro-
8 vider or health plan for the purpose of providing for the
9 payment for, or reviewing the payment of, health care fur-
10 nished to an individual.

11 **SEC. 5212. NEXT OF KIN AND DIRECTORY INFORMATION.**

12 (a) NEXT OF KIN.—A health care provider or person
13 who receives protected health information under section
14 5213 may disclose protected health information to the
15 next of kin, an individual representative of the individual
16 who is the subject of the information, or an individual with
17 whom that individual has a close personal relationship if—

18 (1) the individual who is the subject of the in-
19 formation—

20 (A) has been notified of the individual's
21 right to object and has not objected to the dis-
22 closure;

23 (B) is not competent to be notified about
24 the right to object; or

1 (C) exigent circumstances exist such that
2 it would not be practicable to notify the individ-
3 ual of the right to object; and

4 (2) the information disclosed relates to health
5 care currently being provided to that individual.

6 (b) DIRECTORY INFORMATION.—A health care pro-
7 vider and a person receiving protected health information
8 under section 5213 may disclose protected health informa-
9 tion to any person if—

10 (1) the information does not reveal specific in-
11 formation about the physical or mental condition of
12 the individual who is the subject of the information
13 or health care provided to that person;

14 (2) the individual who is the subject of the in-
15 formation—

16 (A) has been notified of the individual's
17 right to object and has not objected to the dis-
18 closure;

19 (B) is not competent to be notified about
20 the right to object; or

21 (C) exigent circumstances exist such that
22 it would not be practicable to notify the individ-
23 ual of the right to object; and

24 (3) the information consists only of 1 or more
25 of the following items:

1 (A) The name of the individual who is the
2 subject of the information.

3 (B) If the individual who is the subject of
4 the information is receiving health care from a
5 health care provider on a premises controlled by
6 the provider—

7 (i) the location of the individual on
8 the premises; and

9 (ii) the general health status of the in-
10 dividual, described as critical, poor, fair,
11 stable, or satisfactory or in terms denoting
12 similar conditions.

13 (c) IDENTIFICATION OF DECEASED INDIVIDUAL.—A
14 health care provider, health plan, employer, or life insurer,
15 may disclose protected health information if necessary to
16 assist in the identification of a deceased individual.

17 **SEC. 5213. EMERGENCY CIRCUMSTANCES.**

18 A health care provider, health plan, employer, or per-
19 son who receives protected health information under this
20 section may disclose protected health information in emer-
21 gency circumstances where there is a reasonable belief
22 that such information is needed to protect the health or
23 safety of an individual from imminent harm.

1 **Subpart C—Disclosure for Oversight, Public Health,**
2 **and Research Purposes**

3 **SEC. 5216. OVERSIGHT.**

4 (a) IN GENERAL.—A health information trustee may
5 disclose protected health information to a health oversight
6 agency for an oversight function authorized by law.

7 (b) USE IN ACTION AGAINST INDIVIDUALS.—Not-
8 withstanding section 5206(e), protected health informa-
9 tion about an individual that is disclosed under this sec-
10 tion may be used in, or disclosed in, an administrative,
11 civil, or criminal action or investigation directed against
12 the individual who is the subject of the information if the
13 action or investigation arises out of or is directly related
14 to—

15 (1) receipt of health care or payment for health
16 care;

17 (2) an action involving a fraudulent claim relat-
18 ed to health; or

19 (3) an action involving a misrepresentation of
20 the health of the individual who is the subject of the
21 information.

22 **SEC. 5217. PUBLIC HEALTH.**

23 A health care provider, health plan, public health au-
24 thority, employer, or person who receives protected health
25 information under section 5213 may disclose protected

1 health information to a public health authority or other
2 person authorized by law for use in a legally authorized—

3 (1) disease or injury reporting;

4 (2) public health surveillance; or

5 (3) public health investigation or intervention.

6 **SEC. 5218. HEALTH RESEARCH.**

7 (a) IN GENERAL.—A health information trustee may
8 disclose protected health information to a health re-
9 searcher if an institutional review board determines that
10 the research project engaged in by the health researcher—

11 (1) requires use of the protected health infor-
12 mation for the effectiveness of the project; and

13 (2) is of sufficient importance to outweigh the
14 intrusion into the privacy of the individual who is
15 the subject of the information that would result from
16 the disclosure.

17 (b) RESEARCH REQUIRING DIRECT CONTACT.—A
18 health care provider or health plan may disclose protected
19 health information to a health researcher for a research
20 project that includes direct contact with an individual who
21 is the subject of protected health information if an institu-
22 tional review board determines that direct contact is nec-
23 essary and will be made in a manner that minimizes the
24 risk of harm, embarrassment, or other adverse con-
25 sequences to the individual.

1 (c) SPECIAL RULE FOR TRUSTEES OTHER THAN
2 ACADEMIC CENTERS OR HEALTH CARE FACILITIES.—If
3 a health researcher described in subsection (a) or (b) is
4 not an academic center or a health care facility, the deter-
5 minations required by an institutional review board shall
6 be made by such a board that is certified by the Secretary.

7 (d) USE OF HEALTH INFORMATION NETWORK.—A
8 health information trustee may disclose protected health
9 information to a health researcher using the health infor-
10 mation network only if the research project satisfies re-
11 quirements established by the Secretary for protecting the
12 confidentiality of information in the health information
13 network.

14 **Subpart D—Disclosure For Judicial, Administrative,**
15 **and Law Enforcement Purposes**

16 **SEC. 5221. JUDICIAL AND ADMINISTRATIVE PURPOSES.**

17 A health care provider, health plan, health oversight
18 agency, employer, or life insurer may disclose protected
19 health information in connection with litigation or pro-
20 ceedings to which the individual who is the subject of the
21 information—

22 (1) is a party and in which the individual has
23 placed the individual's physical or mental condition
24 in issue; or

1 (2) is deceased and in which the individual's
2 physical or mental condition is in issue.

3 **SEC. 5222. LAW ENFORCEMENT.**

4 A health care provider, health plan, health oversight
5 agency, employer, life insurer, or person who receives pro-
6 tected health information under section 5213 may disclose
7 protected health information to a law enforcement agency
8 (other than a health oversight agency governed by section
9 5216) if the information is requested for use—

10 (1) in an investigation or prosecution of a
11 health information trustee;

12 (2) in the identification of a victim or witness
13 in a law enforcement inquiry;

14 (3) in connection with the investigation of
15 criminal activity committed against the trustee or on
16 premises controlled by the trustee; or

17 (4) in the investigation or prosecution of crimi-
18 nal activity relating to or arising from the provision
19 of health care or payment for health care.

20 **Subpart E—Disclosure Pursuant to Government**

21 **Subpoena or Warrant**

22 **SEC. 5226. GOVERNMENT SUBPOENAS AND WARRANTS.**

23 A health care provider, health plan, health oversight
24 agency, employer, life insurer, or person who receives pro-
25 tected health information under section 5213 shall disclose

1 protected health information under this section if the dis-
2 closure is pursuant to—

3 (1) a subpoena issued under the authority of a
4 grand jury;

5 (2) an administrative subpoena or summons or
6 a judicial subpoena or warrant; or

7 (3) an administrative subpoena or summons, a
8 judicial subpoena or warrant, or a grand jury sub-
9 poena, and the disclosure otherwise meets the condi-
10 tions of section 5216, 5217, 5218, 5221, or 5222.

11 **SEC. 5227. ACCESS PROCEDURES FOR LAW ENFORCEMENT**

12 **SUBPOENAS AND WARRANTS.**

13 (a) PROBABLE CAUSE REQUIREMENT.—A govern-
14 ment authority may not obtain protected health informa-
15 tion about an individual under paragraph (1) or (2) of
16 section 5226 for use in a law enforcement inquiry unless
17 there is probable cause to believe that the information is
18 relevant to a legitimate law enforcement inquiry being con-
19 ducted by the government authority.

20 (b) WARRANTS.—A government authority that ob-
21 tains protected health information about an individual
22 under circumstances described in subsection (a) and pur-
23 suant to a warrant shall, not later than 30 days after the
24 date the warrant was executed, serve the individual with,
25 or mail to the last known address of the individual, a no-

1 tice that protected health information about the individual
2 was so obtained, together with a notice of the individual's
3 right to challenge the warrant.

4 (c) SUBPOENA OR SUMMONS.—Except as provided in
5 subsection (d), a government authority may not obtain
6 protected health information about an individual under
7 circumstances described in subsection (a) and pursuant to
8 a subpoena or summons unless a copy of the subpoena
9 or summons has been served on the individual, if the iden-
10 tity of the individual is known, on or before the date of
11 return of the subpoena or summons, together with notice
12 of the individual's right to challenge the subpoena or sum-
13 mons. If the identity of the individual is not known at the
14 time the subpoena or summons is served, the individual
15 shall be served not later than 30 days thereafter, with no-
16 tice that protected health information about the individual
17 was so obtained together with notice of the individual's
18 right to challenge the subpoena or summons.

19 (d) APPLICATION FOR DELAY.—

20 (1) IN GENERAL.—A government authority may
21 apply ex parte and under seal to an appropriate
22 court to delay serving a notice or copy of a warrant,
23 subpoena, or summons required under subsection (b)
24 or (c).

1 (2) EX PARTE ORDER.—The court shall enter
2 an ex parte order delaying or extending the delay of
3 notice, an order prohibiting the disclosure of the re-
4 quest for, or disclosure of, the protected health in-
5 formation, and an order requiring the disclosure of
6 the protected health information if the court finds
7 that—

8 (A) the inquiry being conducted is within
9 the lawful jurisdiction of the government au-
10 thority seeking the protected health informa-
11 tion;

12 (B) there is probable cause to believe that
13 the protected health information being sought is
14 relevant to a legitimate law enforcement in-
15 quiry;

16 (C) the government authority's need for
17 the information outweighs the privacy interest
18 of the individual who is the subject of the infor-
19 mation; and

20 (D) there is reasonable ground to believe
21 that receipt of notice by the individual will re-
22 sult in—

23 (i) endangering the life or physical
24 safety of any individual;

25 (ii) flight from prosecution;

- 1 (iii) destruction of or tampering with
2 evidence or the information being sought;
- 3 (iv) intimidation of potential wit-
4 nesses; or
- 5 (v) disclosure of the existence or na-
6 ture of a confidential law enforcement in-
7 vestigation or grand jury investigation is
8 likely to seriously jeopardize such inves-
9 tigation.

10 **SEC. 5228. CHALLENGE PROCEDURES FOR LAW ENFORCE-**
11 **MENT WARRANTS, SUBPOENAS, AND SUM-**
12 **MONS.**

13 (a) MOTION TO QUASH.—Within 15 days after the
14 date of service of a notice of execution or a copy of a war-
15 rant, subpoena, or summons of a government authority
16 seeking protected health information about an individual
17 under paragraph (1) or (2) of section 5226, the individual
18 may file a motion to quash.

19 (b) STANDARD FOR DECISION.—The court shall
20 grant a motion under subsection (a) unless the govern-
21 ment demonstrates that there is probable cause to believe
22 the protected health information is relevant to a legitimate
23 law enforcement inquiry being conducted by the govern-
24 ment authority and the government authority's need for

1 the information outweighs the privacy interest of the indi-
2 vidual.

3 (c) ATTORNEY'S FEES.—In the case of a motion
4 brought under subsection (a) in which the individual has
5 substantially prevailed, the court may assess against the
6 government authority a reasonable attorney's fee and
7 other litigation costs (including expert's fees) reasonably
8 incurred.

9 (d) NO INTERLOCUTORY APPEAL.—A ruling denying
10 a motion to quash under this section shall not be deemed
11 to be a final order, and no interlocutory appeal may be
12 taken therefrom by the individual.

13 **Subpart F—Disclosure Pursuant to Party Subpoena**

14 **SEC. 5231. PARTY SUBPOENAS.**

15 A health care provider, health plan, employer, life in-
16 surer, or person who receives protected health information
17 under section 5213 may disclose protected health informa-
18 tion under this section if the disclosure is pursuant to a
19 subpoena issued on behalf of a party who has complied
20 with the access provisions of section 5232.

21 **SEC. 5232. ACCESS PROCEDURES FOR PARTY SUBPOENAS.**

22 A party may not obtain protected health information
23 about an individual pursuant to a subpoena unless a copy
24 of the subpoena together with a notice of the individual's
25 right to challenge the subpoena in accordance with section

1 5233 has been served upon the individual on or before the
2 date of return of the subpoena.

3 **SEC. 5233. CHALLENGE PROCEDURES FOR PARTY SUBPOE-**
4 **NAS.**

5 (a) MOTION TO QUASH SUBPOENA.—After service of
6 a copy of the subpoena seeking protected health informa-
7 tion under section 5231, the individual who is the subject
8 of the protected health information may file in any court
9 of competent jurisdiction a motion to quash the subpoena.

10 (b) STANDARD FOR DECISION.—The court shall
11 grant a motion under subsection (a) unless the respondent
12 demonstrates that—

13 (1) there is reasonable ground to believe the in-
14 formation is relevant to a lawsuit or other judicial
15 or administrative proceeding; and

16 (2) the need of the respondent for the informa-
17 tion outweighs the privacy interest of the individual.

18 (c) ATTORNEY'S FEES.—In the case of a motion
19 brought under subsection (a) in which the individual has
20 substantially prevailed, the court may assess against the
21 respondent a reasonable attorney's fee and other litigation
22 costs and expenses (including expert's fees) reasonably in-
23 curred.

1 **PART 3—PROCEDURES FOR ENSURING SECURITY**
2 **OF PROTECTED HEALTH INFORMATION**
3 **Subpart A—Establishment of Safeguards**

4 **SEC. 5236. ESTABLISHMENT OF SAFEGUARDS.**

5 A health information trustee shall establish and
6 maintain appropriate administrative, technical, and phys-
7 ical safeguards to ensure the integrity and confidentiality
8 of protected health information created or received by the
9 trustee.

10 **SEC. 5237. ACCOUNTING FOR DISCLOSURES.**

11 A health information trustee shall create and main-
12 tain, with respect to any protected health information dis-
13 closed in exceptional circumstances, a record of the disclo-
14 sure in accordance with regulations issued by the Sec-
15 retary.

16 **Subpart B—Review of Protected Health Information**
17 **By Subjects of the Information**

18 **SEC. 5241. INSPECTION OF PROTECTED HEALTH INFORMA-**
19 **TION.**

20 (a) IN GENERAL.—Except as provided in subsection
21 (b), a health care provider or health plan shall permit an
22 individual who is the subject of protected health informa-
23 tion or the individual's designee to inspect any such infor-
24 mation that the provider or plan maintains. A health care
25 provider or health plan may require an individual to reim-
26 burse the provider or plan for the cost of such inspection.

1 (b) EXCEPTIONS.—A health care provider or health
2 plan is not required by this section to permit inspection
3 or copying of protected health information if any of the
4 following conditions apply:

5 (1) MENTAL HEALTH TREATMENT NOTES.—

6 The information consists of psychiatric, psycho-
7 logical, or mental health treatment notes, and the
8 provider or plan determines, based on reasonable
9 medical judgment, that inspection or copying of the
10 notes would cause sufficient harm.

11 (2) ENDANGERMENT TO LIFE OR SAFETY.—

12 The provider or plan determines that disclosure of
13 the information could reasonably be expected to en-
14 danger the life or physical safety of any individual.

15 (3) CONFIDENTIAL SOURCE.—The information

16 identifies or could reasonably lead to the identifica-
17 tion of a person (other than a health care provider)
18 who provided information under a promise of con-
19 fidentiality to a health care provider concerning the
20 individual who is the subject of the information.

21 (4) ADMINISTRATIVE PURPOSES.—The informa-

22 tion is used by the provider or plan solely for admin-
23 istrative purposes and not in the provision of health
24 care to the individual who is the subject of the infor-
25 mation.

1 (c) DEADLINE.—A health care provider or health
2 plan shall comply with or deny (with a statement of the
3 reasons for such denial) a request for inspection or copy-
4 ing of protected health information under this section
5 within the 30-day period beginning on the date on which
6 the provider or plan receives the request.

7 **SEC. 5242. AMENDMENT OF PROTECTED HEALTH INFORMA-**
8 **TION.**

9 A health care provider or health plan shall, within
10 45 days after receiving a written request to correct or
11 amend protected health information from the individual
12 who is the subject of the information—

13 (1) correct or amend such information; or

14 (2) provide the individual with a statement of
15 the reasons for refusing to correct or amend such in-
16 formation and include a copy of such statement in
17 the provider's or plan's records.

18 **SEC. 5243. NOTICE OF INFORMATION PRACTICES.**

19 A health care provider or health plan shall provide
20 written notice of the provider's or plan's information prac-
21 tices, including notice of individual rights with respect to
22 protected health information.

1 **Subpart C—Standards for Electronic Disclosures**

2 **SEC. 5246. STANDARDS FOR ELECTRONIC DISCLOSURES.**

3 The Secretary shall promulgate standards for disclos-
4 ing protected health information in accordance with this
5 subtitle in electronic form.

6 **PART 4—SANCTIONS**

7 **Subpart A—No Sanctions for Permissible Actions**

8 **SEC. 5251. NO LIABILITY FOR PERMISSIBLE DISCLOSURES.**

9 A health information trustee who makes a disclosure
10 of protected health information about an individual that
11 is permitted by this subtitle shall not be liable to the indi-
12 vidual for the disclosure under common law and shall not
13 be subject to criminal prosecution under this subtitle.

14 **Subpart B—Civil Sanctions**

15 **SEC. 5256. CIVIL PENALTY.**

16 (a) VIOLATION.—Any health information trustee who
17 the Secretary determines has substantially and materially
18 failed to comply with this subtitle shall be subject, in addi-
19 tion to any other penalties that may be prescribed by law,
20 to a civil penalty of not more than \$10,000 for each such
21 violation.

22 (b) PROCEDURES FOR IMPOSITION OF PENALTIES.—
23 Section 1128A of the Social Security Act, other than sub-
24 sections (a) and (b) and the second sentence of subsection
25 (f) of that section, shall apply to the imposition of a civil
26 monetary penalty under this section in the same manner

1 as such provisions apply with respect to the imposition of
2 a penalty under section 1128A of such Act.

3 **SEC. 5257. CIVIL ACTION.**

4 (a) IN GENERAL.—An individual who is aggrieved by
5 negligent conduct in violation of this subtitle may bring
6 a civil action to recover—

7 (1) the greater of actual damages or liquidated
8 damages of \$5,000, not to exceed \$50,000;

9 (2) punitive damages;

10 (3) a reasonable attorney's fee and expenses of
11 litigation;

12 (4) costs of litigation; and

13 (5) such preliminary and equitable relief as the
14 court determines to be appropriate.

15 (b) LIMITATION.—No action may be commenced
16 under this section more than 3 years after the date on
17 which the violation was or should reasonably have been
18 discovered.

19 **Subpart C—Criminal Sanctions**

20 **SEC. 5261. WRONGFUL DISCLOSURE OF PROTECTED**
21 **HEALTH INFORMATION.**

22 (a) OFFENSE.—A person who knowingly—

23 (1) obtains protected health information relat-
24 ing to an individual in violation of this subtitle; or

1 (2) discloses protected health information to an-
2 other person in violation of this subtitle,
3 shall be punished as provided in subsection (b).

4 (b) PENALTIES.—A person described in subsection
5 (a) shall—

6 (1) be fined not more than \$50,000, imprisoned
7 not more than 1 year, or both;

8 (2) if the offense is committed under false pre-
9 tenses, be fined not more than \$100,000, imprisoned
10 not more than 5 years, or both; and

11 (3) if the offense is committed with intent to
12 sell, transfer, or use protected health information for
13 commercial advantage, personal gain, or malicious
14 harm, fined not more than \$250,000, imprisoned not
15 more than 10 years, or both.

16 **PART 5—ADMINISTRATIVE PROVISIONS**

17 **SEC. 5266. RELATIONSHIP TO OTHER LAWS.**

18 (a) STATE LAW.—Except as provided in subsections
19 (b), (c), and (d), this subtitle preempts State law.

20 (b) LAWS RELATING TO PUBLIC OR MENTAL
21 HEALTH.—Nothing in this subtitle shall be construed to
22 preempt or operate to the exclusion of any State law relat-
23 ing to public health or mental health that prevents or reg-
24 ulates disclosure of protected health information otherwise
25 allowed under this subtitle.

1 (c) PRIVILEGES.—Nothing in this subtitle is intended
2 to preempt or modify State common or statutory law to
3 the extent such law concerns a privilege of a witness or
4 person in a court of the State. This subtitle does not su-
5 percede or modify Federal common or statutory law to the
6 extent such law concerns a privilege of a witness or person
7 in a court of the United States. Authorizations pursuant
8 to section 5207 shall not be construed as a waiver of any
9 such privilege.

10 (d) CERTAIN DUTIES UNDER STATE OR FEDERAL
11 LAW.—This subtitle shall not be construed to preempt,
12 supersede, or modify the operation of—

13 (1) any law that provides for the reporting of
14 vital statistics such as birth or death information;

15 (2) any law requiring the reporting of abuse or
16 neglect information about any individual;

17 (3) subpart II of part E of title XXVI of the
18 Public Health Service Act (relating to notifications
19 of emergency response employees of possible expo-
20 sure to infectious diseases); or

21 (4) any Federal law or regulation governing
22 confidentiality of alcohol and drug patient records.

23 **SEC. 5267. RIGHTS OF INCOMPETENTS.**

24 (a) EFFECT OF DECLARATION OF INCOMPETENCE.—
25 Except as provided in section 5268, if an individual has

1 been declared to be incompetent by a court of competent
2 jurisdiction, the rights of the individual under this subtitle
3 shall be exercised and discharged in the best interests of
4 the individual through the individual's representative.

5 (b) NO COURT DECLARATION.—Except as provided
6 in section 5268, if a health care provider determines that
7 an individual, who has not been declared to be incom-
8 petent by a court of competent jurisdiction, suffers from
9 a medical condition that prevents the individual from act-
10 ing knowingly or effectively on the individual's own behalf,
11 the right of the individual to authorize disclosure may be
12 exercised and discharged in the best interest of the individ-
13 ual by the individual's representative.

14 **SEC. 5268. EXERCISE OF RIGHTS.**

15 (a) INDIVIDUALS WHO ARE 18 OR LEGALLY CAPA-
16 BLE.—In the case of an individual—

17 (1) who is 18 years of age or older, all rights
18 of the individual shall be exercised by the individual;

19 or

20 (2) who, acting alone, has the legal right, as de-
21 termined by State law, to apply for and obtain a
22 type of medical examination, care, or treatment and
23 who has sought such examination, care, or treat-
24 ment, the individual shall exercise all rights of an in-
25 dividual under this subtitle with respect to protected

1 health information relating to such examination,
2 care, or treatment.

3 (b) INDIVIDUALS UNDER 18.—Except as provided in
4 subsection (a)(2), in the case of an individual who is—

5 (1) under 14 years of age, all the individual’s
6 rights under this subtitle shall be exercised through
7 the parent or legal guardian of the individual; or

8 (2) 14, 15, 16, or 17 years of age, the rights
9 of inspection and amendment, and the right to au-
10 thorize disclosure of protected health information of
11 the individual may be exercised either by the individ-
12 ual or by the parent or legal guardian of the individ-
13 ual.

14 **Subtitle D—Health Care Fraud** 15 **Prevention**

16 **SEC. 5301. SHORT TITLE.**

17 This title may be cited as the “Health Care Fraud
18 Prevention Act of 1995”.

19 **PART A—ALL-PAYER FRAUD AND ABUSE** 20 **CONTROL PROGRAM**

21 **SEC. 5311. ALL-PAYER FRAUD AND ABUSE CONTROL PRO-**
22 **GRAM.**

23 (a) ESTABLISHMENT OF PROGRAM.—

24 (1) IN GENERAL.—Not later than January 1,
25 1996, the Secretary of Health and Human Services

1 (in this title referred to as the “Secretary”), acting
2 through the Office of the Inspector General of the
3 Department of Health and Human Services, and the
4 Attorney General shall establish a program—

5 (A) to coordinate Federal, State, and local
6 law enforcement programs to control fraud and
7 abuse with respect to the delivery of and pay-
8 ment for health care in the United States,

9 (B) to conduct investigations, audits, eval-
10 uations, and inspections relating to the delivery
11 of and payment for health care in the United
12 States,

13 (C) to facilitate the enforcement of the
14 provisions of sections 1128, 1128A, and 1128B
15 of the Social Security Act and other statutes
16 applicable to health care fraud and abuse, and

17 (D) to provide for the modification and es-
18 tablishment of safe harbors and to issue inter-
19 pretative rulings and special fraud alerts pursu-
20 ant to section 5313.

21 (2) COORDINATION WITH HEALTH PLANS.—In
22 carrying out the program established under para-
23 graph (1), the Secretary and the Attorney General
24 shall consult with, and arrange for the sharing of
25 data with representatives of health plans.

1 (3) REGULATIONS.—

2 (A) IN GENERAL.—The Secretary and the
3 Attorney General shall by regulation establish
4 standards to carry out the program under para-
5 graph (1).

6 (B) INFORMATION STANDARDS.—

7 (i) IN GENERAL.—Such standards
8 shall include standards relating to the fur-
9 nishing of information by health plans,
10 providers, and others to enable the Sec-
11 retary and the Attorney General to carry
12 out the program (including coordination
13 with health plans under paragraph (2)).

14 (ii) CONFIDENTIALITY.—Such stand-
15 ards shall include procedures to assure
16 that such information is provided and uti-
17 lized in a manner that appropriately pro-
18 tects the confidentiality of the information
19 and the privacy of individuals receiving
20 health care services and items.

21 (iii) QUALIFIED IMMUNITY FOR PRO-
22 VIDING INFORMATION.—The provisions of
23 section 1157(a) of the Social Security Act
24 (relating to limitation on liability) shall
25 apply to a person providing information to

1 the Secretary or the Attorney General in
2 conjunction with their performance of du-
3 ties under this section.

4 (C) DISCLOSURE OF OWNERSHIP INFOR-
5 MATION.—

6 (i) IN GENERAL.—Such standards
7 shall include standards relating to the dis-
8 closure of ownership information described
9 in clause (ii) by any entity providing health
10 care services and items.

11 (ii) OWNERSHIP INFORMATION DE-
12 SCRIBED.—The ownership information de-
13 scribed in this clause includes—

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

16 (II) the names and unique physi-
17 cian identification numbers of all phy-
18 sicians with a financial relationship
19 (as defined in section 1877(a)(2) of
20 the Social Security Act) with such en-
21 tity;

22 (III) the names of all other indi-
23 viduals with such an ownership or in-
24 vestment interest in such entity; and

1 (IV) any other ownership and re-
2 lated information required to be dis-
3 closed by such entity under section
4 1124 or section 1124A of the Social
5 Security Act, except that the Sec-
6 retary shall establish procedures
7 under which the information required
8 to be submitted under this subclause
9 will be reduced with respect to health
10 care provider entities that the Sec-
11 retary determines will be unduly bur-
12 dened if such entities are required to
13 comply fully with this subclause.

14 (4) AUTHORIZATION OF APPROPRIATIONS FOR
15 INVESTIGATORS AND OTHER PERSONNEL.—In addi-
16 tion to any other amounts authorized to be appro-
17 priated to the Secretary, the Attorney General, the
18 Director of the Federal Bureau of Investigation, and
19 the Inspectors General of the Departments of De-
20 fense, Labor, and Veterans Affairs and of the Office
21 of Personnel Management, for health care anti-fraud
22 and abuse activities for a fiscal year, there are au-
23 thorized to be appropriated additional amounts,
24 from the Health Care Fraud and Abuse Account de-
25 scribed in subsection (b), as may be necessary to en-

1 able the Secretary, the Attorney General, and such
2 Inspectors General to conduct investigations and au-
3 dits of allegations of health care fraud and abuse
4 and otherwise carry out the program established
5 under paragraph (1) in a fiscal year.

6 (5) ENSURING ACCESS TO DOCUMENTATION.—
7 The Inspector General of the Department of Health
8 and Human Services is authorized to exercise the
9 authority described in paragraphs (4) and (5) of sec-
10 tion 6 of the Inspector General Act of 1978 (relating
11 to subpoenas and administration of oaths) with re-
12 spect to the activities under the all-payer fraud and
13 abuse control program established under this sub-
14 section to the same extent as such Inspector General
15 may exercise such authorities to perform the func-
16 tions assigned by such Act.

17 (6) AUTHORITY OF INSPECTOR GENERAL.—
18 Nothing in this Act shall be construed to diminish
19 the authority of any Inspector General, including
20 such authority as provided in the Inspector General
21 Act of 1978.

22 (7) HEALTH PLAN DEFINED.—For the pur-
23 poses of this subsection, the term “health plan”
24 shall have the meaning given such term in section
25 1128(i) of the Social Security Act.

1 (b) HEALTH CARE FRAUD AND ABUSE CONTROL AC-
2 COUNT.—

3 (1) ESTABLISHMENT.—

4 (A) IN GENERAL.—There is hereby estab-
5 lished an account to be known as the “Health
6 Care Fraud and Abuse Control Account” (in
7 this section referred to as the “Anti-Fraud Ac-
8 count”). The Anti-Fraud Account shall consist
9 of—

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

12 (ii) such amounts as may be deposited
13 in the Anti-Fraud Account as provided in
14 subsection (a)(4), sections 5311(b) and
15 5312(b), and title XI of the Social Security
16 Act; and

17 (iii) such amounts as are transferred
18 to the Anti-Fraud Account under subpara-
19 graph (C).

20 (B) AUTHORIZATION TO ACCEPT GIFTS.—

21 The Anti-Fraud Account is authorized to accept
22 on behalf of the United States money gifts and
23 bequests made unconditionally to the Anti-
24 Fraud Account, for the benefit of the Anti-

1 Fraud Account or any activity financed through
2 the Anti-Fraud Account.

3 (C) TRANSFER OF AMOUNTS.—

4 (i) IN GENERAL.—The Secretary of
5 the Treasury shall transfer to the Anti-
6 Fraud Account an amount equal to the
7 sum of the following:

8 (I) Criminal fines imposed in
9 cases involving a Federal health care
10 offense (as defined in section
11 982(a)(6)(B) of title 18, United
12 States Code).

13 (ii) Administrative penalties and as-
14 sessments imposed under titles XI, XVIII,
15 and XIX of the Social Security Act (except
16 as otherwise provided by law).

17 (iii) Amounts resulting from the for-
18 feiture of property by reason of a Federal
19 health care offense.

20 (iv) Penalties and damages imposed
21 under the False Claims Act (31 U.S.C.
22 3729 et seq.), in cases involving claims re-
23 lated to the provision of health care items
24 and services (other than funds awarded to
25 a relator or for restitution).

1 (2) USE OF FUNDS.—

2 (A) IN GENERAL.—Amounts in the Anti-
3 Fraud Account shall be available to carry out
4 the health care fraud and abuse control pro-
5 gram established under subsection (a) (includ-
6 ing the administration of the program), and
7 may be used to cover costs incurred in operat-
8 ing the program, including costs (including
9 equipment, salaries and benefits, and travel and
10 training) of—

11 (i) prosecuting health care matters
12 (through criminal, civil, and administrative
13 proceedings);

14 (ii) investigations;

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

17 (iv) inspections and other evaluations;

18 and

19 (v) provider and consumer education
20 regarding compliance with the provisions of
21 this part.

22 (B) FUNDS USED TO SUPPLEMENT AGEN-
23 CY APPROPRIATIONS.—It is intended that dis-
24 bursements made from the Anti-Fraud Account
25 to any Federal agency be used to increase and

1 not supplant the recipient agency's appro-
2 priated operating budget.

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

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

9 (A) REIMBURSEMENTS FOR INVESTIGA-
10 TIONS.—The Inspector General is authorized to
11 receive and retain for current use reimburse-
12 ment for the costs of conducting investigations,
13 when such restitution is ordered by a court, vol-
14 untarily agreed to by the payer, or otherwise.

15 (B) CREDITING.—Funds received by the
16 Inspector General or the Inspectors General of
17 the Departments of Defense, Labor, and Veter-
18 ans Affairs and of the Office of Personnel Man-
19 agement, as reimbursement for costs of con-
20 ducting investigations shall be deposited to the
21 credit of the appropriation from which initially
22 paid, or to appropriations for similar purposes
23 currently available at the time of deposit, and
24 shall remain available for obligation for 1 year
25 from the date of their deposit.

1 **SEC. 5312. APPLICATION OF CERTAIN FEDERAL HEALTH**
2 **ANTI-FRAUD AND ABUSE SANCTIONS TO**
3 **FRAUD AND ABUSE AGAINST ANY HEALTH**
4 **PLAN.**

5 (a) **CRIMES.—**

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

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

11 (B) In subsection (a)(1)—

12 (i) by striking “title XVIII or” and
13 inserting “title XVIII,” and

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

17 (C) In subsection (a)(5), by striking “title
18 XVIII or a State health care program” and in-
19 sserting “title XVIII, a State health care pro-
20 gram, or a health plan”.

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

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

25 (ii) by inserting after “the State” the
26 following: “or the plan”.

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

5 “(f) The Secretary may—

6 “(1) in consultation with State and local health
7 care officials, identify opportunities for the satisfac-
8 tion of community service obligations that a court
9 may impose upon the conviction of an offense under
10 this section, and

11 “(2) make information concerning such oppor-
12 tunities available to Federal and State law enforce-
13 ment officers and State and local health care
14 officials.”.

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

19 “(i) HEALTH PLAN DEFINED.—For purposes of sec-
20 tions 1128A and 1128B, the term ‘health plan’ means a
21 plan that provides health benefits, whether through di-
22 rectly, through insurance, or otherwise, and includes a pol-
23 icy of health insurance, a contract of a service benefit or-
24 ganization, or a membership agreement with a health
25 maintenance organization or other prepaid health plan,

1 and also includes an employee welfare benefit plan or a
2 multiple employer welfare plan (as such terms are defined
3 in section 3 of the Employee Retirement Income Security
4 Act of 1974).”.

5 (c) EFFECTIVE DATE.—The amendments made by
6 this section shall take effect on January 1, 1996.

7 **SEC. 5313. HEALTH CARE FRAUD AND ABUSE GUIDANCE.**

8 (a) SOLICITATION AND PUBLICATION OF MODIFICA-
9 TIONS TO EXISTING SAFE HARBORS AND NEW SAFE
10 HARBORS.—

11 (1) IN GENERAL.—

12 (A) SOLICITATION OF PROPOSALS FOR
13 SAFE HARBORS.—Not later than January 1,
14 1996, and not less than annually thereafter, the
15 Secretary shall publish a notice in the Federal
16 Register soliciting proposals, which will be ac-
17 cepted during a 60-day period, for—

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

23 (ii) additional safe harbors specifying
24 payment practices that shall not be treated
25 as a criminal offense under section

1 1128B(b) of the Social Security Act the
2 (42 U.S.C. 1320a-7b(b)) and shall not
3 serve as the basis for an exclusion under
4 section 1128(b)(7) of such Act (42 U.S.C.
5 1320a-7(b)(7));

6 (iii) interpretive rulings to be issued
7 pursuant to subsection (b); and

8 (iv) special fraud alerts to be issued
9 pursuant to subsection (c).

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

24 (C) REPORT.—The Inspector General of
25 the Department of Health and Human Services

1 (hereafter in this section referred to as the “In-
2 spector General”) shall, in an annual report to
3 Congress or as part of the year-end semiannual
4 report required by section 5 of the Inspector
5 General Act of 1978 (5 U.S.C. App.), describe
6 the proposals received under clauses (i) and (ii)
7 of subparagraph (A) and explain which propos-
8 als were included in the publication described
9 in subparagraph (B), which proposals were not
10 included in that publication, and the reasons for
11 the rejection of the proposals that were not in-
12 cluded.

13 (2) CRITERIA FOR MODIFYING AND ESTABLISH-
14 ING SAFE HARBORS.—In modifying and establishing
15 safe harbors under paragraph (1)(B), the Secretary
16 may consider the extent to which providing a safe
17 harbor for the specified payment practice may result
18 in any of the following:

19 (A) An increase or decrease in access to
20 health care services.

21 (B) An increase or decrease in the quality
22 of health care services.

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

1 (D) An increase or decrease in competition
2 among health care providers.

3 (E) An increase or decrease in the ability
4 of health care facilities to provide services in
5 medically underserved areas or to medically un-
6 derserved populations.

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

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

11 (H) The existence or nonexistence of any
12 potential financial benefit to a health care pro-
13 fessional or provider which may vary based on
14 their decisions of—

15 (i) whether to order a health care
16 item or service; or

17 (ii) whether to arrange for a referral
18 of health care items or services to a par-
19 ticular practitioner or provider.

20 (I) Any other factors the Secretary deems
21 appropriate in the interest of preventing fraud
22 and abuse in Government health care programs.

23 (b) INTERPRETIVE RULINGS.—

24 (1) IN GENERAL.—

1 (A) REQUEST FOR INTERPRETIVE RUL-
2 ING.—Any person may present, at any time, a
3 request to the Inspector General for a state-
4 ment of the Inspector General’s current inter-
5 pretation of the meaning of a specific aspect of
6 the application of sections 1128A and 1128B of
7 the Social Security Act (hereafter in this sec-
8 tion referred to as an “interpretive ruling”).

9 (B) ISSUANCE AND EFFECT OF INTERPRE-
10 TIVE RULING.—

11 (i) IN GENERAL.—If appropriate, the
12 Inspector General shall in consultation
13 with the Attorney General, issue an inter-
14 pretive ruling in response to a request de-
15 scribed in subparagraph (A). Interpretive
16 rulings shall not have the force of law and
17 shall be treated as an interpretive rule
18 within the meaning of section 553(b) of
19 title 5, United States Code. All interpretive
20 rulings issued pursuant to this provision
21 shall be published in the Federal Register
22 or otherwise made available for public in-
23 spection.

24 (ii) REASONS FOR DENIAL.—If the In-
25 spector General does not issue an interpre-

1 tive ruling in response to a request de-
2 scribed in subparagraph (A), the Inspector
3 General shall notify the requesting party of
4 such decision and shall identify the reasons
5 for such decision.

6 (2) CRITERIA FOR INTERPRETIVE RULINGS.—

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

10 (i) whether and to what extent the re-
11 quest identifies an ambiguity within the
12 language of the statute, the existing safe
13 harbors, or previous interpretive rulings;
14 and

15 (ii) whether the subject of the re-
16 quested interpretive ruling can be ade-
17 quately addressed by interpretation of the
18 language of the statute, the existing safe
19 harbor rules, or previous interpretive rul-
20 ings, or whether the request would require
21 a substantive ruling not authorized under
22 this subsection.

23 (B) NO RULINGS ON FACTUAL ISSUES.—

24 The Inspector General shall not give an inter-
25 pretive ruling on any factual issue, including

1 the intent of the parties or the fair market
2 value of particular leased space or equipment.

3 (c) SPECIAL FRAUD ALERTS.—

4 (1) IN GENERAL.—

5 (A) REQUEST FOR SPECIAL FRAUD
6 ALERTS.—Any person may present, at any
7 time, a request to the Inspector General for a
8 notice which informs the public of practices
9 which the Inspector General considers to be
10 suspect or of particular concern under section
11 1128B(b) of the Social Security Act (42 U.S.C.
12 1320a–7b(b)) (hereafter in this subsection re-
13 ferred to as a “special fraud alert”).

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

1 (2) CRITERIA FOR SPECIAL FRAUD ALERTS.—

2 In determining whether to issue a special fraud alert
3 upon a request described in paragraph (1), the In-
4 spector General may consider—

5 (A) whether and to what extent the prac-
6 tices that would be identified in the special
7 fraud alert may result in any of the con-
8 sequences described in subsection (a)(2); and

9 (B) the volume and frequency of the con-
10 duct that would be identified in the special
11 fraud alert.

12 **SEC. 5314. REPORTING OF FRAUDULENT ACTIONS UNDER**
13 **MEDICARE.**

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

1 **PART B—REVISIONS TO CURRENT SANCTIONS**
2 **FOR FRAUD AND ABUSE**
3 **SEC. 5321. MANDATORY EXCLUSION FROM PARTICIPATION**
4 **IN MEDICARE AND STATE HEALTH CARE PRO-**
5 **GRAMS.**

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

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

12 “(3) FELONY CONVICTION RELATING TO
13 FRAUD.—Any individual or entity that has been con-
14 victed after the date of the enactment of the Health
15 Care Fraud Prevention Act of 1995, under Federal
16 or State law, in connection with the delivery of a
17 health care item or service or with respect to any act
18 or omission in a program (other than those specifi-
19 cally described in paragraph (1)) operated by or fi-
20 nanced in whole or in part by any Federal, State, or
21 local government agency, of a criminal offense con-
22 sisting of a felony relating to fraud, theft, embezzle-
23 ment, breach of fiduciary responsibility, or other fi-
24 nancial misconduct.”.

1 (2) CONFORMING AMENDMENT.—Section
2 1128(b)(1) of such Act (42 U.S.C. 1320a-7(b)(1))
3 is amended—

4 (A) in the heading, by striking “CONVIC-
5 TION” and inserting “MISDEMEANOR CONVIC-
6 TION”; and

7 (B) by striking “criminal offense” and in-
8 serting “criminal offense consisting of a mis-
9 demeanor”.

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

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

16 “(4) FELONY CONVICTION RELATING TO CON-
17 TROLLED SUBSTANCE.—Any individual or entity
18 that has been convicted after the date of the enact-
19 ment of the Health Care Fraud Prevention Act of
20 1995, under Federal or State law, of a criminal of-
21 fense consisting of a felony relating to the unlawful
22 manufacture, distribution, prescription, or dispens-
23 ing of a controlled substance.”.

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

4 (A) in the heading, by striking “CONVIC-
5 TION” and inserting “MISDEMEANOR CONVIC-
6 TION”; and

7 (B) by striking “criminal offense” and in-
8 serting “criminal offense consisting of a mis-
9 demeanor”.

10 **SEC. 5322. ESTABLISHMENT OF MINIMUM PERIOD OF EX-**
11 **CLUSION FOR CERTAIN INDIVIDUALS AND**
12 **ENTITIES SUBJECT TO PERMISSIVE EXCLU-**
13 **SION FROM MEDICARE AND STATE HEALTH**
14 **CARE PROGRAMS.**

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

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

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

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

11 **SEC. 5323. PERMISSIVE EXCLUSION OF INDIVIDUALS WITH**
12 **OWNERSHIP OR CONTROL INTEREST IN**
13 **SANCTIONED ENTITIES.**

14 Section 1128(b) of the Social Security Act (42 U.S.C.
15 1320a-7(b)) is amended by adding at the end the follow-
16 ing new paragraph:

17 “(15) INDIVIDUALS CONTROLLING A SANC-
18 TIONED ENTITY.—Any individual who has a direct
19 or indirect ownership or control interest of 5 percent
20 or more, or an ownership or control interest (as de-
21 fined in section 1124(a)(3)) in, or who is an officer,
22 director, agent, or managing employee (as defined in
23 section 1126(b)) of, an entity—

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

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

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

9 **SEC. 5324. SANCTIONS AGAINST PRACTITIONERS AND PER-**
10 **SONS FOR FAILURE TO COMPLY WITH STATU-**
11 **TORY OBLIGATIONS.**

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

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

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

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

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

8 (2) by striking the third sentence.

9 **SEC. 5325. INTERMEDIATE SANCTIONS FOR MEDICARE**
10 **HEALTH MAINTENANCE ORGANIZATIONS.**

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

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

23 “(A) has failed substantially to carry out
24 the contract;

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

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

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

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

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

23 “(ii) Civil money penalties of not more than
24 \$10,000 for each week beginning after the initiation
25 of procedures by the Secretary under paragraph (9)

1 during which the deficiency that is the basis of a
2 determination under paragraph (1) exists.

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

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

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

19 “(A) the Secretary provides the organization
20 with the opportunity to develop and implement a
21 corrective action plan to correct the deficiencies that
22 were the basis of the Secretary’s determination
23 under paragraph (1);

24 “(B) in deciding whether to impose sanctions,
25 the Secretary considers aggravating factors such as

1 whether an entity has a history of deficiencies or has
2 not taken action to correct deficiencies the Secretary
3 has brought to their attention;

4 “(C) there are no unreasonable or unnecessary
5 delays between the finding of a deficiency and the
6 imposition of sanctions; and

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

12 (4) CONFORMING AMENDMENTS.—Section
13 1876(i)(6)(B) of such Act (42 U.S.C.
14 1395mm(i)(6)(B)) is amended by striking the sec-
15 ond sentence.

16 (b) AGREEMENTS WITH PEER REVIEW ORGANIZA-
17 TIONS.—

18 (1) REQUIREMENT FOR WRITTEN AGREE-
19 MENT.—Section 1876(i)(7)(A) of the Social Security
20 Act (42 U.S.C. 1395mm(i)(7)(A)) is amended by
21 striking “an agreement” and inserting “a written
22 agreement”.

23 (2) DEVELOPMENT OF MODEL AGREEMENT.—
24 Not later than July 1, 1996, the Secretary shall de-
25 velop a model of the agreement that an eligible orga-

1 nization with a risk-sharing contract under section
2 1876 of the Social Security Act must enter into with
3 an entity providing peer review services with respect
4 to services provided by the organization under sec-
5 tion 1876(i)(7)(A) of such Act.

6 (3) REPORT BY GAO.—

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

19 (B) REPORT TO CONGRESS.—Not later
20 than July 1, 1998, the Comptroller General
21 shall submit a report to the Committee on
22 Ways and Means and the Committee on Energy
23 and Commerce of the House of Representatives
24 and the Committee on Finance and the Special

1 Committee on Aging of the Senate on the study
2 conducted under subparagraph (A).

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

6 **SEC. 5326. EFFECTIVE DATE.**

7 The amendments made by this part shall take effect
8 January 1, 1996.

9 **PART C—ADMINISTRATIVE AND MISCELLANEOUS**
10 **PROVISIONS**

11 **SEC. 5331. ESTABLISHMENT OF THE HEALTH CARE FRAUD**
12 **AND ABUSE DATA COLLECTION PROGRAM.**

13 (a) GENERAL PURPOSE.—Not later than January 1,
14 1996, the Secretary shall establish a national health care
15 fraud and abuse data collection program for the reporting
16 of final adverse actions (not including settlements in which
17 no findings of liability have been made) against health
18 care providers, suppliers, or practitioners as required by
19 subsection (b), with access as set forth in subsection (c).

20 (b) REPORTING OF INFORMATION.—

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

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

4 (A) The name of any health care provider,
5 supplier, or practitioner who is the subject of a
6 final adverse action.

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

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

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

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

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

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

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

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

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

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

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

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

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

3 (d) ACCESS TO REPORTED INFORMATION.—

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

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

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

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

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

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

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

7 (C) Actions by Federal or State agencies
8 responsible for the licensing and certification of
9 health care providers, suppliers, and licensed
10 health care practitioners, including—

11 (i) formal or official actions, such as
12 revocation or suspension of a license (and
13 the length of any such suspension), rep-
14 rimand, censure or probation,

15 (ii) any other loss of license of the
16 provider, supplier, or practitioner, by oper-
17 ation of law, or

18 (iii) any other negative action or find-
19 ing by such Federal or State agency that
20 is publicly available information.

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

23 (E) Any other adjudicated actions or deci-
24 sions that the Secretary shall establish by regu-
25 lation.

1 (2) The terms “licensed health care practi-
2 tioner”, “licensed practitioner”, and “practitioner”
3 mean, with respect to a State, an individual who is
4 licensed or otherwise authorized by the State to pro-
5 vide health care services (or any individual who,
6 without authority holds himself or herself out to be
7 so licensed or authorized).

8 (3) The term “health care provider” means a
9 provider of services as defined in section 1861(u) of
10 the Social Security Act, and any entity, including a
11 health maintenance organization, group medical
12 practice, or any other entity listed by the Secretary
13 in regulation, that provides health care services.

14 (4) The term “supplier” means a supplier of
15 health care items and services described in section
16 1819(a) and (b), and section 1861 of the Social Se-
17 curity Act.

18 (5) The term “Government agency” shall in-
19 clude:

20 (A) The Department of Justice.

21 (B) The Department of Health and
22 Human Services.

23 (C) Any other Federal agency that either
24 administers or provides payment for the deliv-
25 ery of health care services, including, but not

1 limited to the Department of Defense and the
2 Veterans' Administration.

3 (D) State law enforcement agencies.

4 (E) State medicaid fraud and abuse units.

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

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

11 (7) For purposes of paragraph (2), the exist-
12 ence of a conviction shall be determined under para-
13 graph (4) of section 1128(j) of the Social Security
14 Act.

15 (g) CONFORMING AMENDMENT.—Section 1921(d) of
16 the Social Security Act is amended by inserting "and sec-
17 tion 301 of the Health Care Fraud Prevention Act of
18 1995" after "section 422 of the Health Care Quality Im-
19 provement Act of 1986".

20 **PART D—CIVIL MONETARY PENALTIES**

21 **SEC. 5341. CIVIL MONETARY PENALTIES.**

22 (a) GENERAL CIVIL MONETARY PENALTIES.—Sec-
23 tion 1128A of the Social Security Act (42 U.S.C. 1320a-
24 7a) is amended as follows:

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

4 (2) In subsection (f)—

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

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

9 “(3) With respect to amounts recovered arising
10 out of a claim under a health plan, the portion of
11 such amounts as is determined to have been paid by
12 the plan shall be repaid to the plan, and the portion
13 of such amounts attributable to the amounts recover-
14 ed under this section by reason of the amendments
15 made by the Health Care Fraud Prevention Act of
16 1995 (as estimated by the Secretary) shall be depos-
17 ited into the Health Care Fraud and Abuse Control
18 Account established under section 101(b) of such
19 Act.”.

20 (3) In subsection (i)—

21 (A) in paragraph (2), by inserting “or
22 under a health plan” before the period at the
23 end, and

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

1 (b) EXCLUDED INDIVIDUAL RETAINING OWNERSHIP
2 OR CONTROL INTEREST IN PARTICIPATING ENTITY.—
3 Section 1128A(a) of the Social Security Act (42 U.S.C.
4 1320a–7a(a)) is amended—

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

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

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

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

13 “(4) in the case of a person who is not an orga-
14 nization, agency, or other entity, is excluded from
15 participating in a program under title XVIII or a
16 State health care program in accordance with this
17 subsection or under section 1128 and who, at the
18 time of a violation of this subsection, retains a direct
19 or indirect ownership or control interest of 5 percent
20 or more, or an ownership or control interest (as de-
21 fined in section 1124(a)(3)) in, or who is an officer,
22 director, agent, or managing employee (as defined in
23 section 1126(b)) of, an entity that is participating in
24 a program under title XVIII or a State health care
25 program;”.

1 (c) MODIFICATIONS OF AMOUNTS OF PENALTIES
2 AND ASSESSMENTS.—Section 1128A(a) of the Social Se-
3 curity Act (42 U.S.C. 1320a–7a(a)), as amended by sub-
4 section (b), is amended in the matter following paragraph
5 (4)—

6 (1) by striking “\$2,000” and inserting
7 “\$10,000”;

8 (2) by inserting “; in cases under paragraph
9 (4), \$10,000 for each day the prohibited relationship
10 occurs” after “false or misleading information was
11 given”; and

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

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

18 (1) in subparagraph (A) by striking “claimed,”
19 and inserting the following: “claimed, including any
20 person who repeatedly presents or causes to be pre-
21 sented a claim for an item or service that is based
22 on a code that the person knows or should know will
23 result in a greater payment to the person than the
24 code the person knows or should know is applicable
25 to the item or service actually provided,”;

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

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

5 (4) by inserting after subparagraph (D) the fol-
6 lowing new subparagraph:

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

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

14 “(3) Any person (including any organization,
15 agency, or other entity, but excluding a beneficiary
16 as defined in subsection (i)(5)) who the Secretary
17 determines has violated section 1128B(b) of this
18 title shall be subject to a civil monetary penalty of
19 not more than \$10,000 for each such violation. In
20 addition, such person shall be subject to an assess-
21 ment of not more than twice the total amount of the
22 remuneration offered, paid, solicited, or received in
23 violation of section 1128B(b). The total amount of
24 remuneration subject to an assessment shall be cal-
25 culated without regard to whether some portion

1 thereof also may have been intended to serve a pur-
2 pose other than one proscribed by section
3 1128B(b).”.

4 (f) SANCTIONS AGAINST PRACTITIONERS AND PER-
5 SONS FOR FAILURE TO COMPLY WITH STATUTORY OBLI-
6 GATIONS.—Section 1156(b)(3) of the Social Security Act
7 (42 U.S.C. 1320c-5(b)(3)) is amended by striking “the
8 actual or estimated cost” and inserting the following: “up
9 to \$10,000 for each instance”.

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

13 “(D) The provisions of section 1128A (other than
14 subsections (a) and (b)) shall apply to a civil money pen-
15 alty under subparagraph (A) or (B) in the same manner
16 as they apply to a civil money penalty or proceeding under
17 section 1128A(a).”.

18 (h) PROHIBITION AGAINST OFFERING INDUCEMENTS
19 TO INDIVIDUALS ENROLLED UNDER PROGRAMS OR
20 PLANS.—

21 (1) OFFER OF REMUNERATION.—Section
22 1128A(a) of the Social Security Act (42 U.S.C.
23 1320a-7a(a)) is amended—

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

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

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

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

7 “(4) offers to or transfers remuneration to any
8 individual eligible for benefits under title XVIII of
9 this Act, or under a State health care program (as
10 defined in section 1128(h)) that such person knows
11 or should know is likely to influence such individual
12 to order or receive from a particular provider, practi-
13 tioner, or supplier any item or service for which pay-
14 ment may be made, in whole or in part, under title
15 XVIII, or a State health care program;”.

16 (2) REMUNERATION DEFINED.—Section
17 1128A(i) of such Act (42 U.S.C. 1320a–7a(i)) is
18 amended by adding the following new paragraph:

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

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

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

3 “(ii) the person does not routinely
4 waive coinsurance or deductible amounts;
5 and

6 “(iii) the person—

7 “(I) waives the coinsurance and
8 deductible amounts after determining
9 in good faith that the individual is in
10 financial need;

11 “(II) fails to collect coinsurance
12 or deductible amounts after making
13 reasonable collection efforts; or

14 “(III) provides for any permis-
15 sible waiver as specified in section
16 1128B(b)(3) or in regulations issued
17 by the Secretary;

18 “(B) differentials in coinsurance and de-
19 ductible amounts as part of a benefit plan de-
20 sign as long as the differentials have been dis-
21 closed in writing to all third party payors to
22 whom claims are presented and as long as the
23 differentials meet the standards as defined in
24 regulations promulgated by the Secretary; or

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

4 (i) EFFECTIVE DATE.—The amendments made by
5 this section shall take effect January 1, 1996.

6 **PART E—AMENDMENTS TO CRIMINAL LAW**

7 **SEC. 5351. HEALTH CARE FRAUD.**

8 (a) IN GENERAL.—

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

13 **“§ 1347. Health care fraud**

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

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

19 “(2) to obtain, by means of false or fraudulent
20 pretenses, representations, or promises, any of the
21 money or property owned by, or under the custody
22 or control of, any health plan, or person in connec-
23 tion with the delivery of or payment for health care
24 benefits, items, or services;

1 shall be fined under this title or imprisoned not more than
2 10 years, or both. If the violation results in serious bodily
3 injury (as defined in section 1365(g)(3) of this title), such
4 person shall be imprisoned for any term of years.

5 “(b) For purposes of this section, the term ‘health
6 plan’ has the same meaning given such term in section
7 1128(i) of the Social Security Act.”.

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

“1347. Health care fraud.”.

12 (b) CRIMINAL FINES DEPOSITED IN THE HEALTH
13 CARE FRAUD AND ABUSE CONTROL ACCOUNT.—The Sec-
14 retary of the Treasury shall deposit into the Health Care
15 Fraud and Abuse Control Account established under sec-
16 tion 5311(b) an amount equal to the criminal fines im-
17 posed under section 1347 of title 18, United States Code
18 (relating to health care fraud).

19 **SEC. 5352. FORFEITURES FOR FEDERAL HEALTH CARE OF-**
20 **FENSES.**

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

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

4 “(i) is used in the commission of the offense if
5 the offense results in a financial loss or gain of
6 \$50,000 or more; or

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

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

12 “(i) section 1347 of this title;

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

14 “(iii) sections 287, 371, 664, 666, 1001, 1027,
15 1341, 1343, or 1954 of this title if the violation or
16 conspiracy relates to health care fraud; and

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

20 (b) PROPERTY FORFEITED DEPOSITED IN HEALTH
21 CARE FRAUD AND ABUSE CONTROL ACCOUNT.—The Sec-
22 retary of the Treasury shall deposit into the Health Care
23 Fraud and Abuse Control Account established under sec-
24 tion 5311(b) an amount equal to amounts resulting from
25 forfeiture of property by reason of a Federal health care

1 offense pursuant to section 982(a)(6) of title 18, United
2 States Code.

3 **SEC. 5353. INJUNCTIVE RELIEF RELATING TO FEDERAL**
4 **HEALTH CARE OFFENSES.**

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

7 (1) by striking “or” at the end of subparagraph
8 (A);

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

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

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

15 (b) FREEZING OF ASSETS.—Section 1345(a)(2) of
16 title 18, United States Code, is amended by inserting “or
17 a Federal health care offense (as defined in section
18 982(a)(6)(B))” after “title”.

19 **SEC. 5354. GRAND JURY DISCLOSURE.**

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

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

24 (2) by inserting after subsection (b) the follow-
25 ing:

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

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

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

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

11 **SEC. 5355. FALSE STATEMENTS.**

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

15 **“§ 1033. False statements relating to health care mat-
16 ters**

17 “Whoever, in any matter involving a health plan,
18 knowingly and willfully falsifies, conceals, or covers up by
19 any trick, scheme, or device a material fact, or makes any
20 false, fictitious, or fraudulent statements or representa-
21 tions, or makes or uses any false writing or document
22 knowing the same to contain any false, fictitious, or fraud-
23 ulent statement or entry, shall be fined under this title
24 or imprisoned not more than 5 years, or both.”.

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

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

4 **SEC. 5356. VOLUNTARY DISCLOSURE PROGRAM.**

5 In consultation with the Attorney General of the
6 United States, the Secretary of Health and Human Serv-
7 ices shall publish proposed regulations not later than 9
8 months after the date of enactment of this Act, and final
9 regulations not later than 18 months after such date of
10 enactment, establishing a program of voluntary disclosure
11 that would facilitate the enforcement of sections 1128A
12 and 1128B of the Social Security Act (42 U.S.C. 1320a-
13 7a and 1320a-7b) and other relevant provisions of Fed-
14 eral law relating to health care fraud and abuse. Such pro-
15 gram should promote and provide incentives for disclo-
16 sures of potential violations of such sections and provi-
17 sions by providing that, under certain circumstances, the
18 voluntary disclosure of wrongdoing would result in the im-
19 position of penalties and punishments less substantial
20 than those that would be assessed for the same wrong-
21 doing if voluntary disclosure did not occur.

1 **SEC. 5357. OBSTRUCTION OF CRIMINAL INVESTIGATIONS**
2 **OF FEDERAL HEALTH CARE OFFENSES.**

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

6 **“§1518. Obstruction of Criminal Investigations of**
7 **Federal Health Care Offenses.**

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

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

18 “(c) CRIMINAL INVESTIGATOR.—As used in this sec-
19 tion the term ‘criminal investigator’ means any individual
20 duly authorized by a department, agency, or armed force
21 of the United States to conduct or engage in investigations
22 for prosecutions for violations of health care offenses.”.

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

“1518. Obstruction of Criminal Investigations of Federal Health Care Offenses.”.

1 **SEC. 5358. THEFT OR EMBEZZLEMENT.**

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

5 **“§ 669. Theft or Embezzlement in Connection with**
6 **Health Care.**

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

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

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

“669. Theft or Embezzlement in Connection with Health Care.”.

1 **SEC. 5359. LAUNDERING OF MONETARY INSTRUMENTS.**

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

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

9 **PART F—PAYMENTS FOR STATE HEALTH CARE**
10 **FRAUD CONTROL UNITS**

11 **SEC. 5361. ESTABLISHMENT OF STATE FRAUD UNITS.**

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

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

22 **SEC. 5362. REQUIREMENTS FOR STATE FRAUD UNITS.**

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

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

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

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

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

8 (1) be a Unit of the office of the State Attorney
9 General or of another department of State govern-
10 ment which possesses statewide authority to pros-
11 ecute individuals for criminal violations;

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

20 (3) have a formal working relationship with the
21 office of the State Attorney General or the appro-
22 priate authority or authorities for prosecution and
23 have formal procedures (including procedures for its
24 referral of suspected criminal violations to such of-
25 fice) which provide effective coordination of activities

1 between the Fraud Unit and such office with respect
2 to the detection, investigation, and prosecution of
3 suspected criminal violations relating to any Feder-
4 ally-funded or mandated health care programs.

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

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

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

13 (d) COOPERATIVE AGREEMENTS; MEMORANDA OF
14 UNDERSTANDING.—The State Fraud Unit shall have co-
15 operative agreements with—

16 (1) Federally-funded or mandated health care
17 programs.

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

22 (3) the Secretary.

23 (e) REPORTS.—The State Fraud Unit shall submit
24 to the Secretary an application and an annual report con-
25 taining such information as the Secretary determines to

1 be necessary to determine whether the State Fraud Unit
2 meets the requirements of this section.

3 (f) FUNDING SOURCE; PARTICIPATION IN ALL-
4 PAYER PROGRAM.—In addition to those sums expended
5 by a State under section 5364(a) for purposes of deter-
6 mining the amount of the Secretary's payments, a State
7 Fraud Unit may receive funding for its activities from
8 other sources, the identity of which shall be reported to
9 the Secretary in its application or annual report. The
10 State Fraud Unit shall participate in the all-payer fraud
11 and abuse control program established under section
12 5311.

13 **SEC. 5363. SCOPE AND PURPOSE.**

14 The State Fraud Unit shall carry out the following
15 activities:

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

24 (2) The State Fraud Unit shall have procedures
25 for reviewing complaints of the abuse or neglect of

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

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

14 **SEC. 5364. PAYMENTS TO STATES.**

15 (a) MATCHING PAYMENTS TO STATES.—Subject to
16 subsection (c), for each year for which a State has a State
17 Fraud Unit approved under section 5362(b) in operation
18 the Secretary shall provide for a payment to the State for
19 each quarter in a fiscal year in an amount equal to the
20 applicable percentage of the sums expended during the
21 quarter by the State Fraud Unit.

22 (b) APPLICABLE PERCENTAGE DEFINED.—

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

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

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

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

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

19 **TITLE VI—MALPRACTICE**
20 **REFORM**

21 **SEC. 6001. ALTERNATIVE DISPUTE RESOLUTION.**

22 (a) ESTABLISHMENT.—The Secretary of Health and
23 Human Services (hereafter referred to in this title as the
24 “Secretary”) shall establish a program of grants to assist

1 States in establishing alternative dispute resolution sys-
2 tems.

3 (b) USE OF FUNDS.—A State may use a grant
4 awarded under subsection (a) to establish alternative dis-
5 pute resolution systems that—

6 (1) identify claims of professional negligence
7 that merit compensation;

8 (2) encourage early resolution of meritorious
9 claims prior to commencement of a lawsuit; and

10 (3) encourage early withdrawal or dismissal of
11 nonmeritorious claims.

12 (c) AWARD OF GRANTS.—The Secretary shall allo-
13 cate grants under this section in accordance with criteria
14 issued by the Secretary.

15 (d) APPLICATION.—To be eligible to receive a grant
16 under this section, a State, acting through the appropriate
17 State health authority, shall submit an application at such
18 time, in such manner, and containing such agreements,
19 assurances, and information as the Assistant Secretary
20 determines to be necessary to carry out this section, in-
21 cluding an assurance that the State system meets the re-
22 quirements of section 6002.

23 (e) AUTHORIZATION OF APPROPRIATIONS.—There
24 are authorized to be appropriated to carry out this section

1 such sums as may be necessary for each of the 1996
2 through 1999 fiscal years.

3 **SEC. 6002. BASIC REQUIREMENTS.**

4 A State's alternative dispute resolution system meets
5 the requirements of this section if the system—

6 (1) applies to all medical malpractice liability
7 claims under the jurisdiction of the courts of that
8 State;

9 (2) requires that a written opinion resolving the
10 dispute be issued not later than 6 months after the
11 date by which each party against whom the claim is
12 filed has received notice of the claim (other than in
13 exceptional cases for which a longer period is re-
14 quired for the issuance of such an opinion), and that
15 the opinion contain—

16 (A) findings of fact relating to the dispute,
17 and

18 (B) a description of the costs incurred in
19 resolving the dispute under the system (includ-
20 ing any fees paid to the individuals hearing and
21 resolving the claim), together with an appro-
22 priate assessment of the costs against any of
23 the parties;

24 (3) requires individuals who hear and resolve
25 claims under the system to meet such qualifications

1 as the State may require (in accordance with regula-
2 tions of the Secretary);

3 (4) is approved by the State or by local govern-
4 ments in the State;

5 (5) with respect to a State system that consists
6 of multiple dispute resolution procedures—

7 (A) permits the parties to a dispute to se-
8 lect the procedure to be used for the resolution
9 of the dispute under the system, and

10 (B) if the parties do not agree on the pro-
11 cedure to be used for the resolution of the dis-
12 pute, assigns a particular procedure to the par-
13 ties;

14 (6) provides for the transmittal to the State
15 agency responsible for monitoring or disciplining
16 health care professionals and health care providers
17 of any findings made under the system that such a
18 professional or provider committed malpractice, un-
19 less, during the 90-day period beginning on the date
20 the system resolves the claim against the profes-
21 sional or provider, the professional or provider
22 brings an action contesting the decision made under
23 the system; and

24 (7) provides for the regular transmittal to the
25 Administrator for Health Care Policy and Research

1 of information on disputes resolved under the sys-
2 tem, in a manner that assures that the identity of
3 the parties to a dispute shall not be revealed.

4 **SEC. 6003. ALTERNATIVE DISPUTE RESOLUTION ADVISORY**
5 **BOARD.**

6 (a) ESTABLISHMENT.—Not later than 1 year after
7 the date of the enactment of this Act, the Secretary shall
8 establish an Alternative Dispute Resolution Advisory
9 Board to advise the Secretary regarding the establishment
10 of alternative dispute resolution systems at the State and
11 Federal levels.

12 (b) COMPOSITION.—The ADR Advisory Board shall
13 be composed of members appointed by the Secretary from
14 among representatives of the following:

15 (1) Physicians.

16 (2) Hospitals.

17 (3) Patient advocacy groups.

18 (4) State governments.

19 (5) Academic experts from applicable disciplines
20 (including medicine, law, public health, and econom-
21 ics) and specialists in arbitration and dispute resolu-
22 tion.

23 (6) Health insurers and medical malpractice in-
24 surers.

25 (7) Medical product manufacturers.

1 (8) Pharmaceutical companies.

2 (9) Other professions and groups determined
3 appropriate by the Secretary.

4 (c) DUTIES.—The ADR Advisory Board shall—

5 (1) examine various dispute resolution systems
6 and provide advice and assistance to States regard-
7 ing the establishment of such systems;

8 (2) not later than 1 year after the appointment
9 of its members, submit to the Secretary—

10 (A) a model alternative dispute resolution
11 system that may be used by a State for pur-
12 poses of this title, and

13 (B) a model alternative Federal system
14 that may be used by the Secretary; and

15 (3) review the applications of States for certifi-
16 cation of State alternative dispute resolution systems
17 and make recommendations to the Secretary regard-
18 ing whether the systems should be certified under
19 section 6004.

20 **SEC. 6004. CERTIFICATION OF STATE SYSTEMS; APPLICA-**
21 **BILITY OF ALTERNATIVE FEDERAL SYSTEM.**

22 (a) CERTIFICATION.—

23 (1) APPLICATION BY STATE.—Each State shall
24 submit an application to the ADR Advisory Board
25 describing its alternative dispute resolution system

1 and containing such information as the ADR Advi-
2 sory Board may require to make a recommendation
3 regarding whether the system meets the require-
4 ments of this title.

5 (2) BASIS FOR CERTIFICATION.—Not later than
6 October 1 of each year (beginning with 1995), the
7 Secretary, taking into consideration the rec-
8 ommendations of the ADR Advisory Board, shall
9 certify a State’s alternative dispute resolution sys-
10 tem under this subsection for the following calendar
11 year if the Secretary determines that the system
12 meets the requirements of section 6002.

13 (b) APPLICABILITY OF ALTERNATIVE FEDERAL SYS-
14 TEM.—

15 (1) ESTABLISHMENT AND APPLICABILITY.—
16 Not later than October 1, 1995, the Secretary, tak-
17 ing into consideration the model alternative Federal
18 system submitted by the ADR Advisory Board under
19 section 6003(c)(2)(B), shall establish by rule an al-
20 ternative Federal ADR system for the resolution of
21 medical malpractice liability claims during a cal-
22 endar year in States that do not have in effect an
23 alternative dispute resolution system certified under
24 subsection (a) for the year.

1 (2) REQUIREMENTS FOR SYSTEM.—Under the
2 alternative Federal ADR system established under
3 paragraph (1)—

4 (A) paragraphs (1), (2), (6), and (7) of
5 section 6002(a) shall apply to claims brought
6 under the system;

7 (B) if the system provides for the resolu-
8 tion of claims through arbitration, the claims
9 brought under the system shall be heard and
10 resolved by arbitrators appointed by the Sec-
11 retary in consultation with the Attorney Gen-
12 eral; and

13 (C) with respect to a State in which the
14 system is in effect, the Secretary may (at the
15 State's request) modify the system to take into
16 account the existence of dispute resolution pro-
17 cedures in the State that affect the resolution
18 of medical malpractice liability claims.

19 (3) TREATMENT OF STATES WITH ALTER-
20 NATIVE SYSTEM IN EFFECT.—If the alternative Fed-
21 eral ADR system established under this subsection is
22 applied with respect to a State for a calendar year,
23 the State shall make a payment to the United States
24 (at such time and in such manner as the Secretary
25 may require) in an amount equal to 110 percent of

1 the costs incurred by the United States during the
2 year as a result of the application of the system with
3 respect to the State.

4 **SEC. 6005. REPORTS ON IMPLEMENTATION AND EFFEC-**
5 **TIVENESS OF ALTERNATIVE DISPUTE RESO-**
6 **LUTION SYSTEMS.**

7 (a) IN GENERAL.—Not later than 5 years after the
8 date of the enactment of this Act, the Secretary shall pre-
9 pare and submit to the Congress a report describing and
10 evaluating State alternative dispute resolution systems op-
11 erated pursuant to this title and the alternative Federal
12 system established under section 6004(b).

13 (b) CONTENTS OF REPORT.—The Secretary shall in-
14 clude in the report prepared and submitted under sub-
15 section (a)—

16 (1) information on—

17 (A) the effect of the alternative dispute
18 resolution systems on the cost of health care
19 within each State,

20 (B) the impact of such systems on the ac-
21 cess of individuals to health care within the
22 State, and

23 (C) the effect of such systems on the qual-
24 ity of health care provided within the State; and

1 (2) to the extent that such report does not pro-
2 vide information on no-fault systems operated by
3 States as alternative dispute resolution systems pur-
4 suant to this part, an analysis of the feasibility and
5 desirability of establishing a system under which
6 medical malpractice liability claims shall be resolved
7 on a no-fault basis.

8 **SEC. 6006. OPTIONAL APPLICATION OF PRACTICE GUIDE-**
9 **LINES.**

10 (a) DEVELOPMENT AND CERTIFICATION OF GUIDE-
11 LINES.—Each State may develop, for certification by the
12 Secretary if the Secretary determines appropriate, a set
13 of specialty clinical practice guidelines.

14 (b) PROVISION OF HEALTH CARE UNDER GUIDE-
15 LINES.—Notwithstanding any other provision of law, in
16 any medical malpractice liability action arising from the
17 conduct of a health care provider or health care profes-
18 sional, if such conduct was in accordance with a guideline
19 developed by the State in which the conduct occurred and
20 certified by the Secretary under subsection (a), the guide-
21 line—

22 (1) may be introduced by any party to the ac-
23 tion (including a health care provider, health care
24 professional, or patient); and

1 (2) if introduced, shall establish a rebuttable
2 presumption that the conduct was in accordance
3 with the appropriate standard of medical care, which
4 may only be overcome by the presentation of clear
5 and convincing evidence on behalf of the party
6 against whom the presumption operates.

7 (c) RESTRICTION ON PARAMETERS CONSIDERED AP-
8 PROPRIATE.—

9 (1) PARAMETERS SANCTIONED BY SEC-
10 RETARY.—For purposes of subsection (a), a spe-
11 cialty clinical practice guideline may not be consid-
12 ered appropriate with respect to actions brought
13 during a year unless the Secretary has sanctioned
14 the use of the guideline for purposes of an affirma-
15 tive defense to medical malpractice liability actions
16 brought during the year in accordance with para-
17 graph (2).

18 (2) PROCESS FOR SANCTIONING PARAM-
19 ETERS.—Not less frequently than October 1 of each
20 year (beginning with 1996), the Secretary shall re-
21 view the practice guidelines and standards submitted
22 by the State under subsection (a), and shall sanction
23 those guidelines which the Secretary considers ap-
24 propriate for purposes of an affirmative defense to
25 medical malpractice liability actions brought during

1 the next calendar year as appropriate practice pa-
 2 rameters for purposes of subsection (a).

3 (d) PROHIBITING APPLICATION OF FAILURE TO FOL-
 4 LOW PARAMETERS AS PRIMA FACIE EVIDENCE OF NEG-
 5 LIGENCE.—No plaintiff in a medical malpractice liability
 6 action may be deemed to have presented prima facie evi-
 7 dence that a defendant was negligent solely by showing
 8 that the defendant failed to follow the appropriate practice
 9 guidelines.

10 **TITLE VII—HEALTH PROMOTION**
 11 **AND DISEASE PREVENTION**

12 **SEC. 7001. DISEASE PREVENTION AND HEALTH PRO-**
 13 **MOTION PROGRAMS TREATED AS MEDICAL**
 14 **CARE.**

15 (a) IN GENERAL.—For purposes of section 213(d)(1)
 16 of the Internal Revenue Code of 1986 (defining medical
 17 care), qualified expenditures (as defined by the Secretary
 18 of Health and Human Services) for disease prevention and
 19 health promotion programs shall be considered amounts
 20 paid for medical care.

21 (b) EFFECTIVE DATE.—Subsection (a) shall apply to
 22 amounts paid in taxable years beginning after December
 23 31, 1995.

1 **SEC. 7002. WORKSITE WELLNESS GRANT PROGRAM.**

2 (a) GRANTS.—The Secretary of Health and Human
3 Services (hereafter referred to in this title as the “Sec-
4 retary”) shall award grants to States (through State
5 health departments or other State agencies working in
6 consultation with the State health agency) to enable such
7 States to provide assistance to businesses with not to ex-
8 ceed 100 employees for the establishment and operation
9 of worksite wellness programs for their employees.

10 (b) APPLICATION.—To be eligible for a grant under
11 subsection (a), a State shall prepare and submit to the
12 Secretary an application at such time, in such manner,
13 and containing such information as the Secretary may re-
14 quire, including—

15 (1) a description of the manner in which the
16 State intends to use amounts received under the
17 grant; and

18 (2) assurances that the State will only use
19 amounts provided under such grant to provide as-
20 sistance to businesses that can demonstrate that
21 they are in compliance with minimum program char-
22 acteristics (relative to scope and regularity of serv-
23 ices offered) that are developed by the Secretary in
24 consultation with experts in public health and rep-
25 resentatives of small business.

1 Grants shall be distributed to States based on the popu-
2 lation of individuals employed by small businesses.

3 (c) PROGRAM CHARACTERISTICS.—In developing
4 minimum program characteristics under subsection (b)(2),
5 the Secretary shall ensure that all activities established or
6 enhanced under a grant under this section have clearly
7 defined goals and objectives and demonstrate how receipt
8 of such assistance will help to achieve established State
9 or local health objectives based on the National Health
10 Promotion and Disease Prevention Objectives.

11 (d) USE OF FUNDS.—Amounts received under a
12 grant awarded under subsection (a) shall be used by a
13 State to provide grants to businesses (as described in sub-
14 section (a)), nonprofit organizations, or public authorities,
15 or to operate State-run worksite wellness programs.

16 (e) SPECIAL EMPHASIS.—In funding business work-
17 site wellness projects under this section, a State shall give
18 special emphasis to—

19 (1) the development of joint wellness programs
20 between employers;

21 (2) the development of employee assistance pro-
22 grams dealing with substance abuse;

23 (3) maximizing the use and coordination with
24 existing community resources such as nonprofit
25 health organizations; and

1 (4) encourage participation of dependents of
2 employees and retirees in wellness programs.

3 (f) AUTHORIZATION OF APPROPRIATIONS.—There
4 are authorized to be appropriated to carry out this section,
5 such sums as may be necessary in each of the fiscal years
6 1995 through 1999.

7 **SEC. 7003. EXPANDING AND IMPROVING SCHOOL HEALTH**
8 **EDUCATION.**

9 (a) AUTHORIZATION OF APPROPRIATIONS.—There
10 are authorized to be appropriated to carry out subsection
11 (b), such sums as may be necessary for each of the fiscal
12 years 1995 through 1999.

13 (b) GENERAL USE OF FUNDS.—The Secretary shall
14 use amounts appropriated under subsection (a) to expand
15 comprehensive school health education programs adminis-
16 tered by the Centers for Disease Control and Prevention
17 under sections 301 and 311 of the Public Health Service
18 Act (42 U.S.C. 241 and 243).

19 (c) SPECIFIC USE OF FUNDS.—In meeting the re-
20 quirement of subsection (b), the Secretary shall expand
21 the number of children receiving planned, sequential kin-
22 dergarten through 12th grade comprehensive school edu-
23 cation as a component of comprehensive programs of
24 school health, including—

1 (1) physical education programs that promote
2 lifelong physical activity;

3 (2) healthy school food service selections;

4 (3) programs that promote a healthy and safe
5 school environment;

6 (4) schoolsite health promotion for faculty and
7 staff;

8 (5) integrated school and community health
9 promotion efforts; and

10 (6) school nursing disease prevention and
11 health promotion services.

12 (d) COORDINATION OF EXISTING PROGRAMS.—The
13 Secretary of Health and Human Services, the Secretary
14 of Education and the Secretary of Agriculture shall work
15 cooperatively to coordinate existing school health edu-
16 cation programs within their Departments in a manner
17 that maximized the efficiency and effectiveness of Federal
18 expenditures in this area.

19 **TITLE VIII—TAX INCENTIVES**
20 **FOR LONG-TERM CARE**

21 **SEC. 8001. SHORT TITLE.**

22 This title may be cited as the “Private Long-Term
23 Care Family Protection Act of 1995”.

1 **SEC. 8002. AMENDMENT OF 1986 CODE.**

2 Except as otherwise expressly provided, whenever in
3 this title an amendment or repeal is expressed in terms
4 of an amendment to, or repeal of, a section or other provi-
5 sion, the reference shall be considered to be made to a
6 section or other provision of the Internal Revenue Code
7 of 1986.

8 **Subtitle A—Tax Treatment of Long-**
9 **Term Care Insurance**

10 **SEC. 8101. QUALIFIED LONG-TERM CARE SERVICES TREAT-**
11 **ED AS MEDICAL CARE.**

12 (a) GENERAL RULE.—Paragraph (1) of section
13 213(d) (defining medical care) is amended by striking
14 “or” at the end of subparagraph (B), by striking subpara-
15 graph (C), and by inserting after subparagraph (B) the
16 following new subparagraphs:

17 “(C) for qualified long-term care services
18 (as defined in subsection (f)),

19 “(D) for insurance covering medical care
20 referred to in—

21 “(i) subparagraphs (A) and (B), or

22 “(ii) subparagraph (C), but only if
23 such insurance is provided under a quali-
24 fied long-term care insurance policy (as de-
25 fined in section 7702B(b)) and the deduc-
26 tion under this section for amounts paid

1 for such insurance is not disallowed under
2 section 7702B(d)(4), or

3 “(E) for premiums under part B of title
4 XVIII of the Social Security Act, relating to
5 supplementary medical insurance for the
6 aged.”.

7 (b) QUALIFIED LONG-TERM CARE SERVICES DE-
8 FINED.—Section 213 (relating to the deduction for medi-
9 cal, dental, etc., expenses) is amended by adding at the
10 end the following new subsection:

11 “(f) QUALIFIED LONG-TERM CARE SERVICES.—For
12 purposes of this section—

13 “(1) IN GENERAL.—The term ‘qualified long-
14 term care services’ means necessary diagnostic, cur-
15 ing, mitigating, treating, preventive, therapeutic, and
16 rehabilitative services, and maintenance and per-
17 sonal care services (whether performed in a residen-
18 tial or nonresidential setting), which—

19 “(A) are required by an individual during
20 any period the individual is an incapacitated in-
21 dividual (as defined in paragraph (2)),

22 “(B) have as their primary purpose—

23 “(i) the provision of needed assistance
24 with 1 or more activities of daily living (as
25 defined in paragraph (3)), or

1 “(ii) protection from threats to health
2 and safety due to severe cognitive impair-
3 ment, and

4 “(C) are provided pursuant to a continuing
5 plan of care prescribed by a licensed profes-
6 sional (as defined in paragraph (4)).

7 “(2) INCAPACITATED INDIVIDUAL.—The term
8 ‘incapacitated individual’ means any individual who
9 has been certified by a licensed professional as—

10 “(A) being unable to perform, without sub-
11 stantial assistance from another individual, at
12 least 2 activities of daily living (as defined in
13 paragraph (3)),

14 “(B) having moderate cognitive impair-
15 ment as defined by the Secretary in consulta-
16 tion with the Secretary of Health and Human
17 Services, or

18 “(C) having a level of disability similar (as
19 determined by the Secretary in consultation
20 with the Secretary of Health and Human Serv-
21 ices) to the level of disability described in sub-
22 paragraph (A).

23 “(3) ACTIVITIES OF DAILY LIVING.—

24 “(A) IN GENERAL.—Each of the following
25 is an activity of daily living:

1 “(i) Eating.

2 “(ii) Toileting.

3 “(iii) Transferring.

4 “(iv) Bathing.

5 “(v) Dressing.

6 “(vi) Continence.

7 “(B) DEFINITIONS.—For purposes of this
8 paragraph:

9 “(i) EATING.—The term ‘eating’
10 means the process of getting food from a
11 plate or its equivalent into the mouth.

12 “(ii) TOILETING.—The term
13 ‘toileting’ means the act of going to the
14 toilet room for bowel and bladder function,
15 transferring on and off of the toilet, clean-
16 ing oneself after elimination, and arrang-
17 ing clothes.

18 “(iii) TRANSFERRING.—The term
19 ‘transferring’ means the process of getting
20 in and out of bed or in and out of a chair
21 or wheelchair.

22 “(iv) BATHING.—The term ‘bathing’
23 means the overall complex behavior of
24 using water for cleansing the whole body,
25 including cleansing as part of a bath,

1 shower, or sponge bath, getting to, in, and
2 out of a tub or shower, and washing and
3 drying oneself.

4 “(v) DRESSING.—The term ‘dressing’
5 means the overall complex behavior of get-
6 ting clothes from closets and drawers and
7 then getting dressed.

8 “(vi) CONTINENCE.—The term ‘con-
9 tinence’ means the ability to voluntarily
10 control bowel and bladder function and to
11 maintain a reasonable level of personal hy-
12 giene.

13 “(4) LICENSED PROFESSIONAL.—

14 “(A) IN GENERAL.—The term ‘licensed
15 professional’ means—

16 “(i) a physician or registered profes-
17 sional nurse,

18 “(ii) a qualified community care case
19 manager (as defined in subparagraph (B)),
20 or

21 “(iii) any other individual who meets
22 such requirements as may be prescribed by
23 the Secretary after consultation with the
24 Secretary of Health and Human Services.

1 “(B) QUALIFIED COMMUNITY CARE CASE
2 MANAGER.—The term ‘qualified community
3 care case manager’ means an individual or en-
4 tity which—

5 “(i) has experience or has been
6 trained in providing case management
7 services and in preparing individual care
8 plans,

9 “(ii) has experience in assessing indi-
10 viduals to determine their functional and
11 cognitive impairment, and

12 “(iii) meets such requirements as may
13 be prescribed by the Secretary after con-
14 sultation with the Secretary of Health and
15 Human Services.

16 “(5) CERTAIN SERVICES NOT INCLUDED.—The
17 term ‘qualified long-term care services’ shall not in-
18 clude any services provided to an individual—

19 “(A) by a relative (directly or through a
20 partnership, corporation, or other entity) unless
21 the relative is a licensed professional with re-
22 spect to such services, or

23 “(B) by a corporation or partnership which
24 is related (within the meaning of section 267(b)
25 or 707(b)) to the individual.

1 For purposes of this paragraph, the term ‘relative’
2 means an individual bearing a relationship to the in-
3 dividual which is described in paragraphs (1)
4 through (8) of section 152(a).”.

5 (c) TECHNICAL AMENDMENTS.—Paragraph (6) of
6 section 213(d) is amended—

7 (1) by striking “subparagraphs (A) and (B)”
8 and inserting “subparagraphs (A), (B), and (C)”,
9 and

10 (2) by striking “paragraph (1)(C) applies” in
11 subparagraph (A) and inserting “subparagraphs (C)
12 and (D) of paragraph (1) apply”.

13 **SEC. 8102. TREATMENT OF LONG-TERM CARE INSURANCE.**

14 (a) GENERAL RULE.—Chapter 79 (relating to defini-
15 tions) is amended by inserting after section 7702A the fol-
16 lowing new section:

17 **“SEC. 7702B. TREATMENT OF LONG-TERM CARE INSUR-**
18 **ANCE.**

19 “(a) IN GENERAL.—For purposes of this subtitle—

20 “(1) a qualified long-term care insurance policy
21 (as defined in subsection (b)) shall be treated as an
22 accident and health insurance contract,

23 “(2) any plan of an employer providing cov-
24 erage under a qualified long-term care insurance pol-

1 icy shall be treated as an accident and health plan
2 with respect to such coverage,

3 “(3) amounts (other than policyholder dividends
4 (as defined in section 808) or premium refunds) re-
5 ceived under a qualified long-term care insurance
6 policy (including nonreimbursement payments de-
7 scribed in subsection (b)(6)) shall be treated—

8 “(A) as amounts received for personal in-
9 juries and sickness, and

10 “(B) as amounts received for the perma-
11 nent loss of a function of the body and as
12 amounts computed with reference to the nature
13 of injury under section 105(c) to the extent
14 that such amounts do not exceed the dollar
15 amount in effect under subsection (f) for the
16 taxable year,

17 “(4) amounts paid for a qualified long-term
18 care insurance policy described in subsection (b)(11)
19 shall be treated as payments made for insurance for
20 purposes of section 213(d)(1)(D), and

21 “(5) a qualified long-term care insurance policy
22 shall be treated as a guaranteed renewable contract
23 subject to the rules of section 816(e).

24 “(b) QUALIFIED LONG-TERM CARE INSURANCE POL-
25 ICY.—For purposes of this title—

1 “(1) IN GENERAL.—The term ‘qualified long-
2 term care insurance policy’ means any long-term
3 care insurance policy (as defined in paragraph (10))
4 that—

5 “(A) limits benefits under such policy to
6 incapacitated individuals (as defined in section
7 213(f)(2)), and

8 “(B) satisfies the requirements of para-
9 graphs (2) through (9).

10 “(2) PREMIUM REQUIREMENTS.—The require-
11 ments of this paragraph are met with respect to a
12 long-term care insurance policy if such policy pro-
13 vides that premium payments may not be made ear-
14 lier than the date such payments would have been
15 made if the policy provided for level annual pay-
16 ments over the life expectancy of the insured or 20
17 years, whichever is shorter. A policy shall not be
18 treated as failing to meet the requirements of the
19 preceding sentence solely by reason of a provision in
20 the policy providing for a waiver of premiums if the
21 insured becomes an incapacitated individual (as de-
22 fined in section 213(f)(2)).

23 “(3) PROHIBITION OF CASH VALUE.—The re-
24 quirements of this paragraph are met with respect
25 to a long-term care insurance policy if such policy

1 does not provide for a cash value or other money
2 that can be paid, assigned, pledged as collateral for
3 a loan, or borrowed, other than as provided in para-
4 graph (4).

5 “(4) REFUNDS OF PREMIUMS AND DIVI-
6 DENDS.—The requirements of this paragraph are
7 met with respect to a long-term care insurance pol-
8 icy if such policy provides that—

9 “(A) policyholder dividends are required to
10 be applied as a reduction in future premiums or
11 to increase benefits described in subsection
12 (a)(2),

13 “(B) refunds of premiums upon a partial
14 surrender or a partial cancellation are required
15 to be applied as a reduction in future pre-
16 miums, and

17 “(C) any refund on the death of the in-
18 sured, or on a complete surrender or cancella-
19 tion of the policy, cannot exceed the aggregate
20 premiums paid under the policy.

21 Any refund on a complete surrender or cancellation
22 of the policy shall be includable in gross income to
23 the extent that any deduction or exclusion was allow-
24 able with respect to the premiums.

1 “(5) COORDINATION WITH OTHER ENTITLED-
2 MENTS.—The requirements of this paragraph are
3 met with respect to a long-term care insurance pol-
4 icy if such policy does not cover expenses incurred
5 to the extent that such expenses are also covered
6 under title XVIII of the Social Security Act. For
7 purposes of this paragraph, a long-term care insur-
8 ance policy which coordinates expenses incurred
9 under such policy with expenses incurred under title
10 XVIII of such Act shall not be considered to dupli-
11 cate such expenses.

12 “(6) REQUIREMENTS OF MODEL REGULATION
13 AND ACT.—

14 “(A) IN GENERAL.—The requirements of
15 this paragraph are met with respect to a long-
16 term care insurance policy if such policy
17 meets—

18 “(i) MODEL REGULATION.—The fol-
19 lowing requirements of the model regula-
20 tion:

21 “(I) Section 7A (relating to guar-
22 anteed renewal or noncancellability),
23 and the requirements of section 6B of
24 the model Act relating to such section
25 7A.

1 “(II) Section 7B (relating to pro-
2 hibitions on limitations and exclu-
3 sions).

4 “(III) Section 7C (relating to ex-
5 tension of benefits).

6 “(IV) Section 7D (relating to
7 continuation or conversion of cov-
8 erage).

9 “(V) Section 7E (relating to dis-
10 continuance and replacement of poli-
11 cies).

12 “(VI) Section 8 (relating to unin-
13 tentional lapse).

14 “(VII) Section 9 (relating to dis-
15 closure), other than section 9F there-
16 of.

17 “(VIII) Section 10 (relating to
18 prohibitions against post-claims un-
19 derwriting).

20 “(IX) Section 11 (relating to
21 minimum standards).

22 “(X) Section 12 (relating to re-
23 quirement to offer inflation protec-
24 tion), except that any requirement for
25 a signature on a rejection of inflation

1 protection shall permit the signature
2 to be on an application or on a sepa-
3 rate form.

4 “(XI) Section 23 (relating to pro-
5 hibition against preexisting conditions
6 and probationary periods in replace-
7 ment policies or certificates).

8 “(ii) MODEL ACT.—The following re-
9 quirements of the model Act:

10 “(I) Section 6C (relating to pre-
11 existing conditions).

12 “(II) Section 6D (relating to
13 prior hospitalization).

14 “(B) DEFINITIONS.—For purposes of this
15 paragraph—

16 “(i) MODEL PROVISIONS.—The terms
17 ‘model regulation’ and ‘model Act’ mean
18 the long-term care insurance model regula-
19 tion, and the long-term care insurance
20 model Act, respectively, promulgated by
21 the National Association of Insurance
22 Commissioners (as adopted in January of
23 1993).

24 “(ii) COORDINATION.—Any provision
25 of the model regulation or model Act listed

1 under clause (i) or (ii) of subparagraph
2 (A) shall be treated as including any other
3 provision of such regulation or Act nec-
4 essary to implement the provision.

5 “(7) TAX DISCLOSURE REQUIREMENT.—The re-
6 quirement of this paragraph is met with respect to
7 a long-term care insurance policy if such policy
8 meets the requirements of section 4980C(d)(1).

9 “(8) NONFORFEITURE REQUIREMENTS.—

10 “(A) IN GENERAL.—The requirements of
11 this paragraph are met with respect to a long-
12 term care insurance policy, if the issuer of such
13 policy offers to the policyholder, including any
14 group policyholder, a nonforfeiture provision
15 meeting the requirements specified in subpara-
16 graph (B).

17 “(B) REQUIREMENTS OF PROVISION.—The
18 requirements specified in this subparagraph are
19 as follows:

20 “(i) The nonforfeiture provision shall
21 be appropriately captioned.

22 “(ii) The nonforfeiture provision shall
23 provide for a benefit available in the event
24 of a default in the payment of any pre-
25 miums and the amount of the benefit may

1 be adjusted subsequent to being initially
2 granted only as necessary to reflect
3 changes in claims, persistency, and interest
4 as reflected in changes in rates for pre-
5 mium paying policies approved by the Sec-
6 retary for the same policy form.

7 “(iii) The nonforfeiture provision shall
8 provide at least 1 of the following:

9 “(I) Reduced paid-up insurance.

10 “(II) Extended term insurance.

11 “(III) Shortened benefit period.

12 “(IV) Other similar offerings ap-
13 proved by the Secretary.

14 “(9) RATE STABILIZATION.—

15 “(A) IN GENERAL.—The requirements of
16 this paragraph are met with respect to a long-
17 term care insurance policy, including any group
18 master policy, if—

19 “(i) such policy contains the minimum
20 rate guarantees specified in subparagraph
21 (B), and

22 “(ii) the issuer of such policy meets
23 the requirements specified in subparagraph
24 (C).

1 “(B) MINIMUM RATE GUARANTEES.—The
2 minimum rate guarantees specified in this sub-
3 paragraph are as follows:

4 “(i) Rates under the policy shall be
5 guaranteed for a period of at least 3 years
6 from the date of issue of the policy.

7 “(ii) After the expiration of the 3-year
8 period required under clause (i), any rate
9 increase shall be guaranteed for a period of
10 at least 2 years from the effective date of
11 such rate increase.

12 “(iii) In the case of any individual age
13 75 or older who has maintained coverage
14 under a long-term care insurance policy for
15 10 years, rate increases under such policy
16 shall not exceed 10 percent in any 12-
17 month period.

18 “(C) INCREASES IN PREMIUMS.—The re-
19 quirements specified in this subparagraph are
20 as follows:

21 “(i) IN GENERAL.—If an issuer of a
22 long-term care insurance policy, including
23 any group master policy, plans to increase
24 the premium rates for a policy, such issuer
25 shall, at least 90 days before the effective

1 date of the rate increase, offer to each in-
2 dividual policyholder under such policy the
3 option to remain insured under the policy
4 at a reduced level of benefits that main-
5 tains the premium rate at the rate in effect
6 on the day before the effective date of the
7 rate increase.

8 “(ii) INCREASES OF MORE THAN 50
9 PERCENT.—If an issuer of a long-term
10 care insurance policy, including any group
11 master policy, increases premium rates for
12 a policy by more than 50 percent in any 3-
13 year period—

14 “(I) in the case of an individual
15 long-term care insurance policy, the
16 issuer shall discontinue issuing all in-
17 dividual long-term care policies in any
18 State in which the issuer issues such
19 policy for a period of 2 years from the
20 effective date of such premium in-
21 crease, and

22 “(II) in the case of a group mas-
23 ter long-term care insurance policy,
24 the issuer shall discontinue issuing all
25 group master long-term care insur-

1 ance policies in any State in which the
2 issuer issues such policy for a period
3 of 2 years from the effective date of
4 such premium increase.

5 This clause shall apply to any issuer of
6 long-term care insurance policies or any
7 other person that purchases or otherwise
8 acquires any long-term care insurance poli-
9 cies from another issuer or person.

10 “(D) MODIFICATIONS OR WAIVERS OF RE-
11 QUIREMENTS.—The Secretary may modify or
12 waive any of the requirements under this para-
13 graph if—

14 “(i) such requirements will adversely
15 affect an issuer’s solvency,

16 “(ii) such modification or waiver is re-
17 quired for the issuer to meet other State or
18 Federal requirements,

19 “(iii) medical developments, new dis-
20 abling diseases, changes in long-term care
21 delivery, or a new method of financing
22 long-term care will result in changes to
23 mortality and morbidity patterns or as-
24 sumptions,

1 “(iv) judicial interpretation of a pol-
2 icy’s benefit features results in unintended
3 claim liabilities, or

4 “(v) in the case of a purchase or other
5 acquisition of long-term care insurance
6 policies of an issuer or other person, the
7 continued sale of other long-term care in-
8 surance policies by the purchasing issuer
9 or person is in the best interests of individ-
10 ual consumers.

11 “(10) LONG-TERM CARE INSURANCE POLICY
12 DEFINED.—

13 “(A) IN GENERAL.—For purposes of this
14 section, the term ‘long-term care insurance pol-
15 icy’ means any product which is advertised,
16 marketed, or offered as long-term care insur-
17 ance (as defined in subparagraph (B)).

18 “(B) LONG-TERM CARE INSURANCE.—

19 “(i) IN GENERAL.—The term ‘long-
20 term care insurance’ means any insurance
21 policy or rider—

22 “(I) advertised, marketed, of-
23 fered, or designed to provide coverage
24 for not less than 12 consecutive
25 months for each covered person on an

1 expense incurred, indemnity, prepaid
2 or other basis for 1 or more necessary
3 or medically necessary diagnostic, pre-
4 ventive, therapeutic, rehabilitative,
5 maintenance, or personal care services
6 provided in a setting other than an
7 acute care unit of a hospital, and

8 “(II) issued by insurers, fraternal
9 benefit societies, nonprofit health, hos-
10 pital, and medical service corpora-
11 tions, prepaid health plans, health
12 maintenance organizations or any
13 similar organization to the extent such
14 organizations are otherwise authorized
15 to issue life or health insurance.

16 Such term includes group and individual
17 annuities and life insurance policies or rid-
18 ers which provide directly or which supple-
19 ment long-term care insurance and in-
20 cludes a policy or rider which provides for
21 payment of benefits based on cognitive im-
22 pairment or the loss of functional capacity.

23 “(ii) EXCLUSIONS.—The term ‘long-
24 term care insurance’ shall not include—

1 “(I) any insurance policy which
2 is offered primarily to provide basic
3 coverage to supplement coverage
4 under the medicare program under
5 title XVIII of the Social Security Act,
6 basic hospital expense coverage, basic
7 medical-surgical expense coverage,
8 hospital confinement coverage, major
9 medical expense coverage, disability
10 income or related asset-protection cov-
11 erage, accident only coverage, speci-
12 fied disease or specified accident cov-
13 erage, or limited benefit health cov-
14 erage, or

15 “(II) life insurance policies—

16 “(aa) which accelerate the
17 death benefit specifically for 1 or
18 more of the qualifying events of
19 terminal illness or medical condi-
20 tions requiring extraordinary
21 medical intervention or perma-
22 nent institutional confinement,

23 “(bb) which provide the op-
24 tion of a lump-sum payment for
25 such benefits, and

1 “(cc) under which neither
2 such benefits nor the eligibility
3 for the benefits is conditioned
4 upon the receipt of long-term
5 care.

6 “(11) NONREIMBURSEMENT PAYMENTS PER-
7 MITTED.—For purposes of subsection (a)(4), a pol-
8 icy is described in this paragraph if, under the pol-
9 icy, payments are made to (or on behalf of) an in-
10 sured individual on a per diem or other periodic
11 basis without regard to the expenses incurred or
12 services rendered during the period to which the
13 payments relate.

14 “(c) TREATMENT OF LONG-TERM CARE INSURANCE
15 POLICIES.—For purposes of this title, any amount re-
16 ceived or coverage provided under a long-term care insur-
17 ance policy that is not a qualified long-term care insurance
18 policy shall not be treated as an amount received for per-
19 sonal injuries or sickness or provided under an accident
20 and health plan and shall not be treated as excludable
21 from gross income under any provision of this title.

22 “(d) TREATMENT OF COVERAGE PROVIDED AS PART
23 OF A LIFE INSURANCE CONTRACT.—Except as otherwise
24 provided in regulations, in the case of any long-term care

1 insurance coverage provided by rider on a life insurance
2 contract, the following rules shall apply:

3 “(1) IN GENERAL.—This section shall apply as
4 if the portion of the contract providing such cov-
5 erage is a separate contract or policy.

6 “(2) PREMIUMS AND CHARGES FOR LONG-TERM
7 CARE COVERAGE.—Premium payments for long-term
8 care insurance policy coverage and charges against
9 the life insurance contract’s cash surrender value
10 (within the meaning of section 7702(f)(2)(A)) for
11 such coverage, shall be treated as premiums for pur-
12 poses of subsection (b)(2).

13 “(3) APPLICATION OF SECTION 7702.—Section
14 7702(c)(2) (relating to the guideline premium limi-
15 tation) shall be applied by increasing, as of any date,
16 the guideline premium limitation with respect to a
17 life insurance contract by an amount equal to—

18 “(A) the sum of any charges (but not pre-
19 mium payments) described in paragraph (2)
20 made to that date under the contract, reduced
21 by

22 “(B) any such charges the imposition of
23 which reduces the premiums paid for the con-
24 tract (within the meaning of section
25 7702(f)(1)).

1 “(4) APPLICATION OF SECTION 213.—No deduc-
2 tion shall be allowed under section 213(a) for
3 charges against the life insurance contract’s cash
4 surrender value described in paragraph (2), unless
5 such charges are includable in income as a result of
6 the application of section 72(e)(10) and the coverage
7 provided by the rider is a qualified long-term care
8 insurance policy under subsection (b).

9 For purposes of this subsection, the term ‘portion’ means
10 only the terms and benefits under a life insurance contract
11 that are in addition to the terms and benefits under the
12 contract without regard to the coverage under a qualified
13 long-term care insurance policy.

14 “(e) EMPLOYER PLANS NOT TREATED AS DE-
15 FERRED COMPENSATION PLANS.—For purposes of this
16 title, a plan of an employer providing coverage under a
17 qualified long-term care insurance policy shall not be
18 treated as a plan which provides for deferred compensa-
19 tion by reason of providing such coverage.

20 “(f) DOLLAR AMOUNT FOR PURPOSES OF GROSS IN-
21 COME EXCLUSION.—

22 “(1) DOLLAR AMOUNT.—

23 “(A) IN GENERAL.—The dollar amount in
24 effect under this subsection shall be \$200 per
25 day.

1 “(B) INFLATION ADJUSTMENTS.—In the
2 case of any taxable year beginning in a calendar
3 year after 1996, the dollar amount contained in
4 subparagraph (A) shall be increased by an
5 amount equal to—

6 “(i) such dollar amount, multiplied by

7 “(ii) the cost-of-living adjustment de-
8 termined under section 1(f)(3) for the cal-
9 endar year in which the taxable year be-
10 gins, by substituting ‘calendar year 1995’
11 for ‘calendar year 1992’ in subparagraph
12 (B) thereof.

13 “(2) AGGREGATION RULE.—For purposes of
14 this subsection, all policies issued with respect to the
15 same taxpayer shall be treated as 1 policy.

16 “(g) REGULATIONS.—The Secretary shall prescribe
17 such regulations as may be necessary to carry out the re-
18 quirements of this section, including regulations to prevent
19 the avoidance of this section by providing long-term care
20 insurance coverage under a life insurance contract and to
21 provide for the proper allocation of amounts between the
22 long-term care and life insurance portions of a contract.”.

23 (b) CLERICAL AMENDMENT.—The table of sections
24 for chapter 79 is amended by inserting after the item re-
25 lating to section 7702A the following new item:

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

1 (c) EFFECTIVE DATE.—

2 (1) IN GENERAL.—The amendments made by
3 this section shall apply to policies issued after De-
4 cember 31, 1995. Solely for purposes of the preced-
5 ing sentence, a policy issued prior to January 1,
6 1996, that satisfies the requirements of a qualified
7 long-term care insurance policy as set forth in sec-
8 tion 7702B(b) of the Internal Revenue Code of 1986
9 (as added by this section) shall, on and after Janu-
10 ary 1, 1996, be treated as having been issued after
11 December 31, 1995.

12 (2) TRANSITION RULE.—If, after the date of
13 enactment of this Act and before January 1, 1996,
14 a policy providing for long-term care insurance cov-
15 erage is exchanged solely for a qualified long-term
16 care insurance policy (as defined in such section
17 7702B(b)), no gain or loss shall be recognized on
18 the exchange. If, in addition to a qualified long-term
19 care insurance policy, money or other property is re-
20 ceived in the exchange, then any gain shall be recog-
21 nized to the extent of the sum of the money and the
22 fair market value of the other property received. For
23 purposes of this paragraph, the cancellation of a pol-
24 icy providing for long-term care insurance coverage
25 and reinvestment of the cancellation proceeds in a

1 qualified long-term care insurance policy within 60
2 days thereafter shall be treated as an exchange.

3 (3) ISSUANCE OF CERTAIN RIDERS PER-
4 MITTED.—For purposes of determining whether sec-
5 tion 7702 or 7702A of the Internal Revenue Code
6 of 1986 applies to any contract, the issuance, wheth-
7 er before, on, or after December 31, 1995, of a rider
8 on a life insurance contract providing long-term care
9 insurance coverage shall not be treated as a modi-
10 fication or material change of such contract.

11 **SEC. 8103. TREATMENT OF QUALIFIED LONG-TERM CARE**
12 **PLANS.**

13 (a) EXCLUSION FROM COBRA CONTINUATION RE-
14 QUIREMENTS.—Subparagraph (A) of section 4980B(f)(2)
15 (defining continuation coverage) is amended by adding at
16 the end the following new sentence: “The coverage shall
17 not include coverage for qualified long-term care services
18 (as defined in section 213(f)).”.

19 (b) BENEFITS INCLUDED IN CAFETERIA PLANS.—
20 Section 125(f) (defining qualified benefits) is amended by
21 adding at the end the following new sentence: “Such term
22 includes coverage under a qualified long-term care insur-
23 ance policy (as defined in section 7702B(b)) which is in-
24 cludible in gross income only because it exceeds the dollar
25 limitation of section 105(c)(2).”.

1 **SEC. 8104. TAX RESERVES FOR QUALIFIED LONG-TERM**
2 **CARE INSURANCE POLICIES.**

3 (a) IN GENERAL.—Subparagraph (A) of section
4 807(d)(3) (relating to tax reserve methods) is amended
5 by redesignating clause (iv) as clause (v) and by inserting
6 after clause (iii) the following new clause:

7 “(iv) QUALIFIED LONG-TERM CARE
8 INSURANCE POLICIES.—In the case of any
9 qualified long-term care insurance policy
10 (as defined in section 7702B(b)), a 1 year
11 full preliminary term method, as prescribed
12 by the National Association of Insurance
13 Commissioners.”.

14 (b) CONFORMING AMENDMENTS.—Section
15 807(d)(3)(A) (relating to tax reserve methods), is amend-
16 ed—

17 (1) in clause (v), as redesignated by subsection
18 (a), by striking “or (iii)” each place it appears and
19 inserting “(iii), or (iv)”; and

20 (2) in clause (iii), by inserting “(other than a
21 qualified long-term care insurance policy)” after “in-
22 surance contract”.

1 **SEC. 8105. TAX TREATMENT OF ACCELERATED DEATH BEN-**
2 **EFITS UNDER LIFE INSURANCE CONTRACTS.**

3 Section 101 (relating to certain death benefits) is
4 amended by adding at the end the following new sub-
5 section:

6 “(g) TREATMENT OF CERTAIN ACCELERATED
7 DEATH BENEFITS.—

8 “(1) IN GENERAL.—For purposes of this sec-
9 tion, any amount distributed to an individual under
10 a life insurance contract on the life of an insured
11 who is a terminally ill individual (as defined in para-
12 graph (3)) shall be treated as an amount paid by
13 reason of the death of such insured.

14 “(2) NECESSARY CONDITIONS.—

15 “(A) IN GENERAL.—Paragraph (1) shall
16 not apply to any distribution unless—

17 “(i) the distribution is not less than
18 the present value (determined under sub-
19 paragraph (B)) of the reduction in the
20 death benefit otherwise payable in the
21 event of the death of the insured, and

22 “(ii) the percentage derived by divid-
23 ing the cash surrender value of the con-
24 tract, if any, immediately after the dis-
25 tribution by the cash surrender value of
26 the contract immediately before the dis-

1 tribution is equal to or greater than the
2 percentage derived by dividing the death
3 benefit immediately after the distribution
4 by the death benefit immediately before the
5 distribution.

6 “(B) REDUCTION VALUE.—The present
7 value of the reduction in the death benefit oc-
8 curring by reason of the distribution shall be
9 determined by—

10 “(i) using as the discount rate a rate
11 not in excess of the highest rate set forth
12 in subparagraph (C), and

13 “(ii) assuming that the death benefit
14 (or the portion thereof) would have been
15 paid at the end of a period that is no more
16 than the insured’s life expectancy from the
17 date of the distribution or 12 months,
18 whichever is shorter.

19 “(C) RATES.—The rates set forth in this
20 subparagraph are the following:

21 “(i) the 90-day Treasury bill yield,

22 “(ii) the rate described as Moody’s
23 Corporate Bond Yield Average-Monthly
24 Average Corporates as published by
25 Moody’s Investors Service, Inc., or any

1 successor thereto, for the calendar month
2 ending 2 months before the date on which
3 the rate is determined,

4 “(iii) the rate used to compute the
5 cash surrender values under the contract
6 during the applicable period plus 1 percent
7 per annum, and

8 “(iv) the maximum permissible inter-
9 est rate applicable to policy loans under
10 the contract.

11 “(3) TERMINALLY ILL INDIVIDUAL.—For pur-
12 poses of this subsection, the term ‘terminally ill indi-
13 vidual’ means an individual who, as determined by
14 the insurer on the basis of an acceptable certifi-
15 cation by a licensed physician, has an illness or
16 physical condition which can reasonably be expected
17 to result in death within 12 months of the date of
18 certification.

19 “(4) APPLICATION OF SECTION 72(e)(10).—For
20 purposes of section 72(e)(10) (relating to the treat-
21 ment of modified endowment contracts), section
22 72(e)(4)(A)(i) shall not apply to distributions de-
23 scribed in paragraph (1).”.

1 **SEC. 8106. TAX TREATMENT OF COMPANIES ISSUING**
2 **QUALIFIED ACCELERATED DEATH BENEFIT**
3 **RIDERS.**

4 (a) QUALIFIED ACCELERATED DEATH BENEFIT RID-
5 ERS TREATED AS LIFE INSURANCE.—Section 818 (relat-
6 ing to other definitions and special rules) is amended by
7 adding at the end the following new subsection:

8 “(g) QUALIFIED ACCELERATED DEATH BENEFIT
9 RIDERS TREATED AS LIFE INSURANCE.—For purposes of
10 this part—

11 “(1) IN GENERAL.—Any reference to a life in-
12 surance contract shall be treated as including a ref-
13 erence to a qualified accelerated death benefit rider
14 on such contract.

15 “(2) QUALIFIED ACCELERATED DEATH BENE-
16 FIT RIDERS.—For purposes of this subsection, the
17 term ‘qualified accelerated death benefit rider’
18 means any rider on a life insurance contract which
19 provides for a distribution to an individual upon the
20 insured becoming a terminally ill individual (as de-
21 fined in section 101(g)(3)).”.

22 (b) DEFINITIONS OF LIFE INSURANCE AND MODI-
23 FIED ENDOWMENT CONTRACTS.—Paragraph (5)(A) of
24 section 7702(f) (defining qualified additional benefits) is
25 amended by striking “or” at the end of clause (iv), by

1 redesignating clause (v) as clause (vi), and by inserting
2 after clause (iv) the following new clause:

3 “(v) any qualified accelerated death
4 benefit rider (as defined in section 818(g)),
5 or”.

6 (c) EFFECTIVE DATE.—

7 (1) IN GENERAL.—The amendments made by
8 this section shall apply to contracts issued after
9 December 31, 1995.

10 (2) TRANSITIONAL RULE.—For purposes of de-
11 termining whether section 7702 or 7702A of the In-
12 ternal Revenue Code of 1986 applies to any con-
13 tract, the issuance, whether before, on, or after De-
14 cember 31, 1995, of a rider on a life insurance con-
15 tract permitting the acceleration of death benefits
16 (as described in section 101(g) of such Code (as
17 added by section 8105)) shall not be treated as a
18 modification or material change of such contract.

19 **Subtitle B—Standards For Long-**
20 **Term Care Insurance**

21 **SEC. 8201. NATIONAL LONG-TERM CARE INSURANCE ADVI-**
22 **SORY COUNCIL.**

23 (a) IN GENERAL.—Congress shall appoint an advi-
24 sory board to be known as the National Long-Term Care

1 Insurance Advisory Council (hereafter referred to in this
2 subtitle as the “Advisory Council”).

3 (b) MEMBERSHIP.—The Advisory Council shall con-
4 sist of 5 members, each of whom has substantial expertise
5 in matters relating to the provision and regulation of long-
6 term care insurance or long-term care financing and deliv-
7 ery systems.

8 (c) DUTIES.—The Advisory Council shall—

9 (1) provide advice, recommendations on the im-
10 plementation of standards for long-term care insur-
11 ance, and assistance to Congress on matters relating
12 to long-term care insurance as specified in this sec-
13 tion and as otherwise required by the Secretary of
14 Health and Human Services;

15 (2) collect, analyze, and disseminate informa-
16 tion relating to long-term care insurance in order to
17 increase the understanding of insurers, providers,
18 consumers, and regulatory bodies of the issues relat-
19 ing to, and to facilitate improvements in, such insur-
20 ance;

21 (3) develop educational models to inform the
22 public on the risks of incurring long-term care ex-
23 penses and private financing options available to
24 them; and

1 (4) monitor the development of the long-term
2 care insurance market and advise Congress concern-
3 ing the need for statutory changes.

4 (d) ADMINISTRATION.—In order to carry out its re-
5 sponsibilities under this section, the Advisory Council is
6 authorized to—

7 (1) consult individuals and public and private
8 entities with experience and expertise in matters re-
9 lating to long-term care insurance;

10 (2) conduct meetings and hold hearings;

11 (3) conduct research (either directly or under
12 grant or contract);

13 (4) collect, analyze, publish, and disseminate
14 data and information (either directly or under grant
15 or contract); and

16 (5) develop model formats and procedures for
17 insurance products, and develop proposed standards,
18 rules and procedures for regulatory programs, as
19 appropriate.

20 (e) AUTHORIZATION OF APPROPRIATIONS.—There
21 are authorized to be appropriated, for activities of the Ad-
22 visory Council, \$1,500,000 for fiscal year 1996, and each
23 subsequent year.

1 **SEC. 8202. ADDITIONAL REQUIREMENTS FOR ISSUERS OF**
2 **LONG-TERM CARE INSURANCE POLICIES.**

3 (a) IN GENERAL.—Chapter 43 is amended by adding
4 at the end the following new section:

5 **“SEC. 4980C. FAILURE TO MEET REQUIREMENTS FOR**
6 **QUALIFIED LONG-TERM CARE INSURANCE**
7 **POLICIES.**

8 “(a) GENERAL RULE.—There is hereby imposed on
9 the issuer of any qualified long-term care insurance policy
10 with respect to which any requirement of subsection (c)
11 or (d) is not met a tax in the amount determined under
12 subsection (b).

13 “(b) AMOUNT OF TAX.—

14 “(1) IN GENERAL.—

15 “(A) PER POLICY.—The amount of the tax
16 imposed by subsection (a) shall be \$100 per
17 policy for each day any requirement of sub-
18 section (c) or (d) is not met with respect to the
19 policy.

20 “(B) LIMITATIONS.—

21 “(i) PER CARRIER.—The amount of
22 the tax imposed under subparagraph (A)
23 against any insurance carrier, association,
24 or any subsidiary thereof, shall not exceed
25 \$25,000 per policy.

1 “(ii) PER AGENT.—The amount of the
2 tax imposed under subparagraph (A)
3 against insurance agent or broker shall not
4 exceed \$15,000 per policy.

5 “(2) WAIVER.—In the case of a failure which is
6 due to reasonable cause and not to willful neglect,
7 the Secretary may waive part or all of the tax im-
8 posed by subsection (a) to the extent that payment
9 of the tax would be excessive relative to the failure
10 involved.

11 “(c) ADDITIONAL RESPONSIBILITIES.—The require-
12 ments of this subsection with respect to any qualified long-
13 term care insurance policy are as follows:

14 “(1) REQUIREMENTS OF MODEL PROVISIONS.—

15 “(A) MODEL REGULATION.—The following
16 requirements of the model regulation shall be
17 met:

18 “(i) Section 13 (relating to application
19 forms and replacement coverage).

20 “(ii) Section 14 (relating to reporting
21 requirements), except that the issuer shall
22 also report at least annually the number of
23 claims denied during the reporting period
24 for each class of business (expended as a
25 percentage of claims denied), other than

1 claims denied for failure to meet the wait-
2 ing period or because of any applicable
3 preexisting condition.

4 “(iii) Section 20 (relating to filing re-
5 quirements for marketing).

6 “(iv) Section 21 (relating to standards
7 for marketing), including inaccurate com-
8 pletion of medical histories, other than sec-
9 tions 21C(1) and 21C(6) thereof, except
10 that—

11 “(I) in addition to such require-
12 ments, no person shall, in selling or
13 offering to sell a qualified long-term
14 care insurance policy, misrepresent a
15 material fact; and

16 “(II) no such requirements shall
17 include a requirement to inquire or
18 identify whether a prospective appli-
19 cant or enrollee for qualified long-
20 term care insurance has accident and
21 sickness insurance.

22 “(v) Section 22 (relating to appro-
23 priateness of recommended purchase).

24 “(vi) Section 24 (relating to standard
25 format outline of coverage).

1 “(vii) Section 25 (relating to require-
2 ment to deliver shopper’s guide).

3 “(B) MODEL ACT.—The following require-
4 ments of the model Act must be met:

5 “(i) Section 6F (relating to right to
6 return), except that such section shall also
7 apply to denials of applications and any re-
8 fund shall be made within 30 days of the
9 return or denial.

10 “(ii) Section 6G (relating to outline of
11 coverage).

12 “(iii) Section 6H (relating to require-
13 ments for certificates under group plans).

14 “(iv) Section 6I (relating to policy
15 summary).

16 “(v) Section 6J (relating to monthly
17 reports on accelerated death benefits).

18 “(vi) Section 7 (relating to incontest-
19 ability period).

20 “(C) DEFINITIONS.—For purposes of this
21 paragraph, the terms ‘model regulation’ and
22 ‘model Act’ have the meanings given such terms
23 by section 7702B(b)(6)(B).

24 “(2) DELIVERY OF POLICY.—If an application
25 for a qualified long-term care insurance policy (or

1 for a certificate under a group qualified long-term
2 care insurance policy) is approved, the issuer shall
3 deliver to the applicant (or policyholder or certifi-
4 cate-holder) the policy (or certificate) of insurance
5 not later than 30 days after the date of the ap-
6 proval.

7 “(3) INFORMATION ON DENIALS OF CLAIMS.—
8 If a claim under a qualified long-term care insurance
9 policy is denied, the issuer shall, within 60 days of
10 the date of a written request by the policyholder or
11 certificate-holder (or representative)—

12 “(A) provide a written explanation of the
13 reasons for the denial, and

14 “(B) make available all information di-
15 rectly relating to such denial.

16 “(d) DISCLOSURE.—The requirements of this sub-
17 section are met with respect to any qualified long-term
18 care insurance policy if the following statement is promi-
19 nently displayed on the front page of the policy and in
20 the outline of coverage required under subsection
21 (c)(1)(B)(ii):

22 ““This is a federally qualified long-term care
23 insurance contract. The policy meets all the Federal
24 consumer protection standards necessary to receive

1 favorable tax treatment under section 7702B(b) of
2 the Internal Revenue Code of 1986.’.

3 “(e) QUALIFIED LONG-TERM CARE INSURANCE POL-
4 ICY DEFINED.—For purposes of this section, the term
5 ‘qualified long-term care insurance policy’ has the mean-
6 ing given such term by section 7702B(b).”.

7 (b) CONFORMING AMENDMENT.—The table of sec-
8 tions for chapter 43 is amended by adding at the end the
9 following new item:

“Sec. 4980C. Failure to meet requirements for long-term care in-
surance policies.”.

10 **SEC. 8203. COORDINATION WITH STATE REQUIREMENTS.**

11 Nothing in this subtitle shall be construed as prevent-
12 ing a State from applying standards that provide greater
13 protection of policyholders of qualified long-term care in-
14 surance policies (as defined in section 7702B(b) of the In-
15 ternal Revenue Code of 1986 (as added by section 8102)).

16 **SEC. 8204. UNIFORM LANGUAGE AND DEFINITIONS.**

17 (a) IN GENERAL.—Not later than June 30, 1996, the
18 Advisory Council shall promulgate standards for the use
19 of uniform language and definitions in qualified long-term
20 care insurance policies (as defined in section 7702B(b) of
21 the Internal Revenue Code of 1986 (as added by section
22 8102)).

23 (b) VARIATIONS.—Standards under subsection (a)
24 may permit the use of nonuniform language to the extent

1 required to take into account differences among States in
 2 the licensing of nursing facilities and other providers of
 3 long-term care.

4 **Subtitle C—Incentives to Encour-**
 5 **age the Purchase of Private In-**
 6 **surance**

7 **SEC. 8301. ASSETS OR RESOURCES DISREGARDED UNDER**
 8 **THE MEDICAID PROGRAM.**

9 (a) MEDICAID ESTATE RECOVERIES.—

10 (1) IN GENERAL.—Section 1917(b) of the So-
 11 cial Security Act (42 U.S.C. 1396p(b)) is amend-
 12 ed—

13 (A) in paragraph (1), by striking subpara-
 14 graph (C);

15 (B) in paragraph (3), by striking “(other
 16 than paragraph (1)(C))”; and

17 (C) in paragraph (4)(B), by striking “(and
 18 shall include, in the case of an individual to
 19 whom paragraph (1)(C)(i) applies)”.

20 (2) EFFECTIVE DATE.—Section 1917(b) of the
 21 Social Security Act (42 U.S.C. 1396p(b)) shall be
 22 applied and administered as if the provisions strick-
 23 en by paragraph (1) had not been enacted.

24 (b) REPORTING REQUIREMENTS FOR CERTAIN
 25 ASSET PROTECTION PROGRAMS.—Section 1902 of the So-

1 cial Security Act (42 U.S.C. 1396a) is amended by adding
2 at the end the following new subsection:

3 “(aa)(1) The Secretary shall not approve any State
4 plan amendment providing for an asset protection pro-
5 gram (as described in paragraph (2)) unless the State re-
6 quires all insurers participating in such program to submit
7 reports to the State and the Secretary at such times, and
8 containing such information, as the Secretary determines
9 appropriate. The information included in the reports re-
10 quired to be submitted under the preceding sentence shall
11 be submitted in accordance with the data standards estab-
12 lished by the Secretary under paragraph (3).

13 “(2) An asset protection program described in this
14 paragraph is a program under which an individual’s assets
15 and resources are disregarded for purposes of the program
16 under this subtitle—

17 “(A) to the extent that payments are made
18 under a qualified long-term care insurance policy (as
19 defined in section 7702B(b) of the Internal Revenue
20 Code of 1986); or

21 “(B) because an individual has received (or is
22 entitled to receive) benefits under a qualified long-
23 term care insurance policy (as defined in section
24 7702B(b) of such Code).

1 “(3)(A) Not later than 90 days after the date of the
2 enactment of the Private Long-Term Care Family Protec-
3 tion Act of 1995, the Secretary shall select data standards
4 for the information required to be included in reports sub-
5 mitted in accordance with paragraph (1). Such data
6 standards shall be selected from the data standards in-
7 cluded in the Long-Term Care Insurance Uniform Data
8 Set developed by the University of Maryland Center on
9 Aging and Laguna Research Associates, and used by the
10 States of California, Connecticut, Indiana, and New York
11 for reports submitted by insurers under the asset protec-
12 tion programs conducted by such States.

13 “(B) The Secretary shall modify the standards se-
14 lected under subparagraph (A) as the Secretary deter-
15 mines appropriate.”.

16 **SEC. 8302. DISTRIBUTIONS FROM INDIVIDUAL RETIRE-**
17 **MENT ACCOUNTS FOR THE PURCHASE OF**
18 **LONG-TERM CARE INSURANCE COVERAGE.**

19 (a) EXCLUSION FROM GROSS INCOME FOR CERTAIN
20 INDIVIDUALS.—Subsection (d) of section 408 (relating to
21 tax treatment of distributions from individual retirement
22 accounts) is amended by adding at the end the following
23 new paragraph:

24 “(8) DISTRIBUTIONS TO PURCHASE LONG-TERM
25 CARE INSURANCE.—Paragraph (1) shall not apply to

1 any amount paid or distributed out of an individual
2 retirement account or individual retirement annuity
3 to the individual for whose benefit the account or
4 annuity is maintained if—

5 “(A) the individual has attained age 59½
6 by the date of the payment or distribution, and

7 “(B) the entire amount received (including
8 money and any other property) is used within
9 90 days to purchase a qualified long-term care
10 insurance policy (as defined in section
11 7702B(b)) for the benefit of the individual or
12 the spouse of the individual (if the spouse has
13 attained age 59½ by the date of the payment
14 or distribution).”.

15 (b) NO PENALTY FOR DISTRIBUTIONS.—

16 (1) IN GENERAL.—Subparagraph (B) of section
17 72(t)(2) (relating to distributions from qualified re-
18 tirement plans not subject to 10 percent additional
19 tax) is amended to read as follows:

20 “(B) MEDICAL EXPENSES.—

21 “(i) IN GENERAL.—Distributions
22 made to the employee (other than distribu-
23 tions described in clause (ii) or subpara-
24 graph (A) or (C)) to the extent such dis-
25 tributions do not exceed the amount allow-

1 able as a deduction under section 213 to
2 the employee for amounts paid during the
3 taxable year for medical care (determined
4 without regard to whether the employee
5 itemizes deductions for such taxable year).

6 “(ii) CERTAIN DISTRIBUTIONS TO
7 PURCHASE LONG-TERM CARE INSUR-
8 ANCE.—Distributions made to the taxpayer
9 out of an individual retirement plan if the
10 entire amount received (including money
11 and any other property) is used within 90
12 days to purchase a qualified long-term care
13 insurance policy (as defined in section
14 7702B(b)) for the benefit of the individual
15 or the spouse of the individual.”.

16 (2) CONFORMING AMENDMENT.—Subparagraph
17 (A) of section 72(t)(3) is amended by striking “(B)”
18 and inserting “(B)(i)”.

19 (c) DEDUCTION FOR EXPENSES TO PURCHASE A
20 QUALIFIED LONG-TERM CARE INSURANCE POLICY.—

21 (1) IN GENERAL.—Paragraph (8) of section
22 408(d) (relating to distributions from individual re-
23 tirement accounts to purchase long-term care insur-
24 ance), as added by subsection (a), is amended by
25 adding at the end the following new subparagraph:

1 “(D) APPLICATION OF SECTION 213.—No
 2 deduction shall be allowed under section 213(a)
 3 for expenses incurred to purchase a qualified
 4 long-term care insurance policy (as defined in
 5 section 7702B(b)) using amounts paid or dis-
 6 tributed out of an individual retirement account
 7 or individual retirement annuity in accordance
 8 with this paragraph.”.

9 (2) CONFORMING AMENDMENT.—Clause (ii) of
 10 section 213(d)(1)(D) (relating to definition of medi-
 11 cal care), as added by section 8101(a), is amended
 12 by striking “section 7702(d)(4)” and inserting “sec-
 13 tion 408(d)(8)(D) or section 7702(d)(4)”.

14 **Subtitle D—Effective Date**

15 **SEC. 8401. EFFECTIVE DATE OF TAX PROVISIONS.**

16 Except as otherwise provided in this title, the amend-
 17 ments made by this title to the Internal Revenue Code
 18 of 1986 shall apply to taxable years beginning after De-
 19 cember 31, 1995.

20 **TITLE IX—BUDGET NEUTRALITY**

21 **SEC. 9001. ASSURANCE OF BUDGET NEUTRALITY.**

22 Notwithstanding any other provision of law, this Act
 23 and the amendments made by this Act shall not become
 24 effective until the date of the enactment of a provision
 25 of law, specifically referring to this section, that by its

1 terms provides for the Federal budget neutrality of this
2 Act.



- S 294 IS—2
- S 294 IS—3
- S 294 IS—4
- S 294 IS—5
- S 294 IS—6
- S 294 IS—7
- S 294 IS—8
- S 294 IS—9
- S 294 IS—10
- S 294 IS—11
- S 294 IS—12
- S 294 IS—13
- S 294 IS—14
- S 294 IS—15
- S 294 IS—16