taken on the question of agreeing to the resolution.

The vote was taken by electronic device, and there were—yeas 229, nays 186, not voting 16, as follows:

[Roll No. 103]

YEAS—229

Allard
Archer
Armey
Bachus
Baker (CA)
Baker (LA)
Ballenger
Barr
Barrett (NE)
Bartlett
Barton
Bass
Bateman
Bereuter
Bilbray
Bilirakis
Bliley
Blute
Boehlert
Boehner
Bonilla
Bono
Brownback
Bryant (TN)
Bunn
Bunning
Burr
Burton
Buyer
Callahan
Calvert
Camp
Campbell
Canady
Castle
Chabot
Chambliss
Chenoweth
Christensen
Chrysler
Clinger
Coble
Coburn
Collins (GA)
Combest
Cooley
Cox
Crane
Crapo
Cremeans
Cubin
Cunningham
Davis
Deal
DeLay
Diaz-Balart
Dickey
Doolittle
Dornan
Dreier
Duncan
Dunn
Ehlers
Ehrlich
Emerson
English
Ensign
Everett
Ewing
Fawell
Fields (TX)
Flanagan
Foley
Forbes
Fox
Franks (CT)
Franks (NJ)
Frelinghuysen
Frisa
Funderburk
Gallegly
Ganske
Gekas
Gilchrest
Gillmor
Gilman
Goodlatte
Goodling
Goss
Graham
Greenwood
Gutknecht
Hall (TX)
Hancock
Hansen
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Heineman
Herger
Hilleary
Hobson
Hoekstra
Hoke
Horn
Hostettler
Houghton
Hunter
Hutchinson
Hyde
Inglis
Istook
Johnson (CT)
Johnson, Sam
Jones
Kasich
Kelly
Kim
King
Kingston
Klug
Knollenberg
Kolbe
LaHood
Largent
Latham
LaTourette
Laughlin
Lazio
Leach
Lewis (CA)
Lewis (KY)
Lightfoot
Linder
Livingston
LoBiondo
Longley
Lucas
Manzullo
Martini
McCollum
McCrery
McDade
McHugh
McInnis
McIntosh
McKeon
Metcalf
Meyers
Mica
Miller (FL)
Molinari
Moorhead
Morella
Myers
Myrick
Nethercutt
Neumann
Ney
Norwood
Nussle
Oxley
Packard
Parker
Paxon
Petri
Pombo
Porter
Portman
Pryce
Quillen
Quinn
Radanovich
Ramstad
Regula
Riggs
Roberts
Rogers
Rohrabacher
Roth
Royce
Salmon
Sanford
Saxton
Scarborough
Schaefer
Schiff
Seastrand
Sensenbrenner
Shadegg
Shaw
Shays
Shuster
Skeen
Smith (MI)
Smith (NJ)
Solomon
Souder
Spence
Stearns
Stockman
Stump
Talent
Tate
Tauzin
Taylor (NC)
Thomas
Thornberry
Tiahrt
Torkildsen
Upton
Vucanovich
Waldholtz
Walker
Walsh
Wamp
Watts (OK)
Weldon (FL)
Weller
White
Whitfield
Wicker
Wolf
Young (AK)
Young (FL)
Zeliff
Zimmer

NAYS—186

Abercrombie
Ackerman
Andrews
Baesler
Baldacci
Barcia
Barrett (WI)
Beilenson
Bentsen
Berman
Bevill
Bishop
Bonior
Borski
Boucher
Brewster
Browder
Brown (CA)
Brown (FL)
Brown (OH)
Cardin
Chapman
Clay
Clayton
Clement
Clyburn
Coleman
Collins (MI)
Condit
Costello
Coyne
Cramer
Danner
de la Garza
DeFazio
DeLauro
Dellums
Deutsch
Dicks
Dingell
Dixon
Doggett
Dooley
Doyle
Durbin
Edwards
Engel
Eshoo
Evans
Farr
Fattah
Fazio
Filner
Flake
Foglietta
Ford
Frank (MA)
Frost
Furse
Gejdenson
Gephardt
Geren
Gibbons
Gonzalez
Gordon
Green
Gunderson
Gutierrez
Hall (OH)
Hamilton
Harman
Hastings (FL)
Hefner
Hilliard
Hinchey
Holden
Hoyer
Jackson (IL)
Jackson-Lee (TX)
Jacobs
Jefferson
Johnson (SD)
Johnson, E. B.
Johnston
Kanjorski
Kaptur
Kennedy (MA)
Kennedy (RI)
Kennelly
Kildee
Kleczka
Klink
LaFalce
Levin
Lewis (GA)
Lincoln
Lipinski
Lofgren
Lowey
Luther
Maloney
Manton
Markey
Martinez
Mascara
Matsui
McCarthy
McDermott
McHale
McKinney
Meehan
Meek
Menendez
Miller (CA)
Minge
Mink
Moakley
Mollohan
Montgomery
Moran
Murtha
Nadler
Oberstar
Obey
Olver
Ortiz
Orton
Owens
Pallone
Pastor
Payne (NJ)
Payne (VA)
Pelosi
Peterson (FL)
Peterson (MN)
Pickett
Pomeroy
Poshard
Rahall
Rangel
Reed
Richardson
Rivers
Roemer
Rose
Roukema
Roybal-Allard
Rush
Sabo
Sanders
Sawyer
Schroeder
Schumer
Scott
Serrano
Sisisky
Skaggs
Skelton
Slaughter
Spratt
Stark
Stenholm
Studds
Stupak
Tanner
Taylor (MS)
Tejeda
Thompson
Thornton
Thurman
Torres
Towns
Traficant
Velazquez
Vento
Visclosky
Volkmer
Ward
Waters
Watt (NC)
Waxman
Williams
Wise
Woolsey
Wynn
Yates

NOT VOTING—16

Becerra
Bryant (TX)
Collins (IL)
Conyers
Fields (LA)
Fowler
Lantos
McNulty
Neal
Ros-Lehtinen
Smith (TX)
Smith (WA)
Stokes
Torricelli
Weldon (PA)
Wilson

□ 1809

Ms. FURSE and Mr. BALDACCI changed their vote from ''yea'' to ''nay.''

Mr. COBURN and Mr. THOMAS of California changed their vote from ''nay'' to ''yea.''

So the previous question was ordered.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore (Mr. COMBEST). The question is on the resolution.

The resolution was agreed to.

A motion to reconsider was laid on the table.

FURTHER MESSAGE FROM THE SENATE

A message from the Senate by Mr. Lundregan, one of its clerks, announced that the Senate has passed without amendment a bill and joint resolution of the House of the following titles:

H.R. 3136. An act to provide for enactment of the Senior Citizens' Right to Work Act of 1996, the Line-Item Veto Act, and the Small Business Growth and Fairness Act of 1996, and to provide for a permanent increase in the public debt limit; and

H.J. Res. 168. Joint resolution waiving certain enrollment requirements with respect to two bills of the One Hundred Fourth Congress.

The message also announced that the Senate agrees, to the report of the committee of conference on the disagreeing votes of the two House on the amendment of the Senate to the bill (H.R. 2854) ''An act to modify the operation of certain agricultural programs.''

□ 1815

HEALTH COVERAGE AVAILABILITY AND AFFORDABILITY ACT OF 1996

Mr. ARCHER. Mr. Speaker, pursuant to House Resolution 392, I call up the bill (H.R. 3103), to amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, to simplify the administration of health insurance, and for other purposes, and ask for its immediate consideration in the House.

The Clerk read the title of the bill.

The SPEAKER pro tempore (Mr. COMBEST). Pursuant to House Resolution 392, the amendment in the nature of a substitute consisting of the text of H.R. 3160 modified by the amendment specified in part 1 of House Report 104–501 is adopted.

The text of H.R. 3103 consisting of the text of H.R. 3160, as modified, is as follows:

H.R. 3160

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

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

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

Sec. 1. Short title; table of contents.

TITLE I—IMPROVED AVAILABILITY AND PORTABILITY OF HEALTH INSURANCE COVERAGE

Subtitle A—Coverage Under Group Health Plans

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

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

Sec. 103. Prohibiting exclusions based on health status and providing for enrollment periods.

Sec. 104. Enforcement.

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

PART 1—AVAILABILITY OF GROUP HEALTH INSURANCE COVERAGE

Sec. 131. Guaranteed availability of general coverage in the small group market.

Sec. 132. Guaranteed renewability of group coverage.

PART 2—AVAILABILITY OF INDIVIDUAL HEALTH INSURANCE COVERAGE

Sec. 141. Guaranteed availability of individual health insurance coverage to certain individuals with prior group coverage.
Sec. 142. Guaranteed renewability of individual health insurance coverage.

PART 3—ENFORCEMENT

Sec. 151. Incorporation of provisions for State enforcement with Federal fallback authority.

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

Sec. 161. Clarification of duty of the Secretary of Labor to implement provisions of current law providing for exemptions and solvency standards for multiple employer health plans.

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

''Sec. 701. Definitions.
''Sec. 702. Clarification of duty of the Secretary to implement provisions of current law providing for exemptions and solvency standards for multiple employer health plans.
''Sec. 703. Requirements relating to sponsors, boards of trustees, and plan operations.
''Sec. 704. Other requirements for exemption.
''Sec. 705. Maintenance of reserves.
''Sec. 706. Notice requirements for voluntary termination.
''Sec. 707. Corrective actions and mandatory termination.
''Sec. 708. Additional rules regarding State authority.''.

Sec. 162. Affordable and available fully insured health coverage through voluntary health insurance associations.
Sec. 163. State authority fully applicable to self-insured multiple employer welfare arrangements providing medical care which are not exempted under new part 7.
Sec. 164. Clarification of treatment of single employer arrangements.
Sec. 165. Clarification of treatment of certain collectively bargained arrangements.
Sec. 166. Treatment of church plans.
Sec. 167. Enforcement provisions relating to multiple employer welfare arrangements.
Sec. 168. Cooperation between Federal and State authorities.
Sec. 169. Filing and disclosure requirements for multiple employer welfare arrangements offering health benefits.
Sec. 170. Single annual filing for all participating employers.
Sec. 171. Effective date; transitional rule.

Subtitle D—Definitions; General Provisions

Sec. 191. Definitions; scope of coverage.
Sec. 192. State flexibility to provide greater protection.
Sec. 193. Effective date.
Sec. 194. Rule of construction.
Sec. 195. Findings relating to exercise of commerce clause authority.

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

Sec. 200. References in title.

Subtitle A—Fraud and Abuse Control Program

Sec. 201. Fraud and abuse control program.
Sec. 202. Medicare integrity program.
Sec. 203. Beneficiary incentive programs.
Sec. 204. Application of certain health anti-fraud and abuse sanctions to fraud and abuse against Federal health care programs.
Sec. 205. Guidance regarding application of health care fraud and abuse sanctions.

Subtitle B—Revisions to Current Sanctions for Fraud and Abuse

Sec. 211. Mandatory exclusion from participation in medicare and State health care programs.
Sec. 212. Establishment of minimum period of exclusion for certain individuals and entities subject to permissive exclusion from medicare and State health care programs.
Sec. 213. Permissive exclusion of individuals with ownership or control interest in sanctioned entities.
Sec. 214. Sanctions against practitioners and persons for failure to comply with statutory obligations.
Sec. 215. Intermediate sanctions for medicare health maintenance organizations.
Sec. 216. Additional exception to anti-kickback penalties for discounting and managed care arrangements.
Sec. 217. Criminal penalty for fraudulent disposition of assets in order to obtain medicaid benefits.
Sec. 218. Effective date.

Subtitle C—Data Collection

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

Subtitle D—Civil Monetary Penalties

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

Subtitle E—Revisions to Criminal Law

Sec. 241. Definitions relating to Federal health care offense.
Sec. 242. Health care fraud.
Sec. 243. Theft or embezzlement.
Sec. 244. False statements.
Sec. 245. Obstruction of criminal investigations of health care offenses.
Sec. 246. Laundering of monetary instruments.
Sec. 247. Injunctive relief relating to health care offenses.
Sec. 248. Authorized investigative demand procedures.
Sec. 249. Forfeitures for Federal health care offenses.
Sec. 250. Relation to ERISA authority.

Subtitle F—Administrative Simplification

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

''PART C—ADMINISTRATIVE SIMPLIFICATION

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

Sec. 253. Changes in membership and duties of National Committee on Vital and Health Statistics.

Subtitle G—Duplication and Coordination of Medicare-Related Plans

Sec. 261. Duplication and coordination of medicare-related plans.

Subtitle H—Medical Liability Reform

PART 1—GENERAL PROVISIONS

Sec. 271. Federal reform of health care liability actions.
Sec. 272. Definitions.
Sec. 273. Effective date.

PART 2—UNIFORM STANDARDS FOR HEALTH CARE LIABILITY ACTIONS

Sec. 281. Statute of limitations.
Sec. 282. Calculation and payment of damages.
Sec. 283. Alternative dispute resolution.

TITLE III—TAX-RELATED HEALTH PROVISIONS

Sec. 300. Amendment of 1986 code.

Subtitle A—Medical Savings Accounts

Sec. 301. Medical savings accounts.

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

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

Subtitle C—Long-Term Care Services and Contracts

PART I—GENERAL PROVISIONS

Sec. 321. Treatment of long-term care insurance.
Sec. 322. Qualified long-term care services treated as medical care.
Sec. 323. Reporting requirements.

PART II—CONSUMER PROTECTION PROVISIONS

Sec. 325. Policy requirements.
Sec. 326. Requirements for issuers of long-term care insurance policies.
Sec. 327. Coordination with State requirements.
Sec. 328. Effective dates.

Subtitle D—Treatment of Accelerated Death Benefits

Sec. 331. Treatment of accelerated death benefits by recipient.
Sec. 332. Tax treatment of companies issuing qualified accelerated death benefit riders.

Subtitle E—High-Risk Pools

Sec. 341. Exemption from income tax for State-sponsored organizations providing health coverage for high-risk individuals.

Subtitle F—Organizations Subject to Section 833

Sec. 351. Organizations subject to section 833.

TITLE IV—REVENUE OFFSETS

Sec. 400. Amendment of 1986 Code.

Subtitle A—Repeal of Bad Debt Reserve Method for Thrift Savings Associations

Sec. 401. Repeal of bad debt reserve method for thrift savings associations.

Subtitle B—Reform of the Earned Income Credit

Sec. 411. Earned income credit denied to individuals not authorized to be employed in the United States.

Subtitle C—Treatment of Individuals Who Lose United States Citizenship

Sec. 421. Revision of income, estate, and gift taxes on individuals who lose United States citizenship.
Sec. 422. Information on individuals losing United States citizenship.
Sec. 423. Report on tax compliance by United States citizens and residents living abroad.

TITLE I—IMPROVED AVAILABILITY AND PORTABILITY OF HEALTH INSURANCE COVERAGE

Subtitle A—Coverage Under Group Health Plans

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

(a) CREDITING PERIODS OF PREVIOUS COVERAGE TOWARD PREEXISTING CONDITION RESTRICTIONS.—Subject to the succeeding provisions of this section, a group health plan, and an insurer or health maintenance organization offering health insurance coverage in connection with a group health plan, shall provide that any preexisting condition limitation period (as defined in subsection (b)(2)) is reduced by the length of the aggregate period of qualified prior coverage (if any, as defined in subsection (b)(3)) applicable to the participant or beneficiary as of the date of commencement of coverage under the plan.

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

(1) PREEXISTING CONDITION.—

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

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

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

whichever is earlier.

(B) TREATMENT OF GENETIC INFORMATION.—For purposes of this section, genetic information shall not be considered to be a preexisting condition, so long as treatment of the condition to which the information is applicable has not been sought during the 6-month period described in subparagraph (A).

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

(3) AGGREGATE PERIOD OF QUALIFIED PRIOR COVERAGE.—

(A) IN GENERAL.—For purposes of this section, the term ''aggregate period of qualified prior coverage'' means, with respect to commencement of coverage of an individual under a group health plan or health insurance coverage offered in connection with a group health plan, the aggregate of the qualified coverage periods (as defined in subparagraph (B)) of such individual occurring before the date of such commencement. Such period shall be treated as zero if there is more than a 60-day break in coverage under a group health plan (or health insurance coverage offered in connection with such a plan) between the date the most recent qualified coverage period ends and the date of such commencement.

(B) QUALIFIED COVERAGE PERIOD.—

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

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

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

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

(c) CERTIFICATIONS OF COVERAGE; CONFORMING COVERAGE.—

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

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

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

(A) the plan, insurer, or HMO shall prominently state in any disclosure statements concerning the plan or coverage and to each enrollee at the time of enrollment under the plan (or at the time the health insurance coverage is offered for sale in the group health market) that the plan or coverage has made such election and shall include a description of the effect of this election; and

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

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

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

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

(a) LIMITATION OF PERIOD.—

(1) IN GENERAL.—Subject to the succeeding provisions of this section, a group health plan, and an insurer or HMO offering health insurance coverage in connection with a group health plan, shall provide that any preexisting condition limitation period (as defined in section 101(b)(2)) does not exceed 12 months, counting from the effective date of coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

with any other applicable waiting period under the plan.

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

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

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

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

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

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

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

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

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

(C) to prevent such a plan, insurer, or HMO from varying the premiums or contributions required of participants or beneficiaries based on factors (such as scope of benefits, geographic area of residence, or wage levels) that are not directly related to health status.

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

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

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

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

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

(d) DEPENDENT BENEFICIARIES.—

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

(A) is a newborn,

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

(C) is a spouse, at the time of marriage,

if the participant has met any waiting period applicable to that participant.

(2) TIMELY ENROLLMENT.—

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

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

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

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

if family coverage is available as of such date.

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

(e) MULTIEMPLOYER PLANS, MULTIPLE EMPLOYER HEALTH PLANS, AND MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.—A group health plan which is a multi-employer plan, a multiple employer health plan (as defined in section 701(4) of the Employee Retirement Income Security Act of 1974), or a multiple employer welfare arrangement (to the extent to which benefits under the arrangement consist of medical care) may not deny an employer whose employees are covered under such a plan or arrangement continued access to the same or different coverage under the terms of such a plan or arrangement, other than—

(1) for nonpayment of contributions,

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

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

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

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

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

(7) in the case of a multiple employer health plan (as defined in section 701(4) of such Act), for failure to meet the requirements under part 7 of subtitle B of title I of such Act for exemption under section 514(b)(6)(B) of such Act.

SEC. 104. ENFORCEMENT.

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

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

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

''(2) subject to subsection (h)—

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

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

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

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

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

''(1) IN GENERAL.—

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

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

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

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

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

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

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

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

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

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

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

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

Act of 1974 for purposes of applying such title.

(2) FEDERAL ENFORCEMENT ONLY IF NO ENFORCEMENT THROUGH STATE.—The Secretary of Labor shall enforce each section referred to in paragraph (1) with respect to any entity which is an insurer or health maintenance organization regulated by a State only if the Secretary of Labor determines that such State has not provided for enforcement of State laws which govern the same matters as are governed by such section and which require compliance by such entity with at least the same requirements as those provided under such section.

(3) LIMITATIONS ON LIABILITY.—

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

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

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

(c) ENFORCEMENT THROUGH CIVIL MONEY PENALTIES.—

(1) IMPOSITION.—

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

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

(C) AMOUNT OF PENALTY.—

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

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

(iii) LIMITATIONS.—

(I) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No civil money penalty shall be imposed under this paragraph on any failure during any period for which it is established to the satisfaction of the Secretary that none of the persons against whom the penalty would be imposed knew, or exercising reasonable diligence would have known, that such failure existed.

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

(D) ADMINISTRATIVE REVIEW.—

(i) OPPORTUNITY FOR HEARING.—The person assessed shall be afforded an opportunity for hearing by the Secretary upon request made within 30 days after the date of the issuance of a notice of assessment. In such hearing the decision shall be made on the record pursuant to section 554 of title 5, United States Code. If no hearing is requested, the assessment shall constitute a final and unappealable order.

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

(E) JUDICIAL REVIEW.—

(i) FILING OF ACTION FOR REVIEW.—Any person against whom an order imposing a civil money penalty has been entered after an agency hearing under this paragraph may obtain review by the United States district court for any district in which such person is located or the United States District Court for the District of Columbia by filing a notice of appeal in such court within 30 days from the date of such order, and simultaneously sending a copy of such notice be registered mail to the Secretary.

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

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

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

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

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

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

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

(2) FEDERAL ENFORCEMENT ONLY IF NO ENFORCEMENT THROUGH STATE.—Paragraph (1) shall apply to enforcement of the requirements of section 101, 102, or 103 (other than section 103(e)) with respect to any entity which offers health insurance coverage and which is an insurer or HMO regulated by a State only if the Secretary of Health and Human Services has determined that such State has not provided for enforcement of State laws which govern the same matters as are governed by such section and which require compliance by such entity with at least the same requirements as those provided under such section.

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

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

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

PART 1—AVAILABILITY OF GROUP HEALTH INSURANCE COVERAGE

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

(a) ISSUANCE OF COVERAGE.—

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

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

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

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

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

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

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

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

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

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

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

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

(i) it will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to

existing group contract holders and enrollees, and

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

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

(c) SPECIAL RULE FOR FINANCIAL CAPACITY LIMITS.—

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

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

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

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

(d) EXCEPTION TO REQUIREMENT FOR ISSUANCE OF COVERAGE BY REASON OF FAILURE BY PLAN TO MEET CERTAIN MINIMUM PARTICIPATION OR CONTRIBUTION RULES.—

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

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

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

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

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

SEC. 132. GUARANTEED RENEWABILITY OF GROUP COVERAGE.

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

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

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

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

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

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

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

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

(c) EXCEPTIONS FOR UNIFORM TERMINATION OF COVERAGE.—

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

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

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

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

(2) DISCONTINUANCE OF ALL COVERAGE.—

(A) IN GENERAL.—Subject to subparagraph (C), in any case in which an insurer or HMO elects to discontinue offering all health insurance coverage in the small group market or the large group market, or both markets, in a State, health insurance coverage may be discontinued by the insurer or organization only if—

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

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

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

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

PART 2—AVAILABILITY OF INDIVIDUAL HEALTH INSURANCE COVERAGE

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

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

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

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

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

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

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

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

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

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

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

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

(2) QUALIFYING COVERAGE.—

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

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

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

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

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

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

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

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

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

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

(B) Mandatory group conversion policies.

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

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

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

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

(4) DEADLINE FOR STATE IMPLEMENTATION.—

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

(B) EXTENSION TO PERMIT LEGISLATION.—The deadline under this paragraph is July 1, 1998, in the case of a State the legislature of which does not have a regular legislative session at any time between January 1, 1997, and June 30, 1997.

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

(i) implementing guaranteed availability mechanisms before the deadline,

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

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

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

(d) FALLBACK PROVISIONS.—

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

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

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

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

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

(3) DESCRIPTION OF FALLBACK MECHANISM.—As provided under paragraphs (1) and (2) and subject to paragraph (5), each insurer or HMO in the State involved that issues individual health insurance coverage—

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

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

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

(5) TERMINATION OF FALLBACK MECHANISM.—The provisions of this subsection shall cease to apply to a State if the Secretary finds that a State has implemented a mechanism that is reasonably designed to meet the goals specified in subsection (a), and until the Secretary finds that such mechanism is no longer being implemented.

(e) CONSTRUCTION.—

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

(2) MARKET REQUIREMENTS.—

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

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

(3) DISREGARD OF ASSOCIATION COVERAGE.—An insurer or HMO that offers health insurance coverage only in connection with a group health plan or in connection with individuals based on affiliation with one or more bona fide associations is not considered, for purposes of this subtitle, to be offering individual health insurance coverage.

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

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

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

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

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

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

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

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

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

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

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

PART 3—ENFORCEMENT

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

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

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

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

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

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

"SEC. 701. DEFINITIONS.

''For purposes of this part—

''(1) FULLY INSURED.—A particular benefit under a group health plan or a multiple employer welfare arrangement is 'fully insured' if such benefit (irrespective of any recourse available against other parties) is provided by an insurer or a health maintenance organization in a manner so that such benefit constitutes insurance regulated by the law of a State (within the meaning of section 514(b)(2)(A)).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(b) TREATMENT UNDER PREEMPTION RULES.—

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

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

''(A) such exemption—

''(i) is administratively feasible,

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

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

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

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

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

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

''(i) the sponsor, and

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

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

''(C) BONDING REQUIREMENTS.—Evidence provided by the board of trustees that the bonding requirements of section 412 will be met as of the date of the application or (if later) commencement of operations.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(e) REPORTING REQUIREMENTS.—Under regulations of the Secretary, the requirements of sections 102, 103, and 104 shall apply with respect to any multiple employer welfare arrangement which is or has been exempt under section 514(b)(6)(B) in the same manner and to the same extent as such requirements apply to employee welfare benefit plans, irrespective of whether such exemption continues in effect. The annual report required under section 103 for any plan year in the case of any such multiple employer welfare arrangement shall also include information described in subsection (b)(3)(F) with respect to the plan year and, notwithstanding section 104(a)(1)(A), shall be filed not later than 90 days after the close of the plan year.

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

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

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

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

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

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

''(1) SPONSOR.—The sponsor is, and has been (together with its immediate predecessor, if any) for a continuous period of not less than 5 years before the date of the application, organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis, as a trade association, an industry association, a professional association, or a chamber of commerce (or similar business group, including a corporation or similar organization that operates on a cooperative basis (within the meaning of section 1381 of the Internal Revenue Code of 1986)), for substantial purposes other than that of obtaining or providing medical care (within the meaning of section 607(1)), and the applicant demonstrates to the satisfaction of the Secretary that the sponsor is established as a permanent entity which receives the active support of its members and collects dues or contributions from its members on a periodic basis, without conditioning such dues or contributions on the basis of the health status of the employees of such members or the dependents of such employees or on the basis of participation in a group health plan. Any sponsor consisting of an association of entities meeting the preceding requirements of this paragraph shall be treated as meeting the requirements of this paragraph.

''(2) BOARD OF TRUSTEES.—The arrangement is operated, pursuant to a trust agreement, by a board of trustees which has complete fiscal control over the arrangement and which is responsible for all operations of the arrangement, and the board of trustees has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the arrangement and to meet all requirements of this title applicable to the arrangement. The members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business. No such member is an owner, officer, director, or employee of, or partner in, a contract administrator or other service provider to the arrangement, except that officers or employees of a sponsor which is a service provider (other than a contract administrator) to the arrangement may be members of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the arrangement other than on behalf of the sponsor. The board has sole authority to approve applications for participation in the arrangement and to contract with a service provider to administer the day-to-day affairs of the arrangement.

''(3) COVERED PERSONS.—The instruments governing the arrangement include a written instrument which provides that, effective upon becoming an arrangement exempt under section 514(b)(6)(B)—

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

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

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

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

''(C) no participating employer may provide health insurance coverage in the individual market for any employee not covered under the arrangement which is similar to the coverage contemporaneously provided to employees of the employer under the arrangement, if such exclusion of the employee from coverage under the arrangement is based in whole or in part on the health status of the employee and such employee would, but for such exclusion on such basis, be eligible for coverage under the arrangement.

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

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

''(b) TREATMENT OF FRANCHISE NETWORKS.—In the case of a multiple employer welfare arrangement which is established and maintained by a franchisor for a franchise network consisting of its franchisees, the requirements of subsection (a)(1) shall not apply with respect to such network in any case in which such requirements would be met if the franchisor were deemed to be the sponsor referred to in subsection (a)(1), such network were deemed to be an association described in subsection (a)(1), and each franchisee were deemed to be a member (of the association and the sponsor) referred to in subsection (a)(1).

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

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

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

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

''(1) IN GENERAL.—In any case in which the majority of the employees covered under a multiple employer welfare arrangement are employees of a single employer (within the meaning of clauses (i) and (ii) of section 3(40)(B)), if all other employees covered under the arrangement are employed by employers who are related to such single employer—

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

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

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

''SEC. 704. OTHER REQUIREMENTS FOR EXEMPTION.

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

''(1) CONTENTS OF GOVERNING INSTRUMENTS.—The instruments governing the arrangement include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—

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

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

''(C) incorporates the requirements of section 705.

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

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

''SEC. 705. MAINTENANCE OF RESERVES.

''(a) IN GENERAL.—Each multiple employer welfare arrangement which is or has been exempt under section 514(b)(6)(B) and under which benefits are not fully insured shall establish and maintain reserves, consisting of—

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

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

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

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

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

''(2) $400,000.

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

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

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

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

''SEC. 706. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

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

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

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

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

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

''SEC. 707. CORRECTIVE ACTIONS AND MANDATORY TERMINATION.

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

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

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

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

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

''SEC. 708. ADDITIONAL RULES REGARDING STATE AUTHORITY.

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

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

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

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

''(B) certification that—

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

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

''(b) EXCEPTIONS.—

''(1) CERTAIN MULTISTATE ASSOCIATIONS.—Subsection (a) shall not apply in the case of a multiple employer welfare arrangement operating in any State which has made a certification under subsection (a)(2)(B) if—

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

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

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

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

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

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

''(B) at the time of the application for the exemption under section 514(b)(6), the arrangement does not have pending against it any enforcement action by the State.

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

''(A) provided guaranteed issue of individual health insurance coverage offered by insurers and health maintenance organizations

in the individual market using pure community rating and did not provide for any transition period (after the effective date of the guaranteed issue requirement) in the implementation of pure community rating; or

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

Regulations under this part may provide for an exemption from the applicability of paragraph (1) in the case of certain arrangements that are limited to a single industry.

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

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

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

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

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

''(A) such tax is computed by applying a rate to the amount of premiums or contributions received by the arrangement from participating employers located in such State with respect to individuals covered under the arrangement who are residents of such State,

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

''(C) such tax is otherwise nondiscriminatory, and

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

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

''(1) SMALL GROUP MARKET.—The term 'small group market' means the health insurance coverage market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) on the basis of employment or other relationship with respect to a small employer.

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

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

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

''(B) The Southeast Region, consisting of the States of Texas, Arkansas, Louisiana, Mississippi, Alabama, Georgia, Florida, South Carolina, North Carolina, Virginia, and Tennessee.

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

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

(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

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

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

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

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

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

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

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

(d) DEFINITIONS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(vi) Automobile medical-payment insurance.

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

''(viii) Hospital or fixed indemnity insurance.

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

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

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

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

''(A) IN GENERAL.—The term'';

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

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

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

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

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

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

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

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

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

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

''Sec. 701. Definitions.

''Sec. 702. Clarification of duty of the Secretary to implement provisions of current law provising for exemptions and solvency standards for multiple employer health plans.

''Sec. 703. Requirements relating to sponsors, boards of trustees, and plan operations.

''Sec. 704. Other requirements for exemption.

''Sec. 705. Maintenance of reserves.
''Sec. 706. Notice requirements for voluntary termination.
''Sec. 707. Corrective actions and mandatory termination.
''Sec. 708. Additional rules regarding State authority.

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

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

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

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

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

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

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

''(C) require—

''(i) health insurance coverage in connection with a voluntary health insurance association to include specific items or services consisting of medical care, or

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

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

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

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

''(B) For purposes of this paragraph, the certification by a State that such State provides 'guaranteed access' to health insurance coverage to the residents of such State means—

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

''(ii) certification that—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(5) For purposes of this subsection—

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

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

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

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

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

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

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

''(i) The sponsor of the association is, and has been (together with its immediate predecessor, if any) for a continuous period of not less than 5 years, organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose, as a trade association, an industry association, a professional association, or a chamber of commerce (or similar business group), for substantial purposes other than that of obtaining or providing medical care (within the meaning of section 607(1)).

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

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

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

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

''(C) The term 'small group market' means the health insurance coverage market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) on the basis of employment or other relationship with respect to a small employer.

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

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

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

''(ii) The Southeast Region, consisting of the States of Texas, Arkansas, Louisiana, Mississippi, Alabama, Georgia, Florida, South Carolina, North Carolina, Virginia, and Tennessee.

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

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

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

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

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

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

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

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

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

(2) in clause (iii)—

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

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

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

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

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

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

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

''(i)(I) under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws, and (II) in accordance with subparagraphs (C), (D), and (E),''.

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

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

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

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

''(II) pay a commission or any other type of compensation to a person, other than a full time employee of the employee organization (or a member of the organization to the extent provided in regulations of the Secretary), that is related either to the volume or number of employers or individuals solicited or enrolled as participating employers or covered individuals under the plan or other arrangement, or to the dollar amount or size of the contributions made by participating employers or covered individuals to the plan or other arrangement, except to the extent that the services used by the plan, arrangement, organization, or other entity consist solely of preparation of documents necessary for compliance with the reporting and disclosure requirements of part 1 or administrative, investment, or consulting services unrelated to solicitation or enrollment of covered individuals.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 166. TREATMENT OF CHURCH PLANS.

(a) SPECIAL RULES FOR CHURCH PLANS.—

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

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

''(a) ELECTION FOR CHURCH PLANS.—

''(1) IN GENERAL.—Notwithstanding section 4(b)(2), if the church or convention or association of churches which maintains a church plan covered under this section makes an election with respect to such plan under this subsection (in such form and manner as the Secretary may by regulations prescribe), then, subject to this section, the provisions of this part (and other provisions of this title to the extent that they apply to group health plans which are multiple employer welfare arrangements) shall apply to such church plan, with respect to benefits provided under such plan consisting of medical care, as if—

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

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

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

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

''(c) SPONSOR AND BOARD OF TRUSTEES.—For purposes of this part, in the case of a church plan to which this part applies pursuant to an election under subsection (a), in treating such plan as if it were a multiple employer welfare arrangement under this part—

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

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

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

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

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

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

terms governing such fund, be used for, or diverted to, any purpose other than for the exclusive benefit of the participants and beneficiaries of the church plans whose assets are pooled in such fund.

''(f) INAPPLICABILITY OF CERTAIN PROVISIONS.—

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

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

(b) CONFORMING AMENDMENTS.—

(1) Section 4(b)(2) of such Act (29 U.S.C. 1003(b)(2)) is amended by inserting before the semicolon the following: '', except with respect to provisions made applicable under any election made under section 704(a) of this Act''.

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

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

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

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

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

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

(a) ENFORCEMENT OF FILING REQUIREMENTS.—Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) (as amended by sections 102(c)) is further amended—

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

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

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

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

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

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

(3) by adding at the end the following:

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

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

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

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

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

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

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

''(3) being a plan or arrangement with respect to which the requirements of subparagraph (C), (D), or (E) of section 3(40) are met, shall, upon conviction, be imprisoned not more than five years, be fined under title 18, United States Code, or both.''.

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

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

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

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

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

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

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

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

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

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

SEC. 168. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

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

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

''(1) STATE ENFORCEMENT.—

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

''(B) DELEGATIONS.—Any department, agency, or instrumentality of a State to which authority is delegated pursuant to an agreement entered into under this paragraph may, if authorized under State law and to the extent consistent with such agreement, exercise the powers of the Secretary under this title which relate to such authority.

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

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

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

''(A) provide enforcement assistance to the States with respect to multiple employer welfare arrangements, including, but not limited to, coordinating Federal and State efforts through the establishment of cooperative agreements with appropriate State agencies under which the Pension and Welfare Benefits Administration keeps the States informed of the status of its cases and makes available to the States information obtained by it,

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

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

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

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

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

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

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

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

''(2) Each registration statement—

''(A) shall be filed in such form, and contain such information concerning the multiple employer welfare arrangement and any persons involved in its operation (including

whether coverage under the arrangement is fully insured), as shall be provided in regulations which shall be prescribed by the Secretary, and

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

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

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

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

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

''(B) in the case of a multiple employer welfare arrangement for which the trustee or trustees cannot be identified, or upon the failure of the trustee or trustees of an arrangement to file, the person or persons actually responsible for the acquisition, disposition, control, or management of the cash or property of the arrangement, irrespective of whether such acquisition, disposition, control, or management is exercised directly by such person or persons or through an agent designated by such person or persons.

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

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

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

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

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

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

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

''(C) a statement indicating—

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

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

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

''(2) TIME FOR DISCLOSURE.—Such information shall be issued to employers within such reasonable period of time before becoming participating employers as may be prescribed in regulations of the Secretary.''.

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

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

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

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

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act. The Secretary of Labor shall prescribe the alternative method referred to in section 110(c) of the Employee Retirement Income Security Act of 1974, as added by such amendment, within 90 days after the date of the enactment of this Act.

SEC. 171. EFFECTIVE DATE; TRANSITIONAL RULE.

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

(b) TRANSITIONAL RULE.—

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

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

(B) 18 months after such effective date.

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

Subtitle D—Definitions; General Provisions

SEC. 191. DEFINITIONS; SCOPE OF COVERAGE.

(a) GROUP HEALTH PLAN.—

(1) DEFINITION.—Subject to the succeeding provisions of this subsection and subsection (d)(1), the term ''group health plan'' means an employee welfare benefit plan to the extent that the plan provides medical care (as defined in subsection (c)(9)) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise, and includes a group health plan (within the meaning of section 5000(b)(1) of the Internal Revenue Code of 1986).

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

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

(4) TREATMENT OF CHURCH PLANS.—

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

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

(5) TREATMENT OF GOVERNMENTAL PLANS.—

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

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

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

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

(b) INCORPORATION OF CERTAIN DEFINITIONS IN EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—Except as provided in this section, the terms ''beneficiary'', ''church plan'', ''employee'', ''employee welfare benefit plan'', ''employer'', ''governmental plan'', ''multiemployer plan'', ''multiple employer welfare arrangement'', ''participant'', ''plan sponsor'', and ''State'' have the meanings given such terms in section 3 of the Employee Retirement Income Security Act of 1974.

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

(1) APPLICABLE STATE AUTHORITY.—The term ''applicable State authority'' means, with respect to an insurer or health maintenance organization in a State, the State insurance commissioner or official or officials

designated by the State to enforce the requirements of this title for the State involved with respect to such insurer or organization.

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

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

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

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

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

(E) does not make health insurance coverage offered through the association available to any individual who is not a member (or dependent of a member) of the association at the time the coverage is initially issued,

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

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

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

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

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

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

(4) HEALTH INSURANCE COVERAGE.—

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

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

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

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

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

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

(v) Workers' compensation or similar insurance.

(vi) Automobile medical-payment insurance.

(vii) Coverage for a specified disease or illness.

(viii) Hospital or fixed indemnity insurance.

(ix) Short-term limited duration insurance.

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

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

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

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

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

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

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

(7) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The term ''individual health insurance coverage'' means health insurance coverage offered to individuals if the coverage is not offered in connection with a group health plan (other than such a plan that has fewer than two participants as current employees on the first day of the plan year).

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

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

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

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

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

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

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

(d) TREATMENT OF PARTNERSHIPS.—

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 192. STATE FLEXIBILITY TO PROVIDE GREATER PROTECTION.

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

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

(2) that require insurers or HMOs—

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

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

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

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

SEC. 193. EFFECTIVE DATE.

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

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

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

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

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

SEC. 194. RULE OF CONSTRUCTION.

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

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

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

(1) Provisions in group health plans and health insurance coverage that impose certain pre-existing conditions impact the ability of employees to seek employment in interstate commerce, thereby impeding such commerce.

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

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

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

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

SEC. 200. REFERENCES IN TITLE.

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

Subtitle A—Fraud and Abuse Control Program

SEC. 201. FRAUD AND ABUSE CONTROL PROGRAM.

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

''FRAUD AND ABUSE CONTROL PROGRAM

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

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

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

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

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

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

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

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

''(3) GUIDELINES.—

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

''(B) INFORMATION GUIDELINES.—

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

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

''(iii) QUALIFIED IMMUNITY FOR PROVIDING INFORMATION.—The provisions of section 1157(a) (relating to limitation on liability) shall apply to a person providing information to the Secretary or the Attorney General in conjunction with their performance of duties under this section.

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

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

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

''(1) REIMBURSEMENTS FOR INVESTIGATIONS.—The Inspector General of the Department of Health and Human Services is authorized to receive and retain for current use reimbursement for the costs of conducting investigations and audits and for monitoring compliance plans when such costs are ordered by a court, voluntarily agreed to by the payor, or otherwise.

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

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

''(1) a policy of health insurance;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(iv) Penalties and damages obtained and otherwise creditable to miscellaneous receipts of the general fund of the Treasury obtained under sections 3729 through 3733 of title 31, United States Code (known as the False Claims Act), in cases involving claims related to the provision of health care items and services (other than funds awarded to a relator, for restitution or otherwise authorized by law).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(ii) investigations;

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

''(iv) inspections and other evaluations; and

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 202. MEDICARE INTEGRITY PROGRAM.

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

''MEDICARE INTEGRITY PROGRAM

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

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

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

''(2) Audit of cost reports.

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

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

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

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

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

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

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

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

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

''(d) PROCESS FOR ENTERING INTO CONTRACTS.—The Secretary shall enter into contracts under the Program in accordance with such procedures as the Secretary shall by regulation establish, except that such procedures shall include the following:

''(1) The Secretary shall determine the appropriate number of separate contracts which are necessary to carry out the Program and the appropriate times at which the Secretary shall enter into such contracts.

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

''(B) Competitive procedures must be used when entering into new contracts under this section, or at any other time considered appropriate by the Secretary, except that the Secretary may contract with entities that are carrying out the activities described in this section pursuant to agreements under section 1816 or contracts under section 1842 in effect on the date of the enactment of this section.

''(3) A contract under this section may be renewed without regard to any provision of law requiring competition if the contractor has met or exceeded the performance requirements established in the current contract.

''(e) LIMITATION ON CONTRACTOR LIABILITY.—The Secretary shall by regulation provide for the limitation of a contractor's liability for actions taken to carry out a contract under the Program, and such regulation shall, to the extent the Secretary finds appropriate, employ the same or comparable standards and other substantive and procedural provisions as are contained in section 1157.''.

(b) ELIMINATION OF FI AND CARRIER RESPONSIBILITY FOR CARRYING OUT ACTIVITIES SUBJECT TO PROGRAM.—

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

''(l) No agency or organization may carry out (or receive payment for carrying out) any activity pursuant to an agreement under this section to the extent that the activity is carried out pursuant to a contract under the Medicare Integrity Program under section 1893.''.

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

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

SEC. 203. BENEFICIARY INCENTIVE PROGRAMS.

(a) CLARIFICATION OF REQUIREMENT TO PROVIDE EXPLANATION OF MEDICARE BENEFITS.—The

Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall provide an explanation of benefits under the medicare program under title XVIII of the Social Security Act with respect to each item or service for which payment may be made under the program which is furnished to an individual, without regard to whether or not a deductible or coinsurance may be imposed against the individual with respect to the item or service.

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

(1) ESTABLISHMENT OF PROGRAM.—Not later than 3 months after the date of the enactment of this Act, the Secretary shall establish a program under which the Secretary shall encourage individuals to report to the Secretary information on individuals and entities who are engaging or who have engaged in acts or omissions which constitute grounds for the imposition of a sanction under section 1128, section 1128A, or section 1128B of the Social Security Act, or who have otherwise engaged in fraud and abuse against the medicare program for which there is a sanction provided under law. The program shall discourage provision of, and not consider, information which is frivolous or otherwise not relevant or material to the imposition of such a sanction.

(2) PAYMENT OF PORTION OF AMOUNTS COLLECTED.—If an individual reports information to the Secretary under the program established under paragraph (1) which serves as the basis for the collection by the Secretary or the Attorney General of any amount of at least $100 (other than any amount paid as a penalty under section 1128B of the Social Security Act), the Secretary may pay a portion of the amount collected to the individual (under procedures similar to those applicable under section 7623 of the Internal Revenue Code of 1986 to payments to individuals providing information on violations of such Code).

(c) PROGRAM TO COLLECT INFORMATION ON PROGRAM EFFICIENCY.—

(1) ESTABLISHMENT OF PROGRAM.—Not later than 3 months after the date of the enactment of this Act, the Secretary shall establish a program under which the Secretary shall encourage individuals to submit to the Secretary suggestions on methods to improve the efficiency of the medicare program.

(2) PAYMENT OF PORTION OF PROGRAM SAVINGS.—If an individual submits a suggestion to the Secretary under the program established under paragraph (1) which is adopted by the Secretary and which results in savings to the program, the Secretary may make a payment to the individual of such amount as the Secretary considers appropriate.

SEC. 204. APPLICATION OF CERTAIN HEALTH ANTI-FRAUD AND ABUSE SANCTIONS TO FRAUD AND ABUSE AGAINST FEDERAL HEALTH CARE PROGRAMS.

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

(1) In the heading, by striking ''MEDICARE OR STATE HEALTH CARE PROGRAMS'' and inserting ''FEDERAL HEALTH CARE PROGRAMS''.

(2) In subsection (a)(1), by striking ''a program under title XVIII or a State health care program (as defined in section 1128(h))'' and inserting ''a Federal health care program''.

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

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

(A) by striking ''a State plan approved under title XIX'' and inserting ''a Federal health care program'', and

(B) by striking ''the State may at its option (notwithstanding any other provision of that title or of such plan)'' and inserting ''the administrator of such program may at its option (notwithstanding any other provision of such program)''.

(5) In subsection (b), by striking ''title XVIII or a State health care program'' each place it appears and inserting ''a Federal health care program''.

(6) In subsection (c), by inserting ''(as defined in section 1128(h))'' after ''a State health care program''.

(7) By adding at the end the following new subsection:

''(f) For purposes of this section, the term 'Federal health care program' means—

''(1) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the health insurance program under chapter 89 of title 5, United States Code); or

''(2) any State health care program, as defined in section 1128(h).''.

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

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

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

''GUIDANCE REGARDING APPLICATION OF HEALTH CARE FRAUD AND ABUSE SANCTIONS

''SEC. 1128D. (a) SOLICITATION AND PUBLICATION OF MODIFICATIONS TO EXISTING SAFE HARBORS AND NEW SAFE HARBORS.—

''(1) IN GENERAL.—

''(A) SOLICITATION OF PROPOSALS FOR SAFE HARBORS.—Not later than January 1, 1997, and not less than annually thereafter, the Secretary shall publish a notice in the Federal Register soliciting proposals, which will be accepted during a 60-day period, for—

''(i) modifications to existing safe harbors issued pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987 (42 U.S.C. 1320a–7b note);

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

''(iii) advisory opinions to be issued pursuant to subsection (b); and

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

''(B) PUBLICATION OF PROPOSED MODIFICATIONS AND PROPOSED ADDITIONAL SAFE HARBORS.—After considering the proposals described in clauses (i) and (ii) of subparagraph (A), the Secretary, in consultation with the Attorney General, shall publish in the Federal Register proposed modifications to existing safe harbors and proposed additional safe harbors, if appropriate, with a 60-day comment period. After considering any public comments received during this period, the Secretary shall issue final rules modifying the existing safe harbors and establishing new safe harbors, as appropriate.

''(C) REPORT.—The Inspector General of the Department of Health and Human Services (in this section referred to as the 'Inspector General') shall, in an annual report to Congress or as part of the year-end semiannual report required by section 5 of the Inspector General Act of 1978 (5 U.S.C. App.), describe the proposals received under clauses (i) and (ii) of subparagraph (A) and explain which proposals were included in the publication described in subparagraph (B), which proposals were not included in that publication, and the reasons for the rejection of the proposals that were not included.

''(2) CRITERIA FOR MODIFYING AND ESTABLISHING SAFE HARBORS.—In modifying and establishing safe harbors under paragraph (1)(B), the Secretary may consider the extent to which providing a safe harbor for the specified payment practice may result in any of the following:

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

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

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

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

''(E) An increase or decrease in the ability of health care facilities to provide services in medically underserved areas or to medically underserved populations.

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

''(G) An increase or decrease in the potential overutilization of health care services.

''(H) The existence or nonexistence of any potential financial benefit to a health care professional or provider which may vary based on their decisions of—

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

''(ii) whether to arrange for a referral of health care items or services to a particular practitioner or provider.

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

''(b) ADVISORY OPINIONS.—

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

''(2) MATTERS SUBJECT TO ADVISORY OPINIONS.—The Secretary shall issue advisory opinions as to the following matters:

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

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

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

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

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

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

''(A) Whether the fair market value shall be, or was paid or received for any goods, services or property.

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

''(4) EFFECT OF ADVISORY OPINIONS.—

''(A) BINDING AS TO SECRETARY AND PARTIES INVOLVED.—Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion.

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

''(5) REGULATIONS.—

''(A) IN GENERAL.—Not later than 180 days after the date of the enactment of this section, the Secretary shall issue regulations to carry out this section. Such regulations shall provide for—

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

''(ii) the procedure to be followed by the Secretary in responding to a request for an advisory opinion;

''(iii) the interval in which the Secretary shall respond;

''(iv) the reasonable fee to be charged to the party requesting an advisory opinion; and

''(v) the manner in which advisory opinions will be made available to the public.

''(B) SPECIFIC CONTENTS.—Under the regulations promulgated pursuant to subparagraph (A)—

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

''(ii) the fee charged to the party requesting an advisory opinion shall be equal to the costs incurred by the Secretary in responding to the request.

''(c) SPECIAL FRAUD ALERTS.—

''(1) IN GENERAL.—

''(A) REQUEST FOR SPECIAL FRAUD ALERTS.—Any person may present, at any time, a request to the Inspector General for a notice which informs the public of practices which the Inspector General considers to be suspect or of particular concern under the medicare program or a State health care program, as defined in section 1128(h) (in this subsection referred to as a 'special fraud alert').

''(B) ISSUANCE AND PUBLICATION OF SPECIAL FRAUD ALERTS.—Upon receipt of a request described in subparagraph (A), the Inspector General shall investigate the subject matter of the request to determine whether a special fraud alert should be issued. If appropriate, the Inspector General shall issue a special fraud alert in response to the request. All special fraud alerts issued pursuant to this subparagraph shall be published in the Federal Register.

''(2) CRITERIA FOR SPECIAL FRAUD ALERTS.—In determining whether to issue a special fraud alert upon a request described in paragraph (1), the Inspector General may consider—

''(A) whether and to what extent the practices that would be identified in the special fraud alert may result in any of the consequences described in subsection (a)(2); and

''(B) the volume and frequency of the conduct that would be identified in the special fraud alert.''.

Subtitle B—Revisions to Current Sanctions for Fraud and Abuse

SEC. 211. MANDATORY EXCLUSION FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS.

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

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

''(3) FELONY CONVICTION RELATING TO HEALTH CARE FRAUD.—Any individual or entity that has been convicted after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program (other than those specifically described in paragraph (1)) operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.''.

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

''(1) CONVICTION RELATING TO FRAUD.—Any individual or entity that has been convicted after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, under Federal or State law—

''(A) of a criminal offense consisting of a misdemeanor relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct—

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

''(ii) with respect to any act or omission in a health care program (other than those specifically described in subsection (a)(1)) operated by or financed in whole or in part by any Federal, State, or local government agency; or

''(B) of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct with respect to any act or omission in a program (other than a health care program) operated by or financed in whole or in part by any Federal, State, or local government agency.''.

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

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

''(4) FELONY CONVICTION RELATING TO CONTROLLED SUBSTANCE.—Any individual or entity that has been convicted after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.''.

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

(A) in the heading, by striking ''CONVICTION'' and inserting ''MISDEMEANOR CONVICTION''; and

(B) by striking ''criminal offense'' and inserting ''criminal offense consisting of a misdemeanor''.

SEC. 212. ESTABLISHMENT OF MINIMUM PERIOD OF EXCLUSION FOR CERTAIN INDIVIDUALS AND ENTITIES SUBJECT TO PERMISSIVE EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS.

Section 1128(c)(3) (42 U.S.C. 1320a–7(c)(3)) is amended by adding at the end the following new subparagraphs:

''(D) In the case of an exclusion of an individual or entity under paragraph (1), (2), or (3) of subsection (b), the period of the exclusion shall be 3 years, unless the Secretary determines in accordance with published regulations that a shorter period is appropriate because of mitigating circumstances or that a longer period is appropriate because of aggravating circumstances.

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

''(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B), the period of the exclusion shall be not less than 1 year.''.

SEC. 213. PERMISSIVE EXCLUSION OF INDIVIDUALS WITH OWNERSHIP OR CONTROL INTEREST IN SANCTIONED ENTITIES.

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

''(15) INDIVIDUALS CONTROLLING A SANCTIONED ENTITY.—(A) Any individual—

''(i) who has a direct or indirect ownership or control interest in a sanctioned entity and who knows or should know (as defined in section 1128A(i)(6)) of the action constituting the basis for the conviction or exclusion described in subparagraph (B); or

''(ii) who is an officer or managing employee (as defined in section 1126(b)) of such an entity.

''(B) For purposes of subparagraph (A), the term 'sanctioned entity' means an entity—

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

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

SEC. 214. SANCTIONS AGAINST PRACTITIONERS AND PERSONS FOR FAILURE TO COMPLY WITH STATUTORY OBLIGATIONS.

(a) MINIMUM PERIOD OF EXCLUSION FOR PRACTITIONERS AND PERSONS FAILING TO MEET STATUTORY OBLIGATIONS.—

(1) IN GENERAL.—The second sentence of section 1156(b)(1) (42 U.S.C. 1320c–5(b)(1)) is amended by striking ''may prescribe)'' and inserting ''may prescribe, except that such period may not be less than 1 year)''.

(2) CONFORMING AMENDMENT.—Section 1156(b)(2) (42 U.S.C. 1320c–5(b)(2)) is amended by striking ''shall remain'' and inserting ''shall (subject to the minimum period specified in the second sentence of paragraph (1)) remain''.

(b) REPEAL OF ''UNWILLING OR UNABLE'' CONDITION FOR IMPOSITION OF SANCTION.—Section 1156(b)(1) (42 U.S.C. 1320c–5(b)(1)) is amended—

(1) in the second sentence, by striking ''and determines'' and all that follows through ''such obligations,''; and

(2) by striking the third sentence.

SEC. 215. INTERMEDIATE SANCTIONS FOR MEDICARE HEALTH MAINTENANCE ORGANIZATIONS.

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

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

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

''(B) is carrying out the contract in a manner substantially inconsistent with the efficient and effective administration of this section; or

''(C) no longer substantially meets the applicable conditions of subsections (b), (c), (e), and (f).''.

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

''(C) In the case of an eligible organization for which the Secretary makes a determination under paragraph (1) the basis of which is not described in subparagraph (A), the Secretary may apply the following intermediate sanctions:

''(i) Civil money penalties of not more than $25,000 for each determination under paragraph (1) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract.

''(ii) Civil money penalties of not more than $10,000 for each week beginning after the initiation of procedures by the Secretary under paragraph (9) during which the deficiency that is the basis of a determination under paragraph (1) exists.

''(iii) Suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.''.

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

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

''(A) the Secretary first provides the organization with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under paragraph (1) and the organization fails to develop or implement such a plan;

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

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

''(D) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before imposing any sanction or terminating the contract.''.

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

(b) AGREEMENTS WITH PEER REVIEW ORGANIZATIONS.—Section 1876(i)(7)(A) (42 U.S.C. 1395mm(i)(7)(A)) is amended by striking ''an agreement'' and inserting ''a written agreement''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to contract years beginning on or after January 1, 1996.

SEC. 216. ADDITIONAL EXCEPTION TO ANTI-KICKBACK PENALTIES FOR DISCOUNTING AND MANAGED CARE ARRANGEMENTS.

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

(1) by striking ''and'' at the end of subparagraph (D);

(2) by striking the period at the end of subparagraph (E) and inserting ''; and''; and

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

''(F) any remuneration between an organization and an individual or entity providing items or services, or a combination thereof, pursuant to a written agreement between the organization and the individual or entity if the organization is an eligible organization under section 1876 or if the written agreement places the individual or entity at substantial financial risk for the cost or utilization of the items or services, or a combination thereof, which the individual or entity is obligated to provide, whether through a withhold, capitation, incentive pool, per diem payment, or any other similar risk arrangement which places the individual or entity at substantial financial risk.''.

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

SEC. 217. CRIMINAL PENALTY FOR FRAUDULENT DISPOSITION OF ASSETS IN ORDER TO OBTAIN MEDICAID BENEFITS.

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

(1) by striking ''or'' at the end of paragraph (4);

(2) by adding ''or'' at the end of paragraph (5); and

(3) by inserting after paragraph (5) the following new paragraph:

''(6) knowingly and willfully disposes of assets (including by any transfer in trust) in order for an individual to become eligible for medical assistance under a State plan under title XIX, if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1917(c),''.

SEC. 218. EFFECTIVE DATE.

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

Subtitle C—Data Collection

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

(a) IN GENERAL.—Title XI (42 U.S.C. 1301 et seq.), as amended by sections 201 and 205, is amended by inserting after section 1128D the following new section:

''HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM

''SEC. 1128E. (a) GENERAL PURPOSE.—Not later than January 1, 1997, the Secretary shall establish a national health care fraud and abuse data collection program for the reporting of final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners as required by subsection (b), with access as set forth in subsection (c).

''(b) REPORTING OF INFORMATION.—

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

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

''(A) The name and TIN (as defined in section 7701(a)(41) of the Internal Revenue Code of 1986) of any health care provider, supplier, or practitioner who is the subject of a final adverse action.

''(B) The name (if known) of any health care entity with which a health care provider, supplier, or practitioner is affiliated or associated.

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

''(D) A description of the acts or omissions and injuries upon which the final adverse action was based, and such other information as the Secretary determines by regulation is required for appropriate interpretation of information reported under this section.

''(3) CONFIDENTIALITY.—In determining what information is required, the Secretary shall include procedures to assure that the privacy of individuals receiving health care services is appropriately protected.

''(4) TIMING AND FORM OF REPORTING.—The information required to be reported under this subsection shall be reported regularly (but not less often than monthly) and in such form and manner as the Secretary prescribes. Such information shall first be required to be reported on a date specified by the Secretary.

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

''(c) DISCLOSURE AND CORRECTION OF INFORMATION.—

''(1) DISCLOSURE.—With respect to the information about final adverse actions (not including settlements in which no findings of liability have been made) reported to the Secretary under this section respecting a health care provider, supplier, or practitioner, the Secretary shall, by regulation, provide for—

''(A) disclosure of the information, upon request, to the health care provider, supplier, or licensed practitioner, and

''(B) procedures in the case of disputed accuracy of the information.

''(2) CORRECTIONS.—Each Government agency and health plan shall report corrections of information already reported about any final adverse action taken against a health care provider, supplier, or practitioner, in such form and manner that the Secretary prescribes by regulation.

''(d) ACCESS TO REPORTED INFORMATION.—

''(1) AVAILABILITY.—The information in this database shall be available to Federal and State government agencies and health plans pursuant to procedures that the Secretary shall provide by regulation.

''(2) FEES FOR DISCLOSURE.—The Secretary may establish or approve reasonable fees for the disclosure of information in this database (other than with respect to requests by Federal agencies). The amount of such a fee shall be sufficient to recover the full costs of operating the database. Such fees shall be available to the Secretary or, in the Secretary's discretion to the agency designated under this section to cover such costs.

''(e) PROTECTION FROM LIABILITY FOR REPORTING.—No person or entity, including the agency designated by the Secretary in subsection (b)(5) shall be held liable in any civil action with respect to any report made as required by this section, without knowledge of the falsity of the information contained in the report.

''(f) DEFINITIONS AND SPECIAL RULES.—For purposes of this section:

''(1) FINAL ADVERSE ACTION.—

''(A) IN GENERAL.—The term 'final adverse action' includes:

''(i) Civil judgments against a health care provider, supplier, or practitioner in Federal or State court related to the delivery of a health care item or service.

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

''(iii) Actions by Federal or State agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners, including—

''(I) formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, censure or probation,

''(II) any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, nonrenewability, or otherwise, or

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

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

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

''(B) EXCEPTION.—The term does not include any action with respect to a malpractice claim.

''(2) PRACTITIONER.—The terms 'licensed health care practitioner', 'licensed practitioner', and 'practitioner' mean, with respect to a State, an individual who is licensed or otherwise authorized by the State to provide health care services (or any individual who, without authority holds himself or herself out to be so licensed or authorized).

''(3) GOVERNMENT AGENCY.—The term 'Government agency' shall include:

''(A) The Department of Justice.

''(B) The Department of Health and Human Services.

''(C) Any other Federal agency that either administers or provides payment for the delivery of health care services, including, but not limited to the Department of Defense and the Veterans' Administration.

''(D) State law enforcement agencies.

''(E) State medicaid fraud control units.

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

''(4) HEALTH PLAN.—The term 'health plan' has the meaning given such term by section 1128C(c).

''(5) DETERMINATION OF CONVICTION.—For purposes of paragraph (1), the existence of a conviction shall be determined under paragraph (4) of section 1128(i).''.

(b) IMPROVED PREVENTION IN ISSUANCE OF MEDICARE PROVIDER NUMBERS.—Section 1842(r) (42 U.S.C. 1395u(r)) is amended by adding at the end the following new sentence: ''Under such system, the Secretary may impose appropriate fees on such physicians to cover the costs of investigation and recertification activities with respect to the issuance of the identifiers.''.

Subtitle D—Civil Monetary Penalties

SEC. 231. SOCIAL SECURITY ACT CIVIL MONETARY PENALTIES.

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

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

(2) In subsection (f)—

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

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

''(3) With respect to amounts recovered arising out of a claim under a Federal health care program (as defined in section 1128B(f)), the portion of such amounts as is determined to have been paid by the program shall be repaid to the program, and the portion of such amounts attributable to the amounts recovered under this section by reason of the amendments made by the Health Coverage Availability and Affordability Act of 1996 (as estimated by the Secretary) shall be deposited into the Federal Hospital Insurance Trust Fund pursuant to section 1817(k)(2)(C).''.

(3) In subsection (i)—

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

(B) in paragraph (4), by striking ''a health insurance or medical services program under title XVIII or XIX of this Act'' and inserting ''a Federal health care program (as so defined)'', and

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

(4) By adding at the end the following new subsection:

''(m)(1) For purposes of this section, with respect to a Federal health care program not contained in this Act, references to the Secretary in this section shall be deemed to be references to the Secretary or Administrator of the department or agency with jurisdiction over such program and references to the Inspector General of the Department of Health and Human Services in this section shall be deemed to be references to the Inspector General of the applicable department or agency.

''(2)(A) The Secretary and Administrator of the departments and agencies referred to in paragraph (1) may include in any action pursuant to this section, claims within the jurisdiction of other Federal departments or agencies as long as the following conditions are satisfied:

''(i) The case involves primarily claims submitted to the Federal health care programs of the department or agency initiating the action.

''(ii) The Secretary or Administrator of the department or agency initiating the action gives notice and an opportunity to participate in the investigation to the Inspector General of the department or agency with primary jurisdiction over the Federal health care programs to which the claims were submitted.

''(B) If the conditions specified in subparagraph (A) are fulfilled, the Inspector General of the department or agency initiating the action is authorized to exercise all powers granted under the Inspector General Act of 1978 with respect to the claims submitted to the other departments or agencies to the same manner and extent as provided in that Act with respect to claims submitted to such departments or agencies.''.

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

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

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

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

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

''(4) in the case of a person who is not an organization, agency, or other entity, is excluded from participating in a program under title XVIII or a State health care program in accordance with this subsection or under section 1128 and who, at the time of a violation of this subsection—

''(A) retains a direct or indirect ownership or control interest in an entity that is participating in a program under title XVIII or a State health care program, and who knows or should know of the action constituting the basis for the exclusion; or

''(B) is an officer or managing employee (as defined in section 1126(b)) of such an entity;''.

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

(1) by striking ''$2,000'' and inserting ''$10,000'';

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

(3) by striking ''twice the amount'' and inserting ''3 times the amount''.

(d) CLAIM FOR ITEM OR SERVICE BASED ON INCORRECT CODING OR MEDICALLY UNNECESSARY SERVICES.—Section 1128A(a)(1) (42 U.S.C. 1320a–7a(a)(1)) is amended—

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

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

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

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

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

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

''(D) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under subparagraph (B)(i) or (C)(i) in the same manner as such provisions apply to a civil money penalty or proceeding under section 1128A(a).''.

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

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

(A) by striking ''or'' at the end of paragraph (3);

(B) by striking the semicolon at the end of paragraph (4) and inserting ''; or''; and

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

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

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

''(6) The term 'remuneration' includes the waiver of coinsurance and deductible amounts (or any part thereof), and transfers of items or services for free or for other than fair market value. The term 'remuneration' does not include—

''(A) the waiver of coinsurance and deductible amounts by a person, if—

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

''(ii) the person does not routinely waive coinsurance or deductible amounts; and

''(iii) the person—

''(I) waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need;

''(II) fails to collect coinsurance or deductible amounts after making reasonable collection efforts; or

''(III) provides for any permissible waiver as specified in section 1128B(b)(3) or in regulations issued by the Secretary;

''(B) differentials in coinsurance and deductible amounts as part of a benefit plan design as long as the differentials have been disclosed in writing to all beneficiaries, third party payers, and providers, to whom claims are presented and as long as the differentials meet the standards as defined in regulations promulgated by the Secretary not later than

180 days after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996; or

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

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

SEC. 232. CLARIFICATION OF LEVEL OF INTENT REQUIRED FOR IMPOSITION OF SANCTIONS.

(a) CLARIFICATION OF LEVEL OF KNOWLEDGE REQUIRED FOR IMPOSITION OF CIVIL MONETARY PENALTIES.—

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

(A) in paragraphs (1) and (2), by inserting ''knowingly'' before ''presents'' each place it appears; and

(B) in paragraph (3), by striking ''gives'' and inserting ''knowingly gives or causes to be given''.

(2) DEFINITION OF STANDARD.—Section 1128A(i) (42 U.S.C. 1320a–7a(i)), as amended by section 231(g)(2), is amended by adding at the end the following new paragraph:

''(7) The term 'should know' means that a person, with respect to information—

''(A) acts in deliberate ignorance of the truth or falsity of the information; or

''(B) acts in reckless disregard of the truth or falsity of the information,

and no proof of specific intent to defraud is required.''.

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

SEC. 233. PENALTY FOR FALSE CERTIFICATION FOR HOME HEALTH SERVICES.

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

''(3)(A) Any physician who executes a document described in subparagraph (B) with respect to an individual knowing that all of the requirements referred to in such subparagraph are not met with respect to the individual shall be subject to a civil monetary penalty of not more than the greater of—

''(i) $5,000, or

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

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

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

Subtitle E—Revisions to Criminal Law

SEC. 241. DEFINITIONS RELATING TO FEDERAL HEALTH CARE OFFENSE.

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

''§ 24. Definitions relating to Federal health care offense

''(a) As used in this title, the term 'Federal health care offense' means a violation of, or a criminal conspiracy to violate—

''(1) section 669, 1035, 1347, or 1518 of this title; or

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

''(b) As used in this title, the term 'health care benefit program' means any public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract.''.

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

''24. Definitions relating to Federal health care offense.''.

SEC. 242. HEALTH CARE FRAUD.

(a) OFFENSE.—

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

''§ 1347. Health care fraud

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

''(1) to defraud any health care benefit program; or

''(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program,

in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 10 years, or both. If the violation results in serious bodily injury (as defined in section 1365 of this title), such person shall be fined under this title or imprisoned not more than 20 years, or both; and if the violation results in death, such person shall be fined under this title, or imprisoned for any term of years or for life, or both.''.

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

''1347. Health care fraud.''.

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

SEC. 243. THEFT OR EMBEZZLEMENT.

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

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

''(a) Whoever embezzles, steals, or otherwise without authority knowingly converts to the use of any person other than the rightful owner, or intentionally misapplies any of the moneys, funds, securities, premiums, credits, property, or other assets of a health care benefit program, shall be fined under this title or imprisoned not more than 10 years, or both; but if the value of such property does not exceed the sum of $100 the defendant shall be fined under this title or imprisoned not more than one year, or both.

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

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

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

SEC. 244. FALSE STATEMENTS.

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

''§ 1035. False statements relating to health care matters

''(a) Whoever, in any matter involving a health care benefit program, knowingly—

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

''(2) makes any false, fictitious, or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry,

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

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

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

''1035. False statements relating to health care matters.''.

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

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

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

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

''(b) As used in this section the term 'criminal investigator' means any individual duly authorized by a department, agency, or armed force of the United States to conduct or engage in investigations for prosecutions for violations of health care offenses.''.

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

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

SEC. 246. LAUNDERING OF MONETARY INSTRUMENTS.

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

''(F) Any act or activity constituting an offense involving a Federal health care offense.''.

SEC. 247. INJUNCTIVE RELIEF RELATING TO HEALTH CARE OFFENSES.

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

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

(2) by inserting ''or'' at the end of subparagraph (B); and

(3) by adding at the end the following:

''(C) committing or about to commit a Federal health care offense.''.

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

SEC. 248. AUTHORIZED INVESTIGATIVE DEMAND PROCEDURES.

(a) IN GENERAL.—Chapter 223 of title 18, United States Code, is amended by adding after section 3485 the following:

''§ 3486. Authorized investigative demand procedures

''(a) AUTHORIZATION.—In any investigation relating to any act or activity involving a

Federal health care offense, the Attorney General or the Attorney General's designee may issue in writing and cause to be served a subpoena requiring the production of any records (including any books, papers, documents, electronic media, or other objects or tangible things), which may be relevant to an authorized law enforcement inquiry, that a person or legal entity may possess or have care, custody, or control. A subpoena shall describe the objects required to be produced and prescribe a return date within a reasonable period of time within which the objects can be assembled and made available.

''(b) SERVICE.—A subpoena issued under this section may be served by any person designated in the subpoena to serve it. Service upon a natural person may be made by personal delivery of the subpoena to him. Service may be made upon a domestic or foreign corporation or upon a partnership or other unincorporated association which is subject to suit under a common name, by delivering the subpoena to an officer, to a managing or general agent, or to any other agent authorized by appointment or by law to receive service of process. The affidavit of the person serving the subpoena entered on a true copy thereof by the person serving it shall be proof of service.

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

''(d) IMMUNITY FROM CIVIL LIABILITY.—Notwithstanding any Federal, State, or local law, any person, including officers, agents, and employees, receiving a summons under this section, who complies in good faith with the summons and thus produces the materials sought, shall not be liable in any court of any State or the United States to any customer or other person for such production or for nondisclosure of that production to the customer.

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

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

''(3) Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.''.

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

''3486. Authorized investigative demand procedures.''.

(c) CONFORMING AMENDMENT.—Section 1510(b)(3)(B) of title 18, United States Code, is amended by inserting ''or a Department of Justice subpoena (issued under section 3486 of title 18),'' after ''subpoena''.

SEC. 249. FORFEITURES FOR FEDERAL HEALTH CARE OFFENSES.

(a) IN GENERAL.—Section 982(a) of title 18, United States Code, is amended by adding after paragraph (5) the following new paragraph:

''(6) The court, in imposing sentence on a person convicted of a Federal health care offense, shall order the person to forfeit property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense.''.

(b) CONFORMING AMENDMENT.—Section 982(b)(1)(A) of title 18, United States Code, is amended by inserting ''or (a)(6)'' after ''(a)(1)''.

(c) PROPERTY FORFEITED DEPOSITED IN FEDERAL HOSPITAL INSURANCE TRUST FUND.—

(1) IN GENERAL.—After the payment of the costs of asset forfeiture has been made, and notwithstanding any other provision of law, the Secretary of the Treasury shall deposit into the Federal Hospital Insurance Trust Fund pursuant to section 1817(k)(2)(C) of the Social Security Act, as added by section 301(b), an amount equal to the net amount realized from the forfeiture of property by reason of a Federal health care offense pursuant to section 982(a)(6) of title 18, United States Code.

(2) COSTS OF ASSET FORFEITURE.—For purposes of paragraph (1), the term ''payment of the costs of asset forfeiture'' means—

(A) the payment, at the discretion of the Attorney General, of any expenses necessary to seize, detain, inventory, safeguard, maintain, advertise, sell, or dispose of property under seizure, detention, or forfeited, or of any other necessary expenses incident to the seizure, detention, forfeiture, or disposal of such property, including payment for—

(i) contract services;

(ii) the employment of outside contractors to operate and manage properties or provide other specialized services necessary to dispose of such properties in an effort to maximize the return from such properties; and

(iii) reimbursement of any Federal, State, or local agency for any expenditures made to perform the functions described in this subparagraph;

(B) at the discretion of the Attorney General, the payment of awards for information or assistance leading to a civil or criminal forfeiture involving any Federal agency participating in the Health Care Fraud and Abuse Control Account;

(C) the compromise and payment of valid liens and mortgages against property that has been forfeited, subject to the discretion of the Attorney General to determine the validity of any such lien or mortgage and the amount of payment to be made, and the employment of attorneys and other personnel skilled in State real estate law as necessary;

(D) payment authorized in connection with remission or mitigation procedures relating to property forfeited; and

(E) the payment of State and local property taxes on forfeited real property that accrued between the date of the violation giving rise to the forfeiture and the date of the forfeiture order.

SEC. 250. RELATION TO ERISA AUTHORITY.

Nothing in this subtitle shall be construed as affecting the authority of the Secretary of Labor under section 506(b) of the Employee Retirement Income Security Act of 1974, including the Secretary's authority with respect to violations of title 18, United States Code (as amended by this subtitle).

Subtitle F—Administrative Simplification

SEC. 251. PURPOSE.

It is the purpose of this subtitle to improve the medicare program under title XVIII of the Social Security Act, the medicaid program under title XIX of such Act, and the efficiency and effectiveness of the health care system, by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information.

SEC. 252. ADMINISTRATIVE SIMPLIFICATION.

(a) IN GENERAL.—Title XI (42 U.S.C. 1301 et seq.) is amended by adding at the end the following:

''PART C—ADMINISTRATIVE SIMPLIFICATION

''DEFINITIONS

''SEC. 1171. For purposes of this part:

''(1) CLEARINGHOUSE.—The term 'clearinghouse' means a public or private entity that processes or facilitates the processing of nonstandard data elements of health information into standard data elements.

''(2) CODE SET.—The term 'code set' means any set of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes.

''(3) HEALTH CARE PROVIDER.—The term 'health care provider' includes a provider of services (as defined in section 1861(u)), a provider of medical or other health services (as defined in section 1861(s)), and any other person furnishing health care services or supplies.

''(4) HEALTH INFORMATION.—The term 'health information' means any information, whether oral or recorded in any form or medium that—

''(A) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or clearinghouse; and

''(B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

''(5) HEALTH PLAN.—The term 'health plan' means a plan which provides, or pays the cost of, health benefits. Such term includes the following, and any combination thereof:

''(A) Part A or part B of the medicare program under title XVIII.

''(B) The medicaid program under title XIX.

''(C) A medicare supplemental policy (as defined in section 1882(g)(1)).

''(D) A long-term care policy, including a nursing home fixed indemnity policy (unless the Secretary determines that such a policy does not provide sufficiently comprehensive coverage of a benefit so that the policy should be treated as a health plan).

''(E) Health benefits of an employee welfare benefit plan, as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(1)), but only to the extent the plan is established or maintained for the purpose of providing health benefits and has 50 or more participants (as defined in section 3(7) of such Act).

''(F) An employee welfare benefit plan or any other arrangement which is established or maintained for the purpose of offering or providing health benefits to the employees of 2 or more employers.

''(G) The health care program for active military personnel under title 10, United States Code.

''(H) The veterans health care program under chapter 17 of title 38, United States Code.

''(I) The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), as defined in section 1073(4) of title 10, United States Code.

''(J) The Indian health service program under the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

''(K) The Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code.

''(6) INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.—The term 'individually identifiable health information' means any information, including demographic information collected from an individual, that—

''(A) is created or received by a health care provider, health plan, employer, or clearinghouse; and

''(B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and—

''(i) identifies the individual; or

''(ii) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

''(7) STANDARD.—The term 'standard', when used with reference to a data element of health information or a transaction referred to in section 1173(a)(1), means any such data element or transaction that meets each of the standards and implementation specifications adopted or established by the Secretary with respect to the data element or transaction under sections 1172 through 1174.

''(8) STANDARD SETTING ORGANIZATION.—The term 'standard setting organization' means a standard setting organization accredited by the American National Standards Institute, including the National Council for Prescription Drug Programs, that develops standards for information transactions, data elements, or any other standard that is necessary to, or will facilitate, the implementation of this part.

''GENERAL REQUIREMENTS FOR ADOPTION OF STANDARDS

''SEC. 1172. (a) APPLICABILITY.—Any standard adopted under this part shall apply, in whole or in part, to the following persons:

''(1) An health plan.

''(2) A clearinghouse.

''(3) A health care provider who transmits any health information in electronic form in connection with a transaction referred to in section 1173(a)(1).

''(b) REDUCTION OF COSTS.—Any standard adopted under this part shall be consistent with the objective of reducing the administrative costs of providing and paying for health care.

''(c) ROLE OF STANDARD SETTING ORGANIZATIONS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), any standard adopted under this part shall be a standard that has been developed, adopted, or modified by a standard setting organization.

''(2) SPECIAL RULES.—

''(A) DIFFERENT STANDARDS.—The Secretary may adopt a standard that is different from any standard developed, adopted, or modified by a standard setting organization, if—

''(i) the different standard will substantially reduce administrative costs to health care providers and health plans compared to the alternatives; and

''(ii) the standard is promulgated in accordance with the rulemaking procedures of subchapter III of chapter 5 of title 5, United States Code.

''(B) NO STANDARD BY STANDARD SETTING ORGANIZATION.—If no standard setting organization has developed, adopted, or modified any standard relating to a standard that the Secretary is authorized or required to adopt under this part—

''(i) paragraph (1) shall not apply; and

''(ii) subsection (f) shall apply.

''(d) IMPLEMENTATION SPECIFICATIONS.—The Secretary shall establish specifications for implementing each of the standards adopted under this part.

''(e) PROTECTION OF TRADE SECRETS.—Except as otherwise required by law, a standard adopted under this part shall not require disclosure of trade secrets or confidential commercial information by a person required to comply with this part.

''(f) ASSISTANCE TO THE SECRETARY.—In complying with the requirements of this part, the Secretary shall rely on the recommendations of the National Committee on Vital and Health Statistics established under section 306(k) of the Public Health Service Act (42 U.S.C. 242k(k)) and shall consult with appropriate Federal and State agencies and private organizations. The Secretary shall publish in the Federal Register any recommendation of the National Committee on Vital and Health Statistics regarding the adoption of a standard under this part.

''(g) APPLICATION TO MODIFICATIONS OF STANDARDS.—This section shall apply to a modification to a standard (including an addition to a standard) adopted under section 1174(b) in the same manner as it applies to an initial standard adopted under section 1174(a).

''STANDARDS FOR INFORMATION TRANSACTIONS AND DATA ELEMENTS

''SEC. 1173. (a) STANDARDS TO ENABLE ELECTRONIC EXCHANGE.—

''(1) IN GENERAL.—The Secretary shall adopt standards for transactions, and data elements for such transactions, to enable health information to be exchanged electronically, that are appropriate for—

''(A) the financial and administrative transactions described in paragraph (2); and

''(B) other financial and administrative transactions determined appropriate by the Secretary consistent with the goals of improving the operation of the health care system and reducing administrative costs.

''(2) TRANSACTIONS.—The transactions referred to in paragraph (1)(A) are the following:

''(A) Claims (including coordination of benefits) or equivalent encounter information.

''(B) Claims attachments.

''(C) Enrollment and disenrollment.

''(D) Eligibility.

''(E) Health care payment and remittance advice.

''(F) Premium payments.

''(G) First report of injury.

''(H) Claims status.

''(I) Referral certification and authorization.

''(3) ACCOMMODATION OF SPECIFIC PROVIDERS.—The standards adopted by the Secretary under paragraph (1) shall accommodate the needs of different types of health care providers.

''(b) UNIQUE HEALTH IDENTIFIERS.—

''(1) IN GENERAL.—The Secretary shall adopt standards providing for a standard unique health identifier for each individual, employer, health plan, and health care provider for use in the health care system. In carrying out the preceding sentence for each health plan and health care provider, the Secretary shall take into account multiple uses for identifiers and multiple locations and specialty classifications for health care providers.

''(2) USE OF IDENTIFIERS.—The standards adopted under paragraphs (1) shall specify the purposes for which a unique health identifier may be used.

''(c) CODE SETS.—

''(1) IN GENERAL.—The Secretary shall adopt standards that—

''(A) select code sets for appropriate data elements for the transactions referred to in subsection (a)(1) from among the code sets that have been developed by private and public entities; or

''(B) establish code sets for such data elements if no code sets for the data elements have been developed.

''(2) DISTRIBUTION.—The Secretary shall establish efficient and low-cost procedures for distribution (including electronic distribution) of code sets and modifications made to such code sets under section 1174(b).

''(d) SECURITY STANDARDS FOR HEALTH INFORMATION.—

''(1) SECURITY STANDARDS.—The Secretary shall adopt security standards that—

''(A) take into account—

''(i) the technical capabilities of record systems used to maintain health information;

''(ii) the costs of security measures;

''(iii) the need for training persons who have access to health information;

''(iv) the value of audit trails in computerized record systems; and

''(v) the needs and capabilities of small health care providers and rural health care providers (as such providers are defined by the Secretary); and

''(B) ensure that a clearinghouse, if it is part of a larger organization, has policies and security procedures which isolate the activities of the clearinghouse with respect to processing information in a manner that prevents unauthorized access to such information by such larger organization.

''(2) SAFEGUARDS.—Each person described in section 1172(a) who maintains or transmits health information shall maintain reasonable and appropriate administrative, technical, and physical safeguards—

''(A) to ensure the integrity and confidentiality of the information;

''(B) to protect against any reasonably anticipated—

''(i) threats or hazards to the security or integrity of the information; and

''(ii) unauthorized uses or disclosures of the information; and

''(C) otherwise to ensure compliance with this part by the officers and employees of such person.

''(e) PRIVACY STANDARDS FOR HEALTH INFORMATION.—The Secretary shall adopt standards with respect to the privacy of individually identifiable health information transmitted in connection with the transactions referred to in subsection (a)(1). Such standards shall include standards concerning at least the following:

''(1) The rights of an individual who is a subject of such information.

''(2) The procedures to be established for the exercise of such rights.

''(3) The uses and disclosures of such information that are authorized or required.

''(f) ELECTRONIC SIGNATURE.—

''(1) IN GENERAL.—

''(A) STANDARDS.—The Secretary, in coordination with the Secretary of Commerce, shall adopt standards specifying procedures for the electronic transmission and authentication of signatures with respect to the transactions referred to in subsection (a)(1).

''(B) EFFECT OF COMPLIANCE.—Compliance with the standards adopted under subparagraph (A) shall be deemed to satisfy Federal and State statutory requirements for written signatures with respect to the transactions referred to in subsection (a)(1).

''(2) PAYMENTS FOR SERVICES AND PREMIUMS.—Nothing in this part shall be construed to prohibit payment for health care services or health plan premiums by debit, credit, payment card or numbers, or other electronic means.

''(g) TRANSFER OF INFORMATION AMONG HEALTH PLANS.—The Secretary shall adopt standards for transferring among health plans appropriate standard data elements needed for the coordination of benefits, the sequential processing of claims, and other data elements for individuals who have more than one health plan.

''TIMETABLES FOR ADOPTION OF STANDARDS

''SEC. 1174. (a) INITIAL STANDARDS.—The Secretary shall carry out section 1173 not later than 18 months after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, except that standards relating to claims attachments shall be adopted not later than 30 months after such date.

''(b) ADDITIONS AND MODIFICATIONS TO STANDARDS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary shall review the standards adopted under section 1173, and shall adopt modifications to the standards (including additions to the standards), as determined appropriate, but not more frequently than once every 6 months. Any addition or modification to a standard shall be completed in a manner which minimizes the disruption and cost of compliance.

''(2) SPECIAL RULES.—

''(A) FIRST 12-MONTH PERIOD.—Except with respect to additions and modifications to code sets under subparagraph (B), the Secretary may not adopt any modification to a standard adopted under this part during the 12-month period beginning on the date the standard is initially adopted, unless the Secretary determines that the modification is necessary in order to permit compliance with the standard.

''(B) ADDITIONS AND MODIFICATIONS TO CODE SETS.—

''(i) IN GENERAL.—The Secretary shall ensure that procedures exist for the routine maintenance, testing, enhancement, and expansion of code sets.

''(ii) ADDITIONAL RULES.—If a code set is modified under this subsection, the modified code set shall include instructions on how data elements of health information that were encoded prior to the modification may be converted or translated so as to preserve the informational value of the data elements that existed before the modification. Any modification to a code set under this subsection shall be implemented in a manner that minimizes the disruption and cost of complying with such modification.

''REQUIREMENTS

''SEC. 1175. (a) CONDUCT OF TRANSACTIONS BY PLANS.—

''(1) IN GENERAL.—If a person desires to conduct a transaction referred to in section 1173(a)(1) with a health plan as a standard transaction—

''(A) the health plan may not refuse to conduct such transaction as a standard transaction;

''(B) the health plan may not delay such transaction, or otherwise adversely affect, or attempt to adversely affect, the person or the transaction on the ground that the transaction is a standard transaction; and

''(C) the information transmitted and received in connection with the transaction shall be in the form of standard data elements of health information.

''(2) SATISFACTION OF REQUIREMENTS.—A health plan may satisfy the requirements under paragraph (1) by—

''(A) directly transmitting and receiving standard data elements of health information; or

''(B) submitting nonstandard data elements to a clearinghouse for processing into standard data elements and transmission by the clearinghouse, and receiving standard data elements through the clearinghouse.

''(3) TIMETABLE FOR COMPLIANCE.—Paragraph (1) shall not be construed to require a health plan to comply with any standard, implementation specification, or modification to a standard or specification adopted or established by the Secretary under sections 1172 through 1174 at any time prior to the date on which the plan is required to comply with the standard or specification under subsection (b).

''(b) COMPLIANCE WITH STANDARDS.—

''(1) INITIAL COMPLIANCE.—

''(A) IN GENERAL.—Not later than 24 months after the date on which an initial standard or implementation specification is adopted or established under sections 1172 and 1173, each person to whom the standard or implementation specification applies shall comply with the standard or specification.

''(B) SPECIAL RULE FOR SMALL HEALTH PLANS.—In the case of a small health plan, paragraph (1) shall be applied by substituting '36 months' for '24 months'. For purposes of this subsection, the Secretary shall determine the plans that qualify as small health plans.

''(2) COMPLIANCE WITH MODIFIED STANDARDS.—If the Secretary adopts a modification to a standard or implementation specification under this part, each person to whom the standard or implementation specification applies shall comply with the modified standard or implementation specification at such time as the Secretary determines appropriate, taking into account the time needed to comply due to the nature and extent of the modification. The time determined appropriate under the preceding sentence may not be earlier than the last day of the 180-day period beginning on the date such modification is adopted. The Secretary may extend the time for compliance for small insurance plans, if the Secretary determines that such extension is appropriate.

''GENERAL PENALTY FOR FAILURE TO COMPLY WITH REQUIREMENTS AND STANDARDS

''SEC. 1176. (a) GENERAL PENALTY.—

''(1) IN GENERAL.—Except as provided in subsection (b), the Secretary shall impose on any person who violates a provision of this part a penalty of not more than $100 for each such violation, except that the total amount imposed on the person for all violations of an identical requirement or prohibition during a calendar year may not exceed $25,000.

''(2) PROCEDURES.—The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to the imposition of a civil money penalty under this subsection in the same manner as such provisions apply to the imposition of a penalty under such section 1128A.

''(b) LIMITATIONS.—

''(1) OFFENSES OTHERWISE PUNISHABLE.—A penalty may not be imposed under subsection (a) with respect to an act if the act constitutes an offense punishable under section 1177.

''(2) NONCOMPLIANCE NOT DISCOVERED.—A penalty may not be imposed under subsection (a) with respect to a provision of this part if it is established to the satisfaction of the Secretary that the person liable for the penalty did not know, and by exercising reasonable diligence would not have known, that such person violated the provision.

''(3) FAILURES DUE TO REASONABLE CAUSE.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), a penalty may not be imposed under subsection (a) if—

''(i) the failure to comply was due to reasonable cause and not to willful neglect; and

''(ii) the failure to comply is corrected during the 30-day period beginning on the first date the person liable for the penalty knew, or by exercising reasonable diligence would have known, that the failure to comply occurred.

''(B) EXTENSION OF PERIOD.—

''(i) NO PENALTY.—The period referred to in subparagraph (A)(ii) may be extended as determined appropriate by the Secretary based on the nature and extent of the failure to comply.

''(ii) ASSISTANCE.—If the Secretary determines that a person failed to comply because the person was unable to comply, the Secretary may provide technical assistance to the person during the period described in subparagraph (A)(ii). Such assistance shall be provided in any manner determined appropriate by the Secretary.

''(4) REDUCTION.—In the case of a failure to comply which is due to reasonable cause and not to willful neglect, any penalty under subsection (a) that is not entirely waived under paragraph (3) may be waived to the extent that the payment of such penalty would be excessive relative to the compliance failure involved.

''WRONGFUL DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

''SEC. 1177. (a) OFFENSE.—A person who knowingly and in violation of this part—

''(1) uses or causes to be used a unique health identifier;

''(2) obtains individually identifiable health information relating to an individual; or

''(3) discloses individually identifiable health information to another person,

shall be punished as provided in subsection (b).

''(b) PENALTIES.—A person described in subsection (a) shall—

''(1) be fined not more than $50,000, imprisoned not more than 1 year, or both;

''(2) if the offense is committed under false pretenses, be fined not more than $100,000, imprisoned not more than 5 years, or both; and

''(3) if the offense is committed with intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm, fined not more than $250,000, imprisoned not more than 10 years, or both.

''EFFECT ON STATE LAW

''SEC. 1178. (a) GENERAL EFFECT.—

''(1) GENERAL RULE.—Except as provided in paragraph (2), a provision or requirement under this part, or a standard or implementation specification adopted or established under sections 1172 through 1174, shall supersede any contrary provision of State law, including a provision of State law that requires medical or health plan records (including billing information) to be maintained or transmitted in written rather than electronic form.

''(2) EXCEPTIONS.—A provision or requirement under this part, or a standard or implementation specification adopted or established under sections 1172 through 1174, shall not supersede a contrary provision of State law, if the provision of State law—

''(A) imposes requirements, standards, or implementation specifications that are more stringent than the requirements, standards, or implementation specifications under this part with respect to the privacy of individually identifiable health information; or

''(B) is a provision the Secretary determines—

''(i) is necessary to prevent fraud and abuse, or for other purposes; or

''(ii) addresses controlled substances.

''(b) PUBLIC HEALTH REPORTING.—Nothing in this part shall be construed to invalidate or limit the authority, power, or procedures established under any law providing for the reporting of disease or injury, child abuse, birth, or death, public health surveillance, or public health investigation or intervention.''.

(b) CONFORMING AMENDMENTS.—

(1) REQUIREMENT FOR MEDICARE PROVIDERS.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended—

(A) by striking ''and'' at the end of subparagraph (P);

(B) by striking the period at the end of subparagraph (Q) and inserting ''; and''; and

(C) by inserting immediately after subparagraph (Q) the following new subparagraph:

''(R) to contract only with a clearinghouse (as defined in section 1171) that meets each standard and implementation specification adopted or established under part C of title XI on or after the date on which the clearinghouse is required to comply with the standard or specification.''.

(2) TITLE HEADING.—Title XI (42 U.S.C. 1301 et seq.) is amended by striking the title heading and inserting the following:

''TITLE XI—GENERAL PROVISIONS, PEER REVIEW, AND ADMINISTRATIVE SIMPLIFICATION''.

SEC. 253. CHANGES IN MEMBERSHIP AND DUTIES OF NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS.

Section 306(k) of the Public Health Service Act (42 U.S.C. 242k(k)) is amended—

(1) in paragraph (1), by striking ''16'' and inserting ''18'';

(2) by amending paragraph (2) to read as follows:

''(2) The members of the Committee shall be appointed from among persons who have distinguished themselves in the fields of health statistics, electronic interchange of health care information, privacy and security of electronic information, population-based public health, purchasing or financing health care services, integrated computerized health information systems, health services research, consumer interests in health information, health data standards, epidemiology, and the provision of health services. Members of the Committee shall be appointed for terms of 4 years.'';

(3) by redesignating paragraphs (3) through (5) as paragraphs (4) through (6), respectively, and inserting after paragraph (2) the following:

''(3) Of the members of the Committee—

''(A) 1 shall be appointed, not later than 60 days after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, by the Speaker of the House of Representatives after consultation with the minority leader of the House of Representatives;

''(B) 1 shall be appointed, not later than 60 days after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, by the President pro tempore of the Senate after consultation with the minority leader of the Senate; and

''(C) 16 shall be appointed by the Secretary.'';

(4) by amending paragraph (5) (as so redesignated) to read as follows:

''(5) The Committee—

''(A) shall assist and advise the Secretary—

''(i) to delineate statistical problems bearing on health and health services which are of national or international interest;

''(ii) to stimulate studies of such problems by other organizations and agencies whenever possible or to make investigations of such problems through subcommittees;

''(iii) to determine, approve, and revise the terms, definitions, classifications, and guidelines for assessing health status and health services, their distribution and costs, for use (I) within the Department of Health and Human Services, (II) by all programs administered or funded by the Secretary, including the Federal-State-local cooperative health statistics system referred to in subsection (e), and (III) to the extent possible as determined by the head of the agency involved, by the Department of Veterans Affairs, the Department of Defense, and other Federal agencies concerned with health and health services;

''(iv) with respect to the design of and approval of health statistical and health information systems concerned with the collection, processing, and tabulation of health statistics within the Department of Health and Human Services, with respect to the Cooperative Health Statistics System established under subsection (e), and with respect to the standardized means for the collection of health information and statistics to be established by the Secretary under subsection (j)(1);

''(v) to review and comment on findings and proposals developed by other organizations and agencies and to make recommendations for their adoption or implementation by local, State, national, or international agencies;

''(vi) to cooperate with national committees of other countries and with the World Health Organization and other national agencies in the studies of problems of mutual interest;

''(vii) to issue an annual report on the state of the Nation's health, its health services, their costs and distributions, and to make proposals for improvement of the Nation's health statistics and health information systems; and

''(viii) in complying with the requirements imposed on the Secretary under part C of title XI of the Social Security Act;

''(B) shall study the issues related to the adoption of uniform data standards for patient medical record information and the electronic exchange of such information;

''(C) shall report to the Secretary not later than 4 years after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996 recommendations and legislative proposals for such standards and electronic exchange; and

''(D) shall be responsible generally for advising the Secretary and the Congress on the status of the implementation of part C of title XI of the Social Security Act.''; and

(5) by adding at the end the following:

''(7) Not later than 1 year after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, and annually thereafter, the Committee shall submit to the Congress, and make public, a report regarding—

''(A) the extent to which persons required to comply with part C of title XI of the Social Security Act are cooperating in implementing the standards adopted under such part;

''(B) the extent to which such entities are meeting the privacy and security standards adopted under such part and the types of penalties assessed for noncompliance with such standards;

''(C) whether the Federal and State Governments are receiving information of sufficient quality to meet their responsibilities under such part;

''(D) any problems that exist with respect to implementation of such part; and

''(E) the extent to which timetables under such part are being met.''.

Subtitle G—Duplication and Coordination of Medicare-Related Plans

SEC. 261. DUPLICATION AND COORDINATION OF MEDICARE-RELATED PLANS.

(a) TREATMENT OF CERTAIN HEALTH INSURANCE POLICIES AS NONDUPLICATIVE.—Effective as if included in the enactment of section 4354 of the Omnibus Budget Reconciliation Act of 1990, section 1882(d)(3)(A) (42 U.S.C. 1395ss(d)(3)(A)) is amended—

(1) in clause (iii), by striking ''clause (i)'' and inserting ''clause (i)(II)''; and

(2) by adding at the end the following:

''(iv) For purposes of this subparagraph, a health insurance policy providing for benefits which are payable to or on behalf of an individual without regard to other health benefit coverage of such individual is not considered to 'duplicate' any health benefits under this title, under title XIX, or under a health insurance policy, and subclauses (I) and (III) of clause (i) does not apply to such a policy.

''(v)(I) For purposes of this subparagraph, a health insurance policy (or a rider to an insurance contract which is not a health insurance policy), providing benefits for long-term care, nursing home care, home health care, or community-based care and that coordinates against or excludes items and services available or paid for under this title and (for policies sold or issued on or after 90 days after the date of enactment of this clause) that discloses such coordination or exclusion in the policy's outline of coverage, is not considered to 'duplicate' health benefits under this title.

''(II) For purposes of this subparagraph, a health insurance policy (which may be a contract with a health maintenance organization) that is a replacement product for another health insurance policy that is being terminated by the issuer, that is being provided to an individual entitled to benefits under part A on the basis of section 226(b), and that coordinates against or excludes items and services available or paid for under this title is not considered to 'duplicate' health benefits under this title.

''(III) For purposes of this clause, the terms 'coordinates' and 'coordination' mean, with respect to a policy in relation to health benefits under this title, that the policy under its terms is secondary to, or excludes from payment, items and services to the extent available or paid for under this title.

''(vi) Notwithstanding any other provision of law, no criminal or civil penalty may be imposed at any time under this subparagraph and no legal action may be brought or continued at any time in any Federal or State court if the penalty or action is based on an act or omission that occurred after November 5, 1991, and before the date of the enactment of this clause, and relates to the sale, issuance, or renewal of any health insurance policy or rider during such period, if such policy or rider meets the nonduplication requirements of clause (iv) or (v).

''(vii) A State may not impose, in the case of the sale, issuance, or renewal of a health insurance policy (other than a medicare supplemental policy) or rider to an insurance contract which is not a health insurance policy, that meets the nonduplication requirements of this section pursuant to clause (iv) or (v) to an individual entitled to benefits under part A or enrolled under part B, any requirement relating to any duplication (or nonduplication) of health benefits under such policy or rider with health benefits to which the individual is otherwise entitled to under this title.''.

(b) CONFORMING AMENDMENTS.—Section 1882(d)(3) (42 U.S.C. 1395ss(d)(3)) is amended—

(1) in subparagraph (C)—

(A) by striking ''with respect to (i)'' and inserting ''with respect to'', and

(B) by striking '', (ii) the sale'' and all that follows up to the period at the end; and

(2) by striking subparagraph (D).

Subtitle H—Medical Liability Reform

PART 1—GENERAL PROVISIONS

SEC. 271. FEDERAL REFORM OF HEALTH CARE LIABILITY ACTIONS.

(a) APPLICABILITY.—This subtitle shall apply with respect to any health care liability action brought in any State or Federal court, except that this subtitle shall not apply to—

(1) an action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the action, or

(2) an action under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.).

(b) PREEMPTION.—This subtitle shall preempt any State law to the extent such law is inconsistent with the limitations contained in this subtitle. This subtitle shall not preempt any State law that provides for defenses or places limitations on a person's liability in addition to those contained in this subtitle or otherwise imposes greater restrictions than those provided in this subtitle.

(c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in subsection (b) shall be construed to—

(1) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(2) waive or affect any defense of sovereign immunity asserted by the United States;

(3) affect the applicability of any provision of the Foreign Sovereign Immunities Act of 1976;

(4) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

(5) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss a claim of a foreign nation or of a citizen of a foreign nation on the ground of inconvenient forum.

(d) AMOUNT IN CONTROVERSY.—In an action to which this subtitle applies and which is brought under section 1332 of title 28, United States Code, the amount of noneconomic damages or punitive damages, and attorneys' fees or costs, shall not be included in determining whether the matter in controversy exceeds the sum or value of $50,000.

(e) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—Nothing in this subtitle shall be construed to establish any jurisdiction in the district courts of the United States over health care liability actions on the basis of section 1331 or 1337 of title 28, United States Code.

SEC. 272. DEFINITIONS.

As used in this subtitle:

(1) ACTUAL DAMAGES.—The term ''actual damages'' means damages awarded to pay for economic loss.

(2) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system established under Federal or State law that provides for the resolution of health care liability claims in a manner other than through health care liability actions.

(3) CLAIMANT.—The term ''claimant'' means any person who brings a health care liability action and any person on whose behalf such an action is brought. If such action is brought through or on behalf of an estate, the term includes the claimant's decedent. If such action is brought through or on behalf of a minor or incompetent, the term includes the claimant's legal guardian.

(4) CLEAR AND CONVINCING EVIDENCE.—The term ''clear and convincing evidence'' is that measure or degree of proof that will produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established. Such measure or degree of proof is more than that required under preponderance of the evidence but less than that required for proof beyond a reasonable doubt.

(5) COLLATERAL SOURCE PAYMENTS.—The term ''collateral source payments'' means any amount paid or reasonably likely to be paid in the future to or on behalf of a claimant, or any service, product, or other benefit provided or reasonably likely to be provided in the future to or on behalf of a claimant, as a result of an injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident or workers' compensation Act;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(6) DRUG.—The term ''drug'' has the meaning given such term in section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)(1)).

(7) ECONOMIC LOSS.—The term ''economic loss'' means any pecuniary loss resulting from injury (including the loss of earnings or other benefits related to employment, medical expense loss, replacement services loss, loss due to death, burial costs, and loss of business or employment opportunities), to the extent recovery for such loss is allowed under applicable State law.

(8) HARM.—The term ''harm'' means any legally cognizable wrong or injury for which punitive damages may be imposed.

(9) HEALTH BENEFIT PLAN.—The term ''health benefit plan'' means—

(A) a hospital or medical expense incurred policy or certificate,

(B) a hospital or medical service plan contract,

(C) a health maintenance subscriber contract,

(D) a multiple employer welfare arrangement or employee benefit plan (as defined under the Employee Retirement Income Security Act of 1974), or

(E) a MedicarePlus product (offered under part C of title XVIII of the Social Security Act),

that provides benefits with respect to health care services.

(10) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action brought in a State or Federal court against a health care provider, an entity which is obligated to provide or pay for health benefits under any health benefit plan (including any person or entity acting under a contract or arrangement to provide or administer any health benefit), or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, in which the claimant alleges a claim (including third party claims, cross claims, counter claims, or distribution claims) based upon the provision of (or the failure to provide or pay for) health care services or the use of a medical product, regardless of the theory of liability on which the claim is based or the number of plaintiffs, defendants, or causes of action.

(11) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a claim in which the claimant alleges that injury was caused by the provision of (or the failure to provide) health care services.

(12) HEALTH CARE PROVIDER.—The term ''health care provider'' means any person that is engaged in the delivery of health care services in a State and that is required by the laws or regulations of the State to be licensed or certified by the State to engage in the delivery of such services in the State.

(13) HEALTH CARE SERVICE.—The term ''health care service'' means any service for which payment may be made under a health benefit plan including services related to the delivery or administration of such service.

(14) MEDICAL DEVICE.—The term ''medical device'' has the meaning given such term in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h)).

(15) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages paid to an individual for pain and suffering, inconvenience, emotional distress, mental anguish, loss of consortium, injury to reputation, humiliation, and other nonpecuniary losses.

(16) PERSON.—The term ''person'' means any individual, corporation, company, association, firm, partnership, society, joint stock company, or any other entity, including any governmental entity.

(17) PRODUCT SELLER.—The term ''product seller'' means a person who, in the course of a business conducted for that purpose, sells, distributes, rents, leases, prepares, blends, packages, labels a product, is otherwise involved in placing a product in the stream of commerce, or installs, repairs, or maintains the harm-causing aspect of a product. The term does not include—

(A) a seller or lessor of real property;

(B) a provider of professional services in any case in which the sale or use of a product is incidental to the transaction and the essence of the transaction is the furnishing of judgment, skill, or services; or

(C) any person who—

(i) acts in only a financial capacity with respect to the sale of a product; or

(ii) leases a product under a lease arrangement in which the selection, possession, maintenance, and operation of the product are controlled by a person other than the lessor.

(18) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded against any person not to compensate for actual injury suffered, but to punish or deter such person or others from engaging in similar behavior in the future.

(19) STATE.—The term ''State'' means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and any other territory or possession of the United States.

SEC. 273. EFFECTIVE DATE.

This subtitle will apply to any health care liability action brought in a Federal or State court and to any health care liability claim subject to an alternative dispute resolution system, that is initiated on or after the date of enactment of this subtitle, except that any health care liability claim or action arising from an injury occurring prior to the date of enactment of this subtitle shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

PART 2—UNIFORM STANDARDS FOR HEALTH CARE LIABILITY ACTIONS

SEC. 281. STATUTE OF LIMITATIONS.

A health care liability action may not be brought after the expiration of the 2-year period that begins on the date on which the alleged injury that is the subject of the action was discovered or should reasonably have been discovered, but in no case after the expiration of the 5-year period that begins on the date the alleged injury occurred.

SEC. 282. CALCULATION AND PAYMENT OF DAMAGES.

(a) TREATMENT OF NONECONOMIC DAMAGES.—

(1) LIMITATION ON NONECONOMIC DAMAGES.—The total amount of noneconomic damages that may be awarded to a claimant for losses resulting from the injury which is the subject of a health care liability action may not exceed $250,000, regardless of the number of parties against whom the action is brought or the number of actions brought with respect to the injury.

(2) JOINT AND SEVERAL LIABILITY.—In any health care liability action brought in State or Federal court, a defendant shall be liable only for the amount of noneconomic damages attributable to such defendant in direct proportion to such defendant's share of fault or responsibility for the claimant's actual damages, as determined by the trier of fact. In all such cases, the liability of a defendant for noneconomic damages shall be several and not joint.

(b) TREATMENT OF PUNITIVE DAMAGES.—

(1) GENERAL RULE.—Punitive damages may, to the extent permitted by applicable State law, be awarded in any health care liability action for harm in any Federal or State court against a defendant if the claimant establishes by clear and convincing evidence that the harm suffered was the result of conduct—

(A) specifically intended to cause harm, or

(B) conduct manifesting a conscious, flagrant indifference to the rights or safety of others.

(2) PROPORTIONAL AWARDS.—The amount of punitive damages that may be awarded in any health care liability action subject to this subtitle shall not exceed 3 times the amount of damages awarded to the claimant for economic loss, or $250,000, whichever is greater. This paragraph shall be applied by the court and shall not be disclosed to the jury.

(3) APPLICABILITY.—This subsection shall apply to any health care liability action brought in any Federal or State court on any theory where punitive damages are sought. This subsection does not create a cause of action for punitive damages. This subsection does not preempt or supersede any State or Federal law to the extent that such law would further limit the award of punitive damages.

(4) BIFURCATION.—At the request of any party, the trier of fact shall consider in a separate proceeding whether punitive damages are to be awarded and the amount of such award. If a separate proceeding is requested, evidence relevant only to the claim of punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether actual damages are to be awarded.

(5) DRUGS AND DEVICES.—

(A) IN GENERAL.—(i) Punitive damages shall not be awarded against a manufacturer or product seller of a drug or medical device which caused the claimant's harm where—

(I) such drug or device was subject to premarket approval by the Food and Drug Administration with respect to the safety of the formulation or performance of the aspect of such drug or device which caused the claimant's harm, or the adequacy of the packaging or labeling of such drug or device which caused the harm, and such drug, device, packaging, or labeling was approved by the Food and Drug Administration; or

(II) the drug is generally recognized as safe and effective pursuant to conditions established by the Food and Drug Administration and applicable regulations, including packaging and labeling regulations.

(ii) Clause (i) shall not apply in any case in which the defendant, before or after premarket approval of a drug or device—

(I) intentionally and wrongfully withheld from or misrepresented to the Food and Drug Administration information concerning such drug or device required to be submitted under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) or section 351 of the Public Health Service Act (42 U.S.C. 262) that is material and relevant to the harm suffered by the claimant, or

(II) made an illegal payment to an official or employee of the Food and Drug Administration for the purpose of securing or maintaining approval of such drug or device.

(B) PACKAGING.—In a health care liability action for harm which is alleged to relate to the adequacy of the packaging or labeling of a drug which is required to have tamper-resistant packaging under regulations of the Secretary of Health and Human Services (including labeling regulations related to such packaging), the manufacturer or product seller of the drug shall not be held liable for punitive damages unless such packaging or labeling is found by the court by clear and convincing evidence to be substantially out of compliance with such regulations.

(c) PERIODIC PAYMENTS FOR FUTURE LOSSES.—

(1) GENERAL RULE.—In any health care liability action in which the damages awarded for future economic and noneconomic loss exceeds $50,000, a person shall not be required to pay such damages in a single, lump-sum payment, but shall be permitted to make such payments periodically based on when the damages are found likely to occur, as such payments are determined by the court.

(2) FINALITY OF JUDGMENT.—The judgment of the court awarding periodic payments under this subsection may not, in the absence of fraud, be reopened at any time to contest, amend, or modify the schedule or amount of the payments.

(3) LUMP-SUM SETTLEMENTS.—This subsection shall not be construed to preclude a settlement providing for a single, lump-sum payment.

(d) TREATMENT OF COLLATERAL SOURCE PAYMENTS.—

(1) INTRODUCTION INTO EVIDENCE.—In any health care liability action, any defendant may introduce evidence of collateral source payments. If any defendant elects to introduce such evidence, the claimant may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the claimant to secure the right to such collateral source payments.

(2) NO SUBROGATION.—No provider of collateral source payments shall recover any amount against the claimant or receive any lien or credit against the claimant's recovery or be equitably or legally subrogated the right of the claimant in a health care liability action.

(3) APPLICATION TO SETTLEMENTS.—This subsection shall apply to an action that is settled as well as an action that is resolved by a fact finder.

SEC. 283. ALTERNATIVE DISPUTE RESOLUTION.

Any ADR used to resolve a health care liability action or claim shall contain provisions relating to statute of limitations, noneconomic damages, joint and several liability, punitive damages, collateral source rule, and periodic payments which are identical to the provisions relating to such matters in this subtitle.

TITLE III—TAX-RELATED HEALTH PROVISIONS

SEC. 300. AMENDMENT OF 1986 CODE.

Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

Subtitle A—Medical Savings Accounts

SEC. 301. MEDICAL SAVINGS ACCOUNTS.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 (relating to additional itemized deductions for individuals) is amended by redesignating section 220 as section 221 and by inserting after section 219 the following new section:

"SEC. 220. MEDICAL SAVINGS ACCOUNTS.

''(a) DEDUCTION ALLOWED.—In the case of an individual who is an eligible individual for any month during the taxable year, there shall be allowed as a deduction for the taxable year an amount equal to the aggregate amount paid in cash during such taxable year by such individual to a medical savings account of such individual.

''(b) LIMITATIONS.—

''(1) IN GENERAL.—Except as otherwise provided in this subsection, the amount allowable as a deduction under subsection (a) to an individual for the taxable year shall not exceed—

''(A) except as provided in subparagraph (B), the lesser of—

''(i) $2,000, or

''(ii) the annual deductible limit for any individual covered under the high deductible health plan, or

''(B) in the case of a high deductible health plan covering the taxpayer and any other eligible individual who is the spouse or any dependent (as defined in section 152) of the taxpayer, the lesser of—

''(i) $4,000, or

''(ii) the annual limit under the plan on the aggregate amount of deductibles required to be paid by all individuals.

The preceding sentence shall not apply if the spouse of such individual is covered under any other high deductible health plan.

''(2) SPECIAL RULE FOR MARRIED INDIVIDUALS.—

''(A) IN GENERAL.—This subsection shall be applied separately for each married individual.

''(B) SPECIAL RULE.—If individuals who are married to each other are covered under the same high deductible health plan, then the amounts applicable under paragraph (1)(B) shall be divided equally between them unless they agree on a different division.

''(3) COORDINATION WITH EXCLUSION FOR EMPLOYER CONTRIBUTIONS.—No deduction shall be allowed under this section for any amount paid for any taxable year to a medical savings account of an individual if—

''(A) any amount is paid to any medical savings account of such individual which is excludable from gross income under section 106(b) for such year, or

''(B) in a case described in paragraph (2)(B), any amount is paid to any medical savings account of either spouse which is so excludable for such year.

''(4) PRORATION OF LIMITATION.—

''(A) IN GENERAL.—The limitation under paragraph (1) shall be the sum of the monthly limitations for months during the taxable year that the individual is an eligible individual if—

''(i) such individual is not an eligible individual for all months of the taxable year,

''(ii) the deductible under the high deductible health plan covering such individual is not the same throughout such taxable year, or

''(iii) such limitation is determined under paragraph (1)(B) for some but not all months during such taxable year.

''(B) MONTHLY LIMITATION.—The monthly limitation for any month shall be an amount

equal to 1/12 of the limitation which would (but for this paragraph and paragraph (3)) be determined under paragraph (1) if the facts and circumstances as of the first day of such month that such individual is covered under a high deductible health plan were true for the entire taxable year.

''(5) DENIAL OF DEDUCTION TO DEPENDENTS.—No deduction shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

''(c) DEFINITIONS.—For purposes of this section—

''(1) ELIGIBLE INDIVIDUAL.—

''(A) IN GENERAL.—The term 'eligible individual' means, with respect to any month, any individual—

''(i) who is covered under a high deductible health plan as of the 1st day of such month, and

''(ii) who is not, while covered under a high deductible health plan, covered under any health plan—

''(I) which is not a high deductible health plan, and

''(II) which provides coverage for any benefit which is covered under the high deductible health plan.

''(B) CERTAIN COVERAGE DISREGARDED.—Subparagraph (A)(ii) shall be applied without regard to—

''(i) coverage for any benefit provided by permitted insurance, and

''(ii) coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

''(2) HIGH DEDUCTIBLE HEALTH PLAN.—The term 'high deductible health plan' means a health plan which—

''(A) has an annual deductible limit for each individual covered by the plan which is not less than $1,500, and

''(B) has an annual limit on the aggregate amount of deductibles required to be paid with respect to all individuals covered by the plan which is not less than $3,000.

Such term does not include a health plan if substantially all of its coverage is coverage described in paragraph (1)(B). A plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for preventive care if the absence of a deductible for such care is required by State law.

''(3) PERMITTED INSURANCE.—The term 'permitted insurance' means—

''(A) Medicare supplemental insurance,

''(B) insurance if substantially all of the coverage provided under such insurance relates to—

''(i) liabilities incurred under workers' compensation laws,

''(ii) tort liabilities,

''(iii) liabilities relating to ownership or use of property, or

''(iv) such other similar liabilities as the Secretary may specify by regulations,

''(C) insurance for a specified disease or illness, and

''(D) insurance paying a fixed amount per day (or other period) of hospitalization.

''(d) MEDICAL SAVINGS ACCOUNT.—For purposes of this section—

''(1) MEDICAL SAVINGS ACCOUNT.—The term 'medical savings account' means a trust created or organized in the United States exclusively for the purpose of paying the qualified medical expenses of the account holder, but only if the written governing instrument creating the trust meets the following requirements:

''(A) Except in the case of a rollover contribution described in subsection (f)(5), no contribution will be accepted—

''(i) unless it is in cash, or

''(ii) to the extent such contribution, when added to previous contributions to the trust for the calendar year, exceeds $4,000.

''(B) The trustee is a bank (as defined in section 408(n)), an insurance company (as defined in section 816), or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with the requirements of this section.

''(C) No part of the trust assets will be invested in life insurance contracts.

''(D) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

''(E) The interest of an individual in the balance in his account is nonforfeitable.

''(2) QUALIFIED MEDICAL EXPENSES.—

''(A) IN GENERAL.—The term 'qualified medical expenses' means, with respect to an account holder, amounts paid by such holder for medical care (as defined in section 213(d)) for such individual, the spouse of such individual, and any dependent (as defined in section 152) of such individual, but only to the extent such amounts are not compensated for by insurance or otherwise.

''(B) HEALTH INSURANCE MAY NOT BE PURCHASED FROM ACCOUNT.—

''(i) IN GENERAL.—Subparagraph (A) shall not apply to any payment for insurance.

''(ii) EXCEPTIONS.—Clause (i) shall not apply to any expense for coverage under—

''(I) a health plan during any period of continuation coverage required under any Federal law,

''(II) a qualified long-term care insurance contract (as defined in section 7702B(b)), or

''(III) a health plan during a period in which the individual is receiving unemployment compensation under any Federal or State law.

''(3) ACCOUNT HOLDER.—The term 'account holder' means the individual on whose behalf the medical savings account was established.

''(4) CERTAIN RULES TO APPLY.—Rules similar to the following rules shall apply for purposes of this section:

''(A) Section 219(d)(2) (relating to no deduction for rollovers).

''(B) Section 219(f)(3) (relating to time when contributions deemed made).

''(C) Except as provided in section 106(b), section 219(f)(5) (relating to employer payments).

''(D) Section 408(g) (relating to community property laws).

''(E) Section 408(h) (relating to custodial accounts).

''(e) TAX TREATMENT OF ACCOUNTS.—

''(1) IN GENERAL.—A medical savings account is exempt from taxation under this subtitle unless such account has ceased to be a medical savings account by reason of paragraph (2) or (3). Notwithstanding the preceding sentence, any such account is subject to the taxes imposed by section 511 (relating to imposition of tax on unrelated business income of charitable, etc. organizations).

''(2) ACCOUNT TERMINATIONS.—Rules similar to the rules of paragraphs (2) and (4) of section 408(e) shall apply to medical savings accounts, and any amount treated as distributed under such rules shall be treated as not used to pay qualified medical expenses.

''(f) TAX TREATMENT OF DISTRIBUTIONS.—

''(1) AMOUNTS USED FOR QUALIFIED MEDICAL EXPENSES.—

''(A) IN GENERAL.—Any amount paid or distributed out of a medical savings account which is used exclusively to pay qualified medical expenses of any account holder (or any spouse or dependent of the holder) shall not be includible in gross income.

''(B) TREATMENT AFTER DEATH OF ACCOUNT HOLDER.—

''(i) TREATMENT IF HOLDER IS SPOUSE.—If, after the death of the account holder, the account holder's interest is payable to (or for the benefit of) the holder's spouse, the medical savings account shall be treated as if the spouse were the account holder.

''(ii) TREATMENT IF DESIGNATED HOLDER IS NOT SPOUSE.—In the case of an account holder's interest in a medical savings account which is payable to (or for the benefit of) any person other than such holder's spouse upon the death of such holder—

''(I) such account shall cease to be a medical savings account as of the date of death, and

''(II) an amount equal to the fair market value of the assets in such account on such date shall be includible if such person is not the estate of such holder, in such person's gross income for the taxable year which includes such date, or if such person is the estate of such holder, in such holder's gross income for the last taxable year of such holder.

''(2) INCLUSION OF AMOUNTS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

''(A) IN GENERAL.—Any amount paid or distributed out of a medical savings account which is not used exclusively to pay the qualified medical expenses of the account holder or of the spouse or dependents of such holder shall be included in the gross income of such holder.

''(B) SPECIAL RULES.—For purposes of subparagraph (A)—

''(i) all medical savings accounts of the account holder shall be treated as 1 account,

''(ii) all payments and distributions during any taxable year shall be treated as 1 distribution, and

''(iii) any distribution of property shall be taken into account at its fair market value on the date of the distribution.

''(3) EXCESS CONTRIBUTIONS RETURNED BEFORE DUE DATE OF RETURN.—If the aggregate contributions (other than rollover contributions) for a taxable year to the medical savings accounts of an individual exceed the amount allowable as a deduction under this section for such contributions, paragraph (2) shall not apply to distributions from such accounts (in an amount not greater than such excess) if—

''(A) such distribution is received by the individual on or before the last day prescribed by law (including extensions of time) for filing such individual's return for such taxable year, and

''(B) such distribution is accompanied by the amount of net income attributable to such excess contribution.

Any net income described in subparagraph (B) shall be included in the gross income of the individual for the taxable year in which it is received.

''(4) PENALTY FOR DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

''(A) IN GENERAL.—The tax imposed by this chapter on the account holder for any taxable year in which there is a payment or distribution from a medical savings account of such holder which is includible in gross income under paragraph (2) shall be increased by 10 percent of the amount which is so includible.

''(B) EXCEPTION FOR DISABILITY OR DEATH.—Subparagraph (A) shall not apply if the payment or distribution is made after the account holder becomes disabled within the meaning of section 72(m)(7) or dies.

''(C) EXCEPTION FOR DISTRIBUTIONS AFTER AGE 59½.—Subparagraph (A) shall not apply to any payment or distribution after the date on which the account holder attains age 59½.

''(5) ROLLOVER CONTRIBUTION.—An amount is described in this paragraph as a rollover contribution if it meets the requirements of subparagraphs (A) and (B).

''(A) IN GENERAL.—Paragraph (2) shall not apply to any amount paid or distributed from a medical savings account to the account holder to the extent the amount received is paid into a medical savings account for the benefit of such holder not later than the 60th day after the day on which the holder receives the payment or distribution.

''(B) LIMITATION.—This paragraph shall not apply to any amount described in subparagraph (A) received by an individual from a medical savings account if, at any time during the 1-year period ending on the day of such receipt, such individual received any other amount described in subparagraph (A) from a medical savings account which was not includible in the individual's gross income because of the application of this paragraph.

''(6) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—For purposes of determining the amount of the deduction under section 213, any payment or distribution out of a medical savings account for qualified medical expenses shall not be treated as an expense paid for medical care.

''(7) TRANSFER OF ACCOUNT INCIDENT TO DIVORCE.—The transfer of an individual's interest in a medical savings account to an individual's spouse or former spouse under a divorce or separation instrument described in subparagraph (A) of section 71(b)(2) shall not be considered a taxable transfer made by such individual notwithstanding any other provision of this subtitle, and such interest shall, after such transfer, be treated as a medical savings account with respect to which the spouse is the account holder.

''(g) COST-OF-LIVING ADJUSTMENT.—

''(1) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1997, each dollar amount in subsection (b)(1), (c)(2), or (d)(1)(A) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the medical care cost adjustment for such calendar year.

If any increase under the preceding sentence is not a multiple of $50, such increase shall be rounded to the nearest multiple of $50.

''(2) MEDICAL CARE COST ADJUSTMENT.—For purposes of paragraph (1), the medical care cost adjustment for any calendar year is the percentage (if any) by which—

''(A) the medical care component of the Consumer Price Index (as defined in section 1(f)(5)) for August of the preceding calendar year, exceeds

''(B) such component for August of 1996.

''(h) REPORTS.—The Secretary may require the trustee of a medical savings account to make such reports regarding such account to the Secretary and to the account holder with respect to contributions, distributions, and such other matters as the Secretary determines appropriate. The reports required by this subsection shall be filed at such time and in such manner and furnished to such individuals at such time and in such manner as may be required by those regulations.''

(b) DEDUCTION ALLOWED WHETHER OR NOT INDIVIDUAL ITEMIZES OTHER DEDUCTIONS.—Subsection (a) of section 62 is amended by inserting after paragraph (15) the following new paragraph:

''(16) MEDICAL SAVINGS ACCOUNTS.—The deduction allowed by section 220.''

(c) EXCLUSIONS FOR EMPLOYER CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

(1) EXCLUSION FROM INCOME TAX.—The text of section 106 (relating to contributions by employer to accident and health plans) is amended to read as follows:

''(a) GENERAL RULE.—Except as otherwise provided in this section, gross income of an employee does not include employer-provided coverage under an accident or health plan.

''(b) CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

''(1) IN GENERAL.—In the case of an employee who is an eligible individual, gross income does not include amounts contributed by such employee's employer to any medical savings account of such employee.

''(2) COORDINATION WITH DEDUCTION LIMITATION.—The amount excluded from the gross income of an employee under this subsection for any taxable year shall not exceed the limitation under section 220(b)(1) (determined without regard to this subsection) which is applicable to such employee for such taxable year.

''(3) NO CONSTRUCTIVE RECEIPT.—No amount shall be included in the gross income of any employee solely because the employee may choose between the contributions referred to in paragraph (1) and employer contributions to another health plan of the employer.

''(4) SPECIAL RULE FOR DEDUCTION OF EMPLOYER CONTRIBUTIONS.—Any employer contribution to a medical savings account, if otherwise allowable as a deduction under this chapter, shall be allowed only for the taxable year in which paid.

''(5) DEFINITIONS.—For purposes of this subsection, the terms 'eligible individual' and 'medical savings account' have the respective meanings given to such terms by section 220.''

(2) EXCLUSION FROM EMPLOYMENT TAXES.—

(A) SOCIAL SECURITY TAXES.—

(i) Subsection (a) of section 3121 is amended by striking ''or'' at the end of paragraph (20), by striking the period at the end of paragraph (21) and inserting ''; or'', and by inserting after paragraph (21) the following new paragraph:

''(22) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b).''

(ii) Subsection (a) of section 209 of the Social Security Act is amended by striking ''or'' at the end of paragraph (17), by striking the period at the end of paragraph (18) and inserting ''; or'', and by inserting after paragraph (18) the following new paragraph:

''(19) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b) of the Internal Revenue Code of 1986.''

(B) RAILROAD RETIREMENT TAX.—Subsection (e) of section 3231 is amended by adding at the end the following new paragraph:

''(10) MEDICAL SAVINGS ACCOUNT CONTRIBUTIONS.—The term 'compensation' shall not include any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b).''

(C) UNEMPLOYMENT TAX.—Subsection (b) of section 3306 is amended by striking ''or'' at the end of paragraph (15), by striking the period at the end of paragraph (16) and inserting ''; or'', and by inserting after paragraph (16) the following new paragraph:

''(17) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b).''

(D) WITHHOLDING TAX.—Subsection (a) of section 3401 is amended by striking ''or'' at the end of paragraph (19), by striking the period at the end of paragraph (20) and inserting ''; or'', and by inserting after paragraph (20) the following new paragraph:

''(21) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b).''

(d) MEDICAL SAVINGS ACCOUNT CONTRIBUTIONS NOT AVAILABLE UNDER CAFETERIA PLANS.—Subsection (f) of section 125 of such Code is amended by inserting ''106(b),'' before ''117''.

(e) EXCLUSION OF MEDICAL SAVINGS ACCOUNTS FROM ESTATE TAX.—Part IV of subchapter A of chapter 11 is amended by adding at the end the following new section:

''SEC. 2057. MEDICAL SAVINGS ACCOUNTS.

''For purposes of the tax imposed by section 2001, the value of the taxable estate shall be determined by deducting from the value of the gross estate an amount equal to the value of any medical savings account (as defined in section 220(d)) included in the gross estate.''

(f) TAX ON EXCESS CONTRIBUTIONS.—Section 4973 (relating to tax on excess contributions to individual retirement accounts, certain section 403(b) contracts, and certain individual retirement annuities) is amended—

(1) by inserting ''**MEDICAL SAVINGS ACCOUNTS,**'' after ''**ACCOUNTS,**'' in the heading of such section,

(2) by striking ''or'' at the end of paragraph (1) of subsection (a),

(3) by redesignating paragraph (2) of subsection (a) as paragraph (3) and by inserting after paragraph (1) the following:

''(2) a medical savings account (within the meaning of section 220(d)), or'', and

(4) by adding at the end the following new subsection:

''(d) EXCESS CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—For purposes of this section, in the case of a medical savings accounts (within the meaning of section 220(d)), the term 'excess contributions' means the sum of—

''(1) the amount by which the amount contributed for the taxable year to the accounts (other than rollover contributions described in section 220(f)(5)) exceeds the amount allowable as a deduction under section 220 for such contributions, and

''(2) the amount determined under this subsection for the preceding taxable year, reduced by the sum of distributions out of the account included in gross income under section 220(f) (2) or (3) and the excess (if any) of the maximum amount allowable as a deduction under section 220 for the taxable year over the amount contributed to the accounts.

For purposes of this subsection, any contribution which is distributed out of the medical savings account in a distribution to which section 220(f)(3) applies shall be treated as an amount not contributed.''

(g) TAX ON PROHIBITED TRANSACTIONS.—

(1) Section 4975 (relating to tax on prohibited transactions) is amended by adding at the end of subsection (c) the following new paragraph:

''(4) SPECIAL RULE FOR MEDICAL SAVINGS ACCOUNTS.—An individual for whose benefit a medical savings account (within the meaning of section 220(d)) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a medical savings account by reason of the application of section 220(e)(2) to such account.''

(2) Paragraph (1) of section 4975(e) is amended to read as follows:

''(1) PLAN.—For purposes of this section, the term 'plan' means—

''(A) a trust described in section 401(a) which forms a part of a plan, or a plan described in section 403(a), which trust or plan is exempt from tax under section 501(a),

''(B) an individual retirement account described in section 408(a),

''(C) an individual retirement annuity described in section 408(b),

''(D) a medical savings account described in section 220(d), or

''(E) a trust, plan, account, or annuity which, at any time, has been determined by the Secretary to be described in any preceding subparagraph of this paragraph.''

(h) FAILURE TO PROVIDE REPORTS ON MEDICAL SAVINGS ACCOUNTS.—

(1) Subsection (a) of section 6693 (relating to failure to provide reports on individual retirement accounts or annuities) is amended to read as follows:

''(a) REPORTS.—

''(1) IN GENERAL.—If a person required to file a report under a provision referred to in paragraph (2) fails to file such report at the time and in the manner required by such provision, such person shall pay a penalty of $50 for each failure unless it is shown that such failure is due to reasonable cause.

''(2) PROVISIONS.—The provisions referred to in this paragraph are—

''(A) subsections (i) and (l) of section 408 (relating to individual retirement plans), and

''(B) section 220(h) (relating to medical savings accounts).''

(i) EXCEPTION FROM CAPITALIZATION OF POLICY ACQUISITION EXPENSES.—Subparagraph (B) of section 848(e)(1) (defining specified insurance contract) is amended by striking ''and'' at the end of clause (ii), by striking the period at the end of clause (iii) and inserting '', and'', and by adding at the end the following new clause:

''(iv) any contract which is a medical savings account (as defined in section 220(d)).''.

(j) CLERICAL AMENDMENTS.—

(1) The table of sections for part VII of subchapter B of chapter 1 is amended by striking the last item and inserting the following:

''Sec. 220. Medical savings accounts.

''Sec. 221. Cross reference.''

(2) The table of sections for part IV of subchapter A of chapter 11 is amended by adding at the end the following new item:

''Sec. 2057. Medical savings accounts.''

(k) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1996.

Subtitle B—Increase in Deduction for Health Insurance Costs of Self-Employed Individuals

SEC. 311. INCREASE IN DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

(a) IN GENERAL.—Paragraph (1) of section 162(l) is amended to read as follows:

''(1) ALLOWANCE OF DEDUCTION.—

''(A) IN GENERAL.—In the case of an individual who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an amount equal to the applicable percentage of the amount paid during the taxable year for insurance which constitutes medical care for the taxpayer, his spouse, and dependents.

''(B) APPLICABLE PERCENTAGE.—For purposes of subparagraph (A), the applicable percentage shall be determined under the following table:

''For taxable years beginning in calendar year—	The applicable percentage is—
1998	35 percent
1999, 2000, or 2001	40 percent
2002	45 percent
2003 or thereafter	50 percent.''

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 1997.

Subtitle C—Long-Term Care Services and Contracts

PART I—GENERAL PROVISIONS

SEC. 321. TREATMENT OF LONG-TERM CARE INSURANCE.

(a) GENERAL RULE.—Chapter 79 (relating to definitions) is amended by inserting after section 7702A the following new section:

''SEC. 7702B. TREATMENT OF QUALIFIED LONG-TERM CARE INSURANCE.

''(a) IN GENERAL.—For purposes of this title—

''(1) a qualified long-term care insurance contract shall be treated as an accident and health insurance contract,

''(2) amounts (other than policyholder dividends, as defined in section 808, or premium refunds) received under a qualified long-term care insurance contract shall be treated as amounts received for personal injuries and sickness and shall be treated as reimbursement for expenses actually incurred for medical care (as defined in section 213(d)),

''(3) any plan of an employer providing coverage under a qualified long-term care insurance contract shall be treated as an accident and health plan with respect to such coverage,

''(4) except as provided in subsection (e)(3), amounts paid for a qualified long-term care insurance contract providing the benefits described in subsection (b)(2)(A) shall be treated as payments made for insurance for purposes of section 213(d)(1)(D), and

''(5) a qualified long-term care insurance contract shall be treated as a guaranteed renewable contract subject to the rules of section 816(e).

''(b) QUALIFIED LONG-TERM CARE INSURANCE CONTRACT.—For purposes of this title—

''(1) IN GENERAL.—The term 'qualified long-term care insurance contract' means any insurance contract if—

''(A) the only insurance protection provided under such contract is coverage of qualified long-term care services,

''(B) such contract does not pay or reimburse expenses incurred for services or items to the extent that such expenses are reimbursable under title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount,

''(C) such contract is guaranteed renewable,

''(D) such contract does not provide for a cash surrender value or other money that can be—

''(i) paid, assigned, or pledged as collateral for a loan, or

''(ii) borrowed,

other than as provided in subparagraph (E) or paragraph (2)(C),

''(E) all refunds of premiums, and all policyholder dividends or similar amounts, under such contract are to be applied as a reduction in future premiums or to increase future benefits, and

''(F) such contract meets the requirements of subsection (f).

''(2) SPECIAL RULES.—

''(A) PER DIEM, ETC. PAYMENTS PERMITTED.—A contract shall not fail to be described in subparagraph (A) or (B) of paragraph (1) by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

''(B) SPECIAL RULES RELATING TO MEDICARE.—

''(i) Paragraph (1)(B) shall not apply to expenses which are reimbursable under title XVIII of the Social Security Act only as a secondary payor.

''(ii) No provision of law shall be construed or applied so as to prohibit the offering of a qualified long-term care insurance contract on the basis that the contract coordinates its benefits with those provided under such title.

''(C) REFUNDS OF PREMIUMS.—Paragraph (1)(E) shall not apply to any refund on the death of the insured, or on a complete surrender or cancellation of the contract, which cannot exceed the aggregate premiums paid under the contract. Any refund on a complete surrender or cancellation of the contract shall be includible in gross income to the extent that any deduction or exclusion was allowable with respect to the premiums.

''(c) QUALIFIED LONG-TERM CARE SERVICES.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualified long-term care services' means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, which—

''(A) are required by a chronically ill individual, and

''(B) are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

''(2) CHRONICALLY ILL INDIVIDUAL.—

''(A) IN GENERAL.—The term 'chronically ill individual' means any individual who has been certified by a licensed health care practitioner as—

''(i) being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living for a period of at least 90 days due to a loss of functional capacity,

''(ii) having a level of disability similar (as determined by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in clause (i), or

''(iii) requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment.

Such term shall not include any individual otherwise meeting the requirements of the preceding sentence unless within the preceding 12-month period a licensed health care practitioner has certified that such individual meets such requirements.

''(B) ACTIVITIES OF DAILY LIVING.—For purposes of subparagraph (A), each of the following is an activity of daily living:

''(i) Eating.

''(ii) Toileting.

''(iii) Transferring.

''(iv) Bathing.

''(v) Dressing.

''(vi) Continence.

Nothing in this section shall be construed to require a contract to take into account all of the preceding activities of daily living.

''(3) MAINTENANCE OR PERSONAL CARE SERVICES.—The term 'maintenance or personal care services' means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

''(4) LICENSED HEALTH CARE PRACTITIONER.—The term 'licensed health care practitioner' means any physician (as defined in section 1861(r)(1) of the Social Security Act) and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary.

''(d) AGGREGATE PAYMENTS IN EXCESS OF LIMITS.—

''(1) IN GENERAL.—If the aggregate amount of periodic payments under all qualified long-term care insurance contracts with respect to an insured for any period exceeds the dollar amount in effect for such period

under paragraph (3), such excess payments shall be treated as made for qualified long-term care services only to the extent of the costs incurred by the payee (not otherwise compensated for by insurance or otherwise) for qualified long-term care services provided during such period for such insured.

''(2) PERIODIC PAYMENTS.—For purposes of paragraph (1), the term 'periodic payment' means any payment (whether on a periodic basis or otherwise) made without regard to the extent of the costs incurred by the payee for qualified long-term care services.

''(3) DOLLAR AMOUNT.—The dollar amount in effect under this subsection shall be $175 per day (or the equivalent amount in the case of payments on another periodic basis).

''(4) INFLATION ADJUSTMENT.—In the case of a calendar year after 1997, the dollar amount contained in paragraph (3) shall be increased at the same time and in the same manner as amounts are increased pursuant to section 213(d)(10).

''(e) TREATMENT OF COVERAGE PROVIDED AS PART OF A LIFE INSURANCE CONTRACT.—Except as otherwise provided in regulations prescribed by the Secretary, in the case of any long-term care insurance coverage (whether or not qualified) provided by a rider on or as part of a life insurance contract—

''(1) IN GENERAL.—This section shall apply as if the portion of the contract providing such coverage is a separate contract.

''(2) APPLICATION OF 7702.—Section 7702(c)(2) (relating to the guideline premium limitation) shall be applied by increasing the guideline premium limitation with respect to a life insurance contract, as of any date—

''(A) by the sum of any charges (but not premium payments) against the life insurance contract's cash surrender value (within the meaning of section 7702(f)(2)(A)) for such coverage made to that date under the contract, less

''(B) any such charges the imposition of which reduces the premiums paid for the contract (within the meaning of section 7702(f)(1)).

''(3) APPLICATION OF SECTION 213.—No deduction shall be allowed under section 213(a) for charges against the life insurance contract's cash surrender value described in paragraph (2), unless such charges are includible in income as a result of the application of section 72(e)(10) and the rider is a qualified long-term care insurance contract under subsection (b).

''(4) PORTION DEFINED.—For purposes of this subsection, the term 'portion' means only the terms and benefits under a life insurance contract that are in addition to the terms and benefits under the contract without regard to the coverage under a qualified long-term care insurance contract.''

(b) LONG-TERM CARE INSURANCE NOT PERMITTED UNDER CAFETERIA PLANS OR FLEXIBLE SPENDING ARRANGEMENTS.—

(1) CAFETERIA PLANS.—Section 125(f) is amended by adding at the end the following new sentence: ''Such term shall not include any long-term care insurance contract (as defined in section 4980C).''

(2) FLEXIBLE SPENDING ARRANGEMENTS.—Section 106 (relating to contributions by employer to accident and health plans), as amended by section 301(c), is amended by adding at the end the following new subsection:

''(c) INCLUSION OF LONG-TERM CARE BENEFITS PROVIDED THROUGH FLEXIBLE SPENDING ARRANGEMENTS.—

''(1) IN GENERAL.—Effective on and after January 1, 1997, gross income of an employee shall include employer-provided coverage for qualified long-term care services (as defined in section 7702B(c)) to the extent that such coverage is provided through a flexible spending or similar arrangement.

''(2) FLEXIBLE SPENDING ARRANGEMENT.—For purposes of this subsection, a flexible spending arrangement is a benefit program which provides employees with coverage under which—

''(A) specified incurred expenses may be reimbursed (subject to reimbursement maximums and other reasonable conditions), and

''(B) the maximum amount of reimbursement which is reasonably available to a participant for such coverage is less than 500 percent of the value of such coverage.

In the case of an insured plan, the maximum amount reasonably available shall be determined on the basis of the underlying coverage.''

(c) CONTINUATION COVERAGE EXCISE TAX NOT TO APPLY.—Subsection (f) of section 4980B is amended by adding at the end the following new paragraph:

''(9) CONTINUATION OF LONG-TERM CARE COVERAGE NOT REQUIRED.—A group health plan shall not be treated as failing to meet the requirements of this subsection solely by reason of failing to provide coverage under any qualified long-term care insurance contract (as defined in section 7702B(b)).''

(d) CLERICAL AMENDMENT.—The table of sections for chapter 79 is amended by inserting after the item relating to section 7702A the following new item:

''Sec. 7702B. Treatment of qualified long-term care insurance.''.

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to contracts issued after December 31, 1996.

(2) CONTINUATION OF EXISTING POLICIES.—In the case of any contract issued before January 1, 1997, which met the long-term care insurance requirements of the State in which the contract was sitused at the time the contract was issued—

(A) such contract shall be treated for purposes of the Internal Revenue Code of 1986 as a qualified long-term care insurance contract (as defined in section 7702B(b) of such Code), and

(B) services provided under, or reimbursed by, such contract shall be treated for such purposes as qualified long-term care services (as defined in section 7702B(c) of such Code).

(3) EXCHANGES OF EXISTING POLICIES.—If, after the date of enactment of this Act and before January 1, 1998, a contract providing for long-term care insurance coverage is exchanged solely for a qualified long-term care insurance contract (as defined in section 7702B(b) of such Code), no gain or loss shall be recognized on the exchange. If, in addition to a qualified long-term care insurance contract, money or other property is received in the exchange, then any gain shall be recognized to the extent of the sum of the money and the fair market value of the other property received. For purposes of this paragraph, the cancellation of a contract providing for long-term care insurance coverage and reinvestment of the cancellation proceeds in a qualified long-term care insurance contract within 60 days thereafter shall be treated as an exchange.

(4) ISSUANCE OF CERTAIN RIDERS PERMITTED.—For purposes of applying sections 101(f), 7702, and 7702A of the Internal Revenue Code of 1986 to any contract—

(A) the issuance of a rider which is treated as a qualified long-term care insurance contract under section 7702B, and

(B) the addition of any provision required to conform any other long-term care rider to be so treated,

shall not be treated as a modification or material change of such contract.

SEC. 322. QUALIFIED LONG-TERM CARE SERVICES TREATED AS MEDICAL CARE.

(a) GENERAL RULE.—Paragraph (1) of section 213(d) (defining medical care) is amended by striking ''or'' at the end of subparagraph (B), by redesignating subparagraph (C) as subparagraph (D), and by inserting after subparagraph (B) the following new subparagraph:

''(C) for qualified long-term care services (as defined in section 7702B(c)), or''.

(b) TECHNICAL AMENDMENTS.—

(1) Subparagraph (D) of section 213(d)(1) (as redesignated by subsection (a)) is amended by inserting before the period ''or for any qualified long-term care insurance contract (as defined in section 7702B(b))''.

(2)(A) Paragraph (1) of section 213(d) is amended by adding at the end the following new flush sentence:

''In the case of a qualified long-term care insurance contract (as defined in section 7702B(b)), only eligible long-term care premiums (as defined in paragraph (10)) shall be taken into account under subparagraph (D).''

(B) Subsection (d) of section 213 is amended by adding at the end the following new paragraphs:

''(10) ELIGIBLE LONG-TERM CARE PREMIUMS.—

''(A) IN GENERAL.—For purposes of this section, the term 'eligible long-term care premiums' means the amount paid during a taxable year for any qualified long-term care insurance contract (as defined in section 7702B(b)) covering an individual, to the extent such amount does not exceed the limitation determined under the following table:

''In the case of an individual with an attained age before the close of the taxable year of:	**The limitation is:**
40 or less	$ 200
More than 40 but not more than 50	375
More than 50 but not more than 60	750
More than 60 but not more than 70	2,000
More than 70	2,500.

''(B) INDEXING.—

''(i) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1997, each dollar amount contained in subparagraph (A) shall be increased by the medical care cost adjustment of such amount for such calendar year. If any increase determined under the preceding sentence is not a multiple of $10, such increase shall be rounded to the nearest multiple of $10.

''(ii) MEDICAL CARE COST ADJUSTMENT.—For purposes of clause (i), the medical care cost adjustment for any calendar year is the percentage (if any) by which—

''(I) the medical care component of the Consumer Price Index (as defined in section 1(f)(5)) for August of the preceding calendar year, exceeds

''(II) such component for August of 1996.

The Secretary shall, in consultation with the Secretary of Health and Human Services, prescribe an adjustment which the Secretary determines is more appropriate for purposes of this paragraph than the adjustment described in the preceding sentence, and the adjustment so prescribed shall apply in lieu of the adjustment described in the preceding sentence.

''(11) CERTAIN PAYMENTS TO RELATIVES TREATED AS NOT PAID FOR MEDICAL CARE.—An amount paid for a qualified long-term care service (as defined in section 7702B(c)) provided to an individual shall be treated as not paid for medical care if such service is provided—

''(A) by the spouse of the individual or by a relative (directly or through a partnership, corporation, or other entity) unless the service is provided by a licensed professional with respect to such service, or

''(B) by a corporation or partnership which is related (within the meaning of section 267(b) or 707(b)) to the individual.

For purposes of this paragraph, the term 'relative' means an individual bearing a relationship to the individual which is described in any of paragraphs (1) through (8) of section 152(a). This paragraph shall not apply for purposes of section 105(b) with respect to reimbursements through insurance.''

(3) Paragraph (6) of section 213(d) is amended—

(A) by striking ''subparagraphs (A) and (B)'' and inserting ''subparagraphs (A), (B), and (C)'', and

(B) by striking ''paragraph (1)(C)'' in subparagraph (A) and inserting ''paragraph (1)(D)''.

(4) Paragraph (7) of section 213(d) is amended by striking ''subparagraphs (A) and (B)'' and inserting ''subparagraphs (A), (B), and (C)''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to taxable years beginning after December 31, 1996.

(2) DEDUCTION FOR LONG-TERM CARE SERVICES.—Amounts paid for qualified long-term care services (as defined in section 7702B(c) of the Internal Revenue Code of 1986, as added by this Act) furnished in any taxable year beginning before January 1, 1998, shall not be taken into account under section 213 of the Internal Revenue Code of 1986.

SEC. 323. REPORTING REQUIREMENTS.

(a) IN GENERAL.—Subpart B of part III of subchapter A of chapter 61 is amended by adding at the end the following new section:

''SEC. 6050Q. CERTAIN LONG-TERM CARE BENEFITS.

''(a) REQUIREMENT OF REPORTING.—Any person who pays long-term care benefits shall make a return, according to the forms or regulations prescribed by the Secretary, setting forth—

''(1) the aggregate amount of such benefits paid by such person to any individual during any calendar year, and

''(2) the name, address, and TIN of such individual.

''(b) STATEMENTS TO BE FURNISHED TO PERSONS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required to be set forth in such return a written statement showing—

''(1) the name of the person making the payments, and

''(2) the aggregate amount of long-term care benefits paid to the individual which are required to be shown on such return.

The written statement required under the preceding sentence shall be furnished to the individual on or before January 31 of the year following the calendar year for which the return under subsection (a) was required to be made.

''(c) LONG-TERM CARE BENEFITS.—For purposes of this section, the term 'long-term care benefit' means—

''(1) any amount paid under a long-term care insurance policy (within the meaning of section 4980C(e)), and

''(2) payments which are excludable from gross income by reason of section 101(g).''.

(b) PENALTIES.—

(1) Subparagraph (B) of section 6724(d)(1) is amended by redesignating clauses (ix) through (xiv) as clauses (x) through (xv), respectively, and by inserting after clause (viii) the following new clause:

''(ix) section 6050Q (relating to certain long-term care benefits),''.

(2) Paragraph (2) of section 6724(d) is amended by redesignating subparagraphs (Q) through (T) as subparagraphs (R) through (U), respectively, and by inserting after subparagraph (P) the following new subparagraph:

''(Q) section 6050Q(b) (relating to certain long-term care benefits),''.

(c) CLERICAL AMENDMENT.—The table of sections for subpart B of part III of subchapter A of chapter 61 is amended by adding at the end the following new item:

''Sec. 6050Q. Certain long-term care benefits.''

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to benefits paid after December 31, 1996.

PART II—CONSUMER PROTECTION PROVISIONS

SEC. 325. POLICY REQUIREMENTS.

Section 7702B (as added by section 321) is amended by adding at the end the following new subsection:

''(f) CONSUMER PROTECTION PROVISIONS.—

''(1) IN GENERAL.—The requirements of this subsection are met with respect to any contract if any long-term care insurance policy issued under the contract meets—

''(A) the requirements of the model regulation and model Act described in paragraph (2),

''(B) the disclosure requirement of paragraph (3), and

''(C) the requirements relating to nonforfeitability under paragraph (4).

''(2) REQUIREMENTS OF MODEL REGULATION AND ACT.—

''(A) IN GENERAL.—The requirements of this paragraph are met with respect to any policy if such policy meets—

''(i) MODEL REGULATION.—The following requirements of the model regulation:

''(I) Section 7A (relating to guaranteed renewal or noncancellability), and the requirements of section 6B of the model Act relating to such section 7A.

''(II) Section 7B (relating to prohibitions on limitations and exclusions).

''(III) Section 7C (relating to extension of benefits).

''(IV) Section 7D (relating to continuation or conversion of coverage).

''(V) Section 7E (relating to discontinuance and replacement of policies).

''(VI) Section 8 (relating to unintentional lapse).

''(VII) Section 9 (relating to disclosure), other than section 9F thereof.

''(VIII) Section 10 (relating to prohibitions against post-claims underwriting).

''(IX) Section 11 (relating to minimum standards).

''(X) Section 12 (relating to requirement to offer inflation protection), except that any requirement for a signature on a rejection of inflation protection shall permit the signature to be on an application or on a separate form.

''(XI) Section 23 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

''(ii) MODEL ACT.—The following requirements of the model Act:

''(I) Section 6C (relating to preexisting conditions).

''(II) Section 6D (relating to prior hospitalization).

''(B) DEFINITIONS.—For purposes of this paragraph—

''(i) MODEL PROVISIONS.—The terms 'model regulation' and 'model Act' mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of January 1993).

''(ii) COORDINATION.—Any provision of the model regulation or model Act listed under clause (i) or (ii) of subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision.

''(iii) DETERMINATION.—For purposes of this section and section 4980C, the determination of whether any requirement of a model regulation or the model Act has been met shall be made by the Secretary.

''(3) DISCLOSURE REQUIREMENT.—The requirement of this paragraph is met with respect to any policy if such policy meets the requirements of section 4980C(d)(1).

''(4) NONFORFEITURE REQUIREMENTS.—

''(A) IN GENERAL.—The requirements of this paragraph are met with respect to any level premium long-term care insurance policy, if the issuer of such policy offers to the policyholder, including any group policyholder, a nonforfeiture provision meeting the requirements of subparagraph (B).

''(B) REQUIREMENTS OF PROVISION.—The nonforfeiture provision required under subparagraph (A) shall meet the following requirements:

''(i) The nonforfeiture provision shall be appropriately captioned.

''(ii) The nonforfeiture provision shall provide for a benefit available in the event of a default in the payment of any premiums and the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying policies approved by the Secretary for the same policy form.

''(iii) The nonforfeiture provision shall provide at least one of the following:

''(I) Reduced paid-up insurance.

''(II) Extended term insurance.

''(III) Shortened benefit period.

''(IV) Other similar offerings approved by the Secretary.

''(5) LONG-TERM CARE INSURANCE POLICY DEFINED.—For purposes of this subsection, the term 'long-term care insurance policy' has the meaning given such term by section 4980C(e).''.

SEC. 326. REQUIREMENTS FOR ISSUERS OF LONG-TERM CARE INSURANCE POLICIES.

(a) IN GENERAL.—Chapter 43 is amended by adding at the end the following new section:

''SEC. 4980C. REQUIREMENTS FOR ISSUERS OF LONG-TERM CARE INSURANCE POLICIES.

''(a) GENERAL RULE.—There is hereby imposed on any person failing to meet the requirements of subsection (c) or (d) a tax in the amount determined under subsection (b).

''(b) AMOUNT.—

''(1) IN GENERAL.—The amount of the tax imposed by subsection (a) shall be $100 per policy for each day any requirements of subsection (c) or (d) are not met with respect to each long-term care insurance policy.

''(2) WAIVER.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that payment of the tax would be excessive relative to the failure involved.

''(c) RESPONSIBILITIES.—The requirements of this subsection are as follows:

''(1) REQUIREMENTS OF MODEL PROVISIONS.—

''(A) MODEL REGULATION.—The following requirements of the model regulation must be met:

''(i) Section 13 (relating to application forms and replacement coverage).

''(ii) Section 14 (relating to reporting requirements), except that the issuer shall also

report at least annually the number of claims denied during the reporting period for each class of business (expressed as a percentage of claims denied), other than claims denied for failure to meet the waiting period or because of any applicable preexisting condition.

''(iii) Section 20 (relating to filing requirements for marketing).

''(iv) Section 21 (relating to standards for marketing), including inaccurate completion of medical histories, other than sections 21C(1) and 21C(6) thereof, except that—

''(I) in addition to such requirements, no person shall, in selling or offering to sell a long-term care insurance policy, misrepresent a material fact; and

''(II) no such requirements shall include a requirement to inquire or identify whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance.

''(v) Section 22 (relating to appropriateness of recommended purchase).

''(vi) Section 24 (relating to standard format outline of coverage).

''(vii) Section 25 (relating to requirement to deliver shopper's guide).

''(B) MODEL ACT.—The following requirements of the model Act must be met:

''(i) Section 6F (relating to right to return), except that such section shall also apply to denials of applications and any refund shall be made within 30 days of the return or denial.

''(ii) Section 6G (relating to outline of coverage).

''(iii) Section 6H (relating to requirements for certificates under group plans).

''(iv) Section 6I (relating to policy summary).

''(v) Section 6J (relating to monthly reports on accelerated death benefits).

''(vi) Section 7 (relating to incontestability period).

''(C) DEFINITIONS.—For purposes of this paragraph, the terms 'model regulation' and 'model Act' have the meanings given such terms by section 7702B(f)(2)(B).

''(2) DELIVERY OF POLICY.—If an application for a long-term care insurance policy (or for a certificate under a group long-term care insurance policy) is approved, the issuer shall deliver to the applicant (or policyholder or certificateholder) the policy (or certificate) of insurance not later than 30 days after the date of the approval.

''(3) INFORMATION ON DENIALS OF CLAIMS.—If a claim under a long-term care insurance policy is denied, the issuer shall, within 60 days of the date of a written request by the policyholder or certificateholder (or representative)—

''(A) provide a written explanation of the reasons for the denial, and

''(B) make available all information directly relating to such denial.

''(d) DISCLOSURE.—The requirements of this subsection are met if the issuer of a long-term care insurance policy discloses in such policy and in the outline of coverage required under subsection (c)(1)(B)(ii) that the policy is intended to be a qualified long-term care insurance contract under section 7702B(b).

''(e) LONG-TERM CARE INSURANCE POLICY DEFINED.—For purposes of this section, the term 'long-term care insurance policy' means any product which is advertised, marketed, or offered as long-term care insurance.''.

(b) CONFORMING AMENDMENT.—The table of sections for chapter 43 is amended by adding at the end the following new item:

''Sec. 4980C. Requirements for issuers of long-term care insurance policies.''.

SEC. 327. COORDINATION WITH STATE REQUIREMENTS.

Nothing in this part shall prevent a State from establishing, implementing, or continuing in effect standards related to the protection of policyholders of long-term care insurance policies (as defined in section 4980C(e) of the Internal Revenue Code of 1986), if such standards are not in conflict with or inconsistent with the standards established under such Code.

SEC. 328. EFFECTIVE DATES.

(a) IN GENERAL.—The provisions of, and amendments made by, this part shall apply to contracts issued after December 31, 1996. The provisions of section 321(g) (relating to transition rule) shall apply to such contracts.

(b) ISSUERS.—The amendments made by section 326 shall apply to actions taken after December 31, 1996.

Subtitle D—Treatment of Accelerated Death Benefits

SEC. 331. TREATMENT OF ACCELERATED DEATH BENEFITS BY RECIPIENT.

(a) IN GENERAL.—Section 101 (relating to certain death benefits) is amended by adding at the end the following new subsection:

''(g) TREATMENT OF CERTAIN ACCELERATED DEATH BENEFITS.—

''(1) IN GENERAL.—For purposes of this section, the following amounts shall be treated as an amount paid by reason of the death of an insured:

''(A) Any amount received under a life insurance contract on the life of an insured who is a terminally ill individual.

''(B) Any amount received under a life insurance contract on the life of an insured who is a chronically ill individual (as defined in section 7702B(c)(2)) but only if such amount is received under a rider or other provision of such contract which is treated as a qualified long-term care insurance contract under section 7702B and such amount is treated under section 7702B (after the application of subsection (d) thereof) as a payment for qualified long-term care services (as defined in such section).

''(2) TREATMENT OF VIATICAL SETTLEMENTS.—

''(A) IN GENERAL.—In the case of a life insurance contract on the life of an insured described in paragraph (1), if—

''(i) any portion of such contract is sold to any viatical settlement provider, or

''(ii) any portion of the death benefit is assigned to such a provider,

the amount paid for such sale or assignment shall be treated as an amount paid under the life insurance contract by reason of the death of such insured.

''(B) VIATICAL SETTLEMENT PROVIDER.—The term 'viatical settlement provider' means any person regularly engaged in the trade or business of purchasing, or taking assignments of, life insurance contracts on the lives of insureds described in paragraph (1) if—

''(i) such person is licensed for such purposes in the State in which the insured resides, or

''(ii) in the case of an insured who resides in a State not requiring the licensing of such persons for such purposes—

''(I) such person meets the requirements of sections 8 and 9 of the Viatical Settlements Model Act of the National Association of Insurance Commissioners, and

''(II) meets the requirements of the Model Regulations of the National Association of Insurance Commissioners (relating to standards for evaluation of reasonable payments) in determining amounts paid by such person in connection with such purchases or assignments.

''(3) DEFINITIONS.—For purposes of this subsection—

''(A) TERMINALLY ILL INDIVIDUAL.—The term 'terminally ill individual' means an individual who has been certified by a physician as having an illness or physical condition which can reasonably be expected to result in death in 24 months or less after the date of the certification.

''(B) PHYSICIAN.—The term 'physician' has the meaning given to such term by section 1861(r)(1) of the Social Security Act (42 U.S.C. 1395x(r)(1)).

''(4) EXCEPTION FOR BUSINESS-RELATED POLICIES.—This subsection shall not apply in the case of any amount paid to any taxpayer other than the insured if such taxpayer has an insurable interest with respect to the life of the insured by reason of the insured being a director, officer, or employee of the taxpayer or by reason of the insured being financially interested in any trade or business carried on by the taxpayer.''

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to amounts received after December 31, 1996.

SEC. 332. TAX TREATMENT OF COMPANIES ISSUING QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.

(a) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—Section 818 (relating to other definitions and special rules) is amended by adding at the end the following new subsection:

''(g) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—For purposes of this part—

''(1) IN GENERAL.—Any reference to a life insurance contract shall be treated as including a reference to a qualified accelerated death benefit rider on such contract.

''(2) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.—For purposes of this subsection, the term 'qualified accelerated death benefit rider' means any rider on a life insurance contract if the only payments under the rider are payments meeting the requirements of section 101(g).

''(3) EXCEPTION FOR LONG-TERM CARE RIDERS.—Paragraph (1) shall not apply to any rider which is treated as a long-term care insurance contract under section 7702B.''

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by this section shall take effect on January 1, 1997.

(2) ISSUANCE OF RIDER NOT TREATED AS MATERIAL CHANGE.—For purposes of applying sections 101(f), 7702, and 7702A of the Internal Revenue Code of 1986 to any contract—

(A) the issuance of a qualified accelerated death benefit rider (as defined in section 818(g) of such Code (as added by this Act)), and

(B) the addition of any provision required to conform an accelerated death benefit rider to the requirements of such section 818(g),

shall not be treated as a modification or material change of such contract.

Subtitle E—High-Risk Pools

SEC. 341. EXEMPTION FROM INCOME TAX FOR STATE-SPONSORED ORGANIZATIONS PROVIDING HEALTH COVERAGE FOR HIGH-RISK INDIVIDUALS.

(a) IN GENERAL.—Subsection (c) of section 501 (relating to list of exempt organizations) is amended by adding at the end the following new paragraph:

''(26) Any membership organization if—

''(A) such organization is established by a State exclusively to provide coverage for medical care (as defined in section 213(d)) on a not-for-profit basis to individuals described in subparagraph (B) through—

''(i) insurance issued by the organization, or

''(ii) a health maintenance organization under an arrangement with the organization,

''(B) the only individuals receiving such coverage through the organization are individuals—

''(i) who are residents of such State, and

''(ii) who, by reason of the existence or history of a medical condition, are unable to acquire medical care coverage for such condition through insurance or from a health maintenance organization or are able to acquire such coverage only at a rate which is substantially in excess of the rate for such coverage through the membership organization,

''(C) the composition of the membership in such organization is specified by such State, and

''(D) no part of the net earnings of the organization inures to the benefit of any private shareholder or individual.''

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 1996.

Subtitle F—Organizations Subject to Section 833

SEC. 351. ORGANIZATIONS SUBJECT TO SECTION 833.

(a) IN GENERAL.—Section 833(c) (relating to organization to which section applies) is amended by adding at the end the following new paragraph:

''(4) TREATMENT AS EXISTING BLUE CROSS OR BLUE SHIELD ORGANIZATION.—

''(A) IN GENERAL.—Paragraph (2) shall be applied to an organization described in subparagraph (B) as if it were a Blue Cross or Blue Shield organization.

''(B) APPLICABLE ORGANIZATION.—An organization is described in this subparagraph if it—

''(i) is organized under, and governed by, State laws which are specifically and exclusively applicable to not-for-profit health insurance or health service type organizations, and

''(ii) is not a Blue Cross or Blue Shield organization or health maintenance organization.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years ending after December 31, 1996.

TITLE IV—REVENUE OFFSETS

SEC. 400. AMENDMENT OF 1986 CODE.

Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

Subtitle A—Repeal of Bad Debt Reserve Method for Thrift Savings Associations

SEC. 401. REPEAL OF BAD DEBT RESERVE METHOD FOR THRIFT SAVINGS ASSOCIATIONS.

(a) IN GENERAL.—Section 593 (relating to reserves for losses on loans) is amended by adding at the end the following new subsections:

''(f) TERMINATION OF RESERVE METHOD.—Subsections (a), (b), (c), and (d) shall not apply to any taxable year beginning after December 31, 1995.

''(g) 6-YEAR SPREAD OF ADJUSTMENTS.—

''(1) IN GENERAL.—In the case of any taxpayer who is required by reason of subsection (f) to change its method of computing reserves for bad debts—

''(A) such change shall be treated as a change in a method of accounting,

''(B) such change shall be treated as initiated by the taxpayer and as having been made with the consent of the Secretary, and

''(C) the net amount of the adjustments required to be taken into account by the taxpayer under section 481(a)—

''(i) shall be determined by taking into account only applicable excess reserves, and

''(ii) as so determined, shall be taken into account ratably over the 6-taxable year period beginning with the first taxable year beginning after December 31, 1995.

''(2) APPLICABLE EXCESS RESERVES.—

''(A) IN GENERAL.—For purposes of paragraph (1), the term 'applicable excess reserves' means the excess (if any) of—

''(i) the balance of the reserves described in subsection (c)(1) (other than the supplemental reserve) as of the close of the taxpayer's last taxable year beginning before December 31, 1995, over

''(ii) the lesser of—

''(I) the balance of such reserves as of the close of the taxpayer's last taxable year beginning before January 1, 1988, or

''(II) the balance of the reserves described in subclause (I), reduced in the same manner as under section 585(b)(2)(B)(ii) on the basis of the taxable years described in clause (i) and this clause.

''(B) SPECIAL RULE FOR THRIFTS WHICH BECOME SMALL BANKS.—In the case of a bank (as defined in section 581) which was not a large bank (as defined in section 585(c)(2)) for its first taxable year beginning after December 31, 1995—

''(i) the balance taken into account under subparagraph (A)(ii) shall not be less than the amount which would be the balance of such reserves as of the close of its last taxable year beginning before such date if the additions to such reserves for all taxable years had been determined under section 585(b)(2)(A), and

''(ii) the opening balance of the reserve for bad debts as of the beginning of such first taxable year shall be the balance taken into account under subparagraph (A)(ii) (determined after the application of clause (i) of this subparagraph).

The preceding sentence shall not apply for purposes of paragraphs (5) and (6) or subsection (e)(1).

''(3) RECAPTURE OF PRE-1988 RESERVES WHERE TAXPAYER CEASES TO BE BANK.—If, during any taxable year beginning after December 31, 1995, a taxpayer to which paragraph (1) applied is not a bank (as defined in section 581), paragraph (1) shall apply to the reserves described in paragraph (2)(A)(ii) and the supplemental reserve; except that such reserves shall be taken into account ratably over the 6-taxable year period beginning with such taxable year.

''(4) SUSPENSION OF RECAPTURE IF RESIDENTIAL LOAN REQUIREMENT MET.—

''(A) IN GENERAL.—In the case of a bank which meets the residential loan requirement of subparagraph (B) for the first taxable year beginning after December 31, 1995, or for the following taxable year—

''(i) no adjustment shall be taken into account under paragraph (1) for such taxable year, and

''(ii) such taxable year shall be disregarded in determining—

''(I) whether any other taxable year is a taxable year for which an adjustment is required to be taken into account under paragraph (1), and

''(II) the amount of such adjustment.

''(B) RESIDENTIAL LOAN REQUIREMENT.—A taxpayer meets the residential loan requirement of this subparagraph for any taxable year if the principal amount of the residential loans made by the taxpayer during such year is not less than the base amount for such year.

''(C) RESIDENTIAL LOAN.—For purposes of this paragraph, the term 'residential loan' means any loan described in clause (v) of section 7701(a)(19)(C) but only if such loan is incurred in acquiring, constructing, or improving the property described in such clause.

''(D) BASE AMOUNT.—For purposes of subparagraph (B), the base amount is the average of the principal amounts of the residential loans made by the taxpayer during the 6 most recent taxable years beginning on or before December 31, 1995. At the election of the taxpayer who made such loans during each of such 6 taxable years, the preceding sentence shall be applied without regard to the taxable year in which such principal amount was the highest and the taxable year in such principal amount was the lowest. Such an election may be made only for the first taxable year beginning after such date, and, if made for such taxable year, shall apply to the succeeding taxable year unless revoked with the consent of the Secretary.

''(E) CONTROLLED GROUPS.—In the case of a taxpayer which is a member of any controlled group of corporations described in section 1563(a)(1), subparagraph (B) shall be applied with respect to such group.

''(5) CONTINUED APPLICATION OF FRESH START UNDER SECTION 585 TRANSITIONAL RULES.—In the case of a taxpayer to which paragraph (1) applied and which was not a large bank (as defined in section 585(c)(2)) for its first taxable year beginning after December 31, 1995:

''(A) IN GENERAL.—For purposes of determining the net amount of adjustments referred to in section 585(c)(3)(A)(iii), there shall be taken into account only the excess (if any) of the reserve for bad debts as of the close of the last taxable year before the disqualification year over the balance taken into account by such taxpayer under paragraph (2)(A)(ii) of this subsection.

''(B) TREATMENT UNDER ELECTIVE CUT-OFF METHOD.—For purposes of applying section 585(c)(4)—

''(i) the balance of the reserve taken into account under subparagraph (B) thereof shall be reduced by the balance taken into account by such taxpayer under paragraph (2)(A)(ii) of this subsection, and

''(ii) no amount shall be includible in gross income by reason of such reduction.

''(6) SUSPENDED RESERVE INCLUDED AS SECTION 381(c) ITEMS.—The balance taken into account by a taxpayer under paragraph (2)(A)(ii) of this subsection and the supplemental reserve shall be treated as items described in section 381(c).

''(7) CONVERSIONS TO CREDIT UNIONS.—In the case of a taxpayer to which paragraph (1) applied which becomes a credit union described in section 501(c) and exempt from taxation under section 501(a)—

''(A) any amount required to be included in the gross income of the credit union by reason of this subsection shall be treated as derived from an unrelated trade or business (as defined in section 513), and

''(B) for purposes of paragraph (3), the credit union shall not be treated as if it were a bank.

''(8) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out this subsection and subsection (e), including regulations providing for the application of such subsections in the case of acquisitions, mergers, spin-offs, and other reorganizations.''

(b) CONFORMING AMENDMENTS.—

(1) Subsection (d) of section 50 is amended by adding at the end the following new sentence:

''Paragraphs (1)(A), (2)(A), and (4) of the section 46(e) referred to in paragraph (1) of this subsection shall not apply to any taxable year beginning after December 31, 1995.''

(2) Subsection (e) of section 52 is amended by striking paragraph (1) and by redesignating paragraphs (2) and (3) as paragraphs (1) and (2), respectively.

(3) Subsection (a) of section 57 is amended by striking paragraph (4).

(4) Section 246 is amended by striking subsection (f).

(5) Clause (i) of section 291(e)(1)(B) is amended by striking ''or to which section 593 applies''.

(6) Subparagraph (A) of section 585(a)(2) is amended by striking ''other than an organization to which section 593 applies''.

(7)(A) The material preceding subparagraph (A) of section 593(e)(1) is amended by striking ''by a domestic building and loan association or an institution that is treated as a mutual savings bank under section 591(b)'' and inserting ''by a taxpayer having a balance described in subsection (g)(2)(A)(ii)''.

(B) Subparagraph (B) of section 593(e)(1) is amended to read as follows:

''(B) then out of the balance taken into account under subsection (g)(2)(A)(ii) (properly adjusted for amounts charged against such reserves for taxable years beginning after December 31, 1987),''.

(C) Paragraph (1) of section 593(e) is amended by adding at the end the following new sentence: ''This paragraph shall not apply to any distribution of all of the stock of a bank (as defined in section 581) to another corporation if, immediately after the distribution, such bank and such other corporation are members of the same affiliated group (as defined in section 1504) and the provisions of section 5(e) of the Federal Deposit Insurance Act (as in effect on December 31, 1995) or similar provisions are in effect.''

(8) Section 595 is hereby repealed.

(9) Section 596 is hereby repealed.

(10) Subsection (a) of section 860E is amended—

(A) by striking ''Except as provided in paragraph (2), the'' in paragraph (1) and inserting ''The'',

(B) by striking paragraphs (2) and (4) and redesignating paragraphs (3) and (5) as paragraphs (2) and (3), respectively, and

(C) by striking in paragraph (2) (as so redesignated) all that follows ''subsection'' and inserting a period.

(11) Paragraph (3) of section 992(d) is amended by striking ''or 593''.

(12) Section 1038 is amended by striking subsection (f).

(13) Clause (ii) of section 1042(c)(4)(B) is amended by striking ''or 593''.

(14) Subsection (c) of section 1277 is amended by striking ''or to which section 593 applies''.

(15) Subparagraph (B) of section 1361(b)(2) is amended by striking ''or to which section 593 applies''.

(16) The table of sections for part II of subchapter H of chapter 1 is amended by striking the items relating to sections 595 and 596.

(c) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall apply to taxable years beginning after December 31, 1995.

(2) SUBSECTION (b)(7).—The amendments made by subsection (b)(7) shall not apply to any distribution with respect to preferred stock if—

(A) such stock is outstanding at all times after October 31, 1995, and before the distribution, and

(B) such distribution is made before the date which is 1 year after the date of the enactment of this Act (or, in the case of stock which may be redeemed, if later, the date which is 30 days after the earliest date that such stock may be redeemed).

(3) SUBSECTION (b)(8).—The amendment made by subsection (b)(8) shall apply to property acquired in taxable years beginning after December 31, 1995.

(4) SUBSECTION (b)(10).—The amendments made by subsection (b)(10) shall not apply to any residual interest held by a taxpayer if such interest has been held by such taxpayer at all times after October 31, 1995.

Subtitle B—Reform of the Earned Income Credit

SEC. 411. EARNED INCOME CREDIT DENIED TO INDIVIDUALS NOT AUTHORIZED TO BE EMPLOYED IN THE UNITED STATES.

(a) IN GENERAL.—Section 32(c)(1) (relating to individuals eligible to claim the earned income credit) is amended by adding at the end the following new subparagraph:

''(F) IDENTIFICATION NUMBER REQUIREMENT.—The term 'eligible individual' does not include any individual who does not include on the return of tax for the taxable year—

''(i) such individual's taxpayer identification number, and

''(ii) if the individual is married (within the meaning of section 7703), the taxpayer identification number of such individual's spouse.''.

(b) SPECIAL IDENTIFICATION NUMBER.—Section 32 is amended by adding at the end the following new subsection:

''(l) IDENTIFICATION NUMBERS.—Solely for purposes of subsections (c)(1)(F) and (c)(3)(D), a taxpayer identification number means a social security number issued to an individual by the Social Security Administration (other than a social security number issued pursuant to clause (II) (or that portion of clause (III) that relates to clause (II)) of section 205(c)(2)(B)(i) of the Social Security Act).''.

(c) EXTENSION OF PROCEDURES APPLICABLE TO MATHEMATICAL OR CLERICAL ERRORS.—Section 6213(g)(2) (relating to the definition of mathematical or clerical errors) is amended by striking ''and'' at the end of subparagraph (D), by striking the period at the end of subparagraph (E) and inserting a comma, and by inserting after subparagraph (E) the following new subparagraphs:

''(F) an omission of a correct taxpayer identification number required under section 32 (relating to the earned income credit) to be included on a return, and

''(G) an entry on a return claiming the credit under section 32 with respect to net earnings from self-employment described in section 32(c)(2)(A) to the extent the tax imposed by section 1401 (relating to self-employment tax) on such net earnings has not been paid.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

Subtitle C—Treatment of Individuals Who Lose United States Citizenship

SEC. 421. REVISION OF INCOME, ESTATE, AND GIFT TAXES ON INDIVIDUALS WHO LOSE UNITED STATES CITIZENSHIP.

(a) IN GENERAL.—Subsection (a) of section 877 is amended to read as follows:

''(a) TREATMENT OF EXPATRIATES.—

''(1) IN GENERAL.—Every nonresident alien individual who, within the 10-year period immediately preceding the close of the taxable year, lost United States citizenship, unless such loss did not have for 1 of its principal purposes the avoidance of taxes under this subtitle or subtitle B, shall be taxable for such taxable year in the manner provided in subsection (b) if the tax imposed pursuant to such subsection exceeds the tax which, without regard to this section, is imposed pursuant to section 871.

''(2) CERTAIN INDIVIDUALS TREATED AS HAVING TAX AVOIDANCE PURPOSE.—For purposes of paragraph (1), an individual shall be treated as having a principal purpose to avoid such taxes if—

''(A) the average annual net income tax (as defined in section 38(c)(1)) of such individual for the period of 5 taxable years ending before the date of the loss of United States citizenship is greater than $100,000, or

''(B) the net worth of the individual as of such date is $500,000 or more.

In the case of the loss of United States citizenship in any calendar year after 1996, such $100,000 and $500,000 amounts shall be increased by an amount equal to such dollar amount multiplied by the cost-of-living adjustment determined under section 1(f)(3) for such calendar year by substituting '1994' for '1992' in subparagraph (B) thereof. Any increase under the preceding sentence shall be rounded to the nearest multiple of $1,000.''

(b) EXCEPTIONS.—

(1) IN GENERAL.—Section 877 is amended by striking subsection (d), by redesignating subsection (c) as subsection (d), and by inserting after subsection (b) the following new subsection:

''(c) TAX AVOIDANCE NOT PRESUMED IN CERTAIN CASES.—

''(1) IN GENERAL.—Subsection (a)(2) shall not apply to an individual if—

''(A) such individual is described in a subparagraph of paragraph (2) of this subsection, and

''(B) within the 1-year period beginning on the date of the loss of United States citizenship, such individual submits a ruling request for the Secretary's determination as to whether such loss has for 1 of its principal purposes the avoidance of taxes under this subtitle or subtitle B.

''(2) INDIVIDUALS DESCRIBED.—

''(A) DUAL CITIZENSHIP, ETC.—An individual is described in this subparagraph if—

''(i) the individual became at birth a citizen of the United States and a citizen of another country and continues to be a citizen of such other country, or

''(ii) the individual becomes (not later than the close of a reasonable period after loss of United States citizenship) a citizen of the country in which—

''(I) such individual was born,

''(II) if such individual is married, such individual's spouse was born, or

''(III) either of such individual's parents were born.

''(B) LONG-TERM FOREIGN RESIDENTS.—An individual is described in this subparagraph if, for each year in the 10-year period ending on the date of loss of United States citizenship, the individual was present in the United States for 30 days or less. The rule of section 7701(b)(3)(D)(ii) shall apply for purposes of this subparagraph.

''(C) RENUNCIATION UPON REACHING AGE OF MAJORITY.—An individual is described in this subparagraph if the individual's loss of United States citizenship occurs before such individual attains age 18½.

''(D) INDIVIDUALS SPECIFIED IN REGULATIONS.—An individual is described in this subparagraph if the individual is described in a category of individuals prescribed by regulation by the Secretary.''

(2) TECHNICAL AMENDMENT.—Paragraph (1) of section 877(b) of such Code is amended by striking ''subsection (c)'' and inserting ''subsection (d)''.

(c) TREATMENT OF PROPERTY DISPOSED OF IN NONRECOGNITION TRANSACTIONS; TREATMENT OF DISTRIBUTIONS FROM CERTAIN CONTROLLED FOREIGN CORPORATIONS.—Subsection (d) of section 877, as redesignated by subsection (b), is amended to read as follows:

''(d) SPECIAL RULES FOR SOURCE, ETC.—For purposes of subsection (b)—

''(1) SOURCE RULES.—The following items of gross income shall be treated as income from sources within the United States:

''(A) SALE OF PROPERTY.—Gains on the sale or exchange of property (other than stock or debt obligations) located in the United States.

''(B) STOCK OR DEBT OBLIGATIONS.—Gains on the sale or exchange of stock issued by a domestic corporation or debt obligations of

United States persons or of the United States, a State or political subdivision thereof, or the District of Columbia.

''(C) INCOME OR GAIN DERIVED FROM CONTROLLED FOREIGN CORPORATION.—Any income or gain derived from stock in a foreign corporation but only—

''(i) if the individual losing United States citizenship owned (within the meaning of section 958(a)), or is considered as owning (by applying the ownership rules of section 958(b)), at any time during the 2-year period ending on the date of the loss of United States citizenship, more than 50 percent of—

''(I) the total combined voting power of all classes of stock entitled to vote of such corporation, or

''(II) the total value of the stock of such corporation, and

''(ii) to the extent such income or gain does not exceed the earnings and profits attributable to such stock which were earned or accumulated before the loss of citizenship and during periods that the ownership requirements of clause (i) are met.

''(2) GAIN RECOGNITION ON CERTAIN EXCHANGES.—

''(A) IN GENERAL.—In the case of any exchange of property to which this paragraph applies, notwithstanding any other provision of this title, such property shall be treated as sold for its fair market value on the date of such exchange, and any gain shall be recognized for the taxable year which includes such date.

''(B) EXCHANGES TO WHICH PARAGRAPH APPLIES.—This paragraph shall apply to any exchange during the 10-year period described in subsection (a) if—

''(i) gain would not (but for this paragraph) be recognized on such exchange in whole or in part for purposes of this subtitle,

''(ii) income derived from such property was from sources within the United States (or, if no income was so derived, would have been from such sources), and

''(iii) income derived from the property acquired in the exchange would be from sources outside the United States.

''(C) EXCEPTION.—Subparagraph (A) shall not apply if the individual enters into an agreement with the Secretary which specifies that any income or gain derived from the property acquired in the exchange (or any other property which has a basis determined in whole or part by reference to such property) during such 10-year period shall be treated as from sources within the United States. If the property transferred in the exchange is disposed of by the person acquiring such property, such agreement shall terminate and any gain which was not recognized by reason of such agreement shall be recognized as of the date of such disposition.

''(D) SECRETARY MAY EXTEND PERIOD.—To the extent provided in regulations prescribed by the Secretary, subparagraph (B) shall be applied by substituting the 15-year period beginning 5 years before the loss of United States citizenship for the 10-year period referred to therein.

''(E) SECRETARY MAY REQUIRE RECOGNITION OF GAIN IN CERTAIN CASES.—To the extent provided in regulations prescribed by the Secretary—

''(i) the removal of appreciated tangible personal property from the United States, and

''(ii) any other occurrence which (without recognition of gain) results in a change in the source of the income or gain from property from sources within the United States to sources outside the United States,

shall be treated as an exchange to which this paragraph applies.

''(3) SUBSTANTIAL DIMINISHING OF RISKS OF OWNERSHIP.—For purposes of determining whether this section applies to any gain on the sale or exchange of any property, the running of the 10-year period described in subsection (a) shall be suspended for any period during which the individual's risk of loss with respect to the property is substantially diminished by—

''(A) the holding of a put with respect to such property (or similar property),

''(B) the holding by another person of a right to acquire the property, or

''(C) a short sale or any other transaction.''

(d) CREDIT FOR FOREIGN TAXES IMPOSED ON UNITED STATES SOURCE INCOME.—

(1) Subsection (b) of section 877 is amended by adding at the end the following new sentence: ''The tax imposed solely by reason of this section shall be reduced (but not below zero) by the amount of any income, war profits, and excess profits taxes (within the meaning of section 903) paid to any foreign country or possession of the United States on any income of the taxpayer on which tax is imposed solely by reason of this section.''

(2) Subsection (a) of section 877, as amended by subsection (a), is amended by inserting ''(after any reduction in such tax under the last sentence of such subsection)'' after ''such subsection''.

(e) COMPARABLE ESTATE AND GIFT TAX TREATMENT.—

(1) ESTATE TAX.—

(A) IN GENERAL.—Subsection (a) of section 2107 is amended to read as follows:

''(a) TREATMENT OF EXPATRIATES.—

''(1) RATE OF TAX.—A tax computed in accordance with the table contained in section 2001 is hereby imposed on the transfer of the taxable estate, determined as provided in section 2106, of every decedent nonresident not a citizen of the United States if, within the 10-year period ending with the date of death, such decedent lost United States citizenship, unless such loss did not have for 1 of its principal purposes the avoidance of taxes under this subtitle or subtitle A.

''(2) CERTAIN INDIVIDUALS TREATED AS HAVING TAX AVOIDANCE PURPOSE.—

''(A) IN GENERAL.—For purposes of paragraph (1), an individual shall be treated as having a principal purpose to avoid such taxes if such individual is so treated under section 877(a)(2).

''(B) EXCEPTION.—Subparagraph (A) shall not apply to a decedent meeting the requirements of section 877(c)(1).''

(B) CREDIT FOR FOREIGN DEATH TAXES.—Subsection (c) of section 2107 is amended by redesignating paragraph (2) as paragraph (3) and by inserting after paragraph (1) the following new paragraph:

''(2) CREDIT FOR FOREIGN DEATH TAXES.—

''(A) IN GENERAL.—The tax imposed by subsection (a) shall be credited with the amount of any estate, inheritance, legacy, or succession taxes actually paid to any foreign country in respect of any property which is included in the gross estate solely by reason of subsection (b).

''(B) LIMITATION ON CREDIT.—The credit allowed by subparagraph (A) for such taxes paid to a foreign country shall not exceed the lesser of—

''(i) the amount which bears the same ratio to the amount of such taxes actually paid to such foreign country in respect of property included in the gross estate as the value of the property included in the gross estate solely by reason of subsection (b) bears to the value of all property subjected to such taxes by such foreign country, or

''(ii) such property's proportionate share of the excess of—

''(I) the tax imposed by subsection (a), over

''(II) the tax which would be imposed by section 2101 but for this section.

''(C) PROPORTIONATE SHARE.—For purposes of subparagraph (B), a property's proportionate share is the percentage of the value of the property which is included in the gross estate solely by reason of subsection (b) bears to the total value of the gross estate.''

(C) EXPANSION OF INCLUSION IN GROSS ESTATE OF STOCK OF FOREIGN CORPORATIONS.—Paragraph (2) of section 2107(b) is amended by striking ''more than 50 percent of'' and all that follows and inserting ''more than 50 percent of—

''(A) the total combined voting power of all classes of stock entitled to vote of such corporation, or

''(B) the total value of the stock of such corporation,''.

(2) GIFT TAX.—

(A) IN GENERAL.—Paragraph (3) of section 2501(a) is amended to read as follows:

''(3) EXCEPTION.—

''(A) CERTAIN INDIVIDUALS.—Paragraph (2) shall not apply in the case of a donor who, within the 10-year period ending with the date of transfer, lost United States citizenship, unless such loss did not have for 1 of its principal purposes the avoidance of taxes under this subtitle or subtitle A.

''(B) CERTAIN INDIVIDUALS TREATED AS HAVING TAX AVOIDANCE PURPOSE.—For purposes of subparagraph (A), an individual shall be treated as having a principal purpose to avoid such taxes if such individual is so treated under section 877(a)(2).

''(C) EXCEPTION FOR CERTAIN INDIVIDUALS.—Subparagraph (B) shall not apply to a decedent meeting the requirements of section 877(c)(1).

''(D) CREDIT FOR FOREIGN GIFT TAXES.—The tax imposed by this section solely by reason of this paragraph shall be credited with the amount of any gift tax actually paid to any foreign country in respect of any gift which is taxable under this section solely by reason of this paragraph.''

(f) COMPARABLE TREATMENT OF LAWFUL PERMANENT RESIDENTS WHO CEASE TO BE TAXED AS RESIDENTS.—

(1) IN GENERAL.—Section 877 is amended by redesignating subsection (e) as subsection (f) and by inserting after subsection (d) the following new subsection:

''(e) COMPARABLE TREATMENT OF LAWFUL PERMANENT RESIDENTS WHO CEASE TO BE TAXED AS RESIDENTS.—

''(1) IN GENERAL.—Any long-term resident of the United States who—

''(A) ceases to be a lawful permanent resident of the United States (within the meaning of section 7701(b)(6)), or

''(B) commences to be treated as a resident of a foreign country under the provisions of a tax treaty between the United States and the foreign country and who does not waive the benefits of such treaty applicable to residents of the foreign country,

shall be treated for purposes of this section and sections 2107, 2501, and 6039F in the same manner as if such resident were a citizen of the United States who lost United States citizenship on the date of such cessation or commencement.

''(2) LONG-TERM RESIDENT.—For purposes of this subsection, the term 'long-term resident' means any individual (other than a citizen of the United States) who is a lawful permanent resident of the United States in at least 8 taxable years during the period of 15 taxable years ending with the taxable year during which the event described in subparagraph (A) or (B) of paragraph (1) occurs. For purposes of the preceding sentence, an individual shall not be treated as a lawful permanent resident for any taxable year if such individual is treated as a resident of a foreign country for the taxable year under the provisions of a tax treaty between the United States and the foreign country and does not waive the benefits of such treaty applicable to residents of the foreign country.

''(3) SPECIAL RULES.—

''(A) EXCEPTIONS NOT TO APPLY.—Subsection (c) shall not apply to an individual who is treated as provided in paragraph (1).

''(B) STEP-UP IN BASIS.—Solely for purposes of determining any tax imposed by reason of this subsection, property which was held by the long-term resident on the date the individual first became a resident of the United States shall be treated as having a basis on such date of not less than the fair market value of such property on such date. The preceding sentence shall not apply if the individual elects not to have such sentence apply. Such an election, once made, shall be irrevocable.

''(4) AUTHORITY TO EXEMPT INDIVIDUALS.—This subsection shall not apply to an individual who is described in a category of individuals prescribed by regulation by the Secretary.

''(5) REGULATIONS.—The Secretary shall prescribe such regulations as may be appropriate to carry out this subsection, including regulations providing for the application of this subsection in cases where an alien individual becomes a resident of the United States during the 10-year period after being treated as provided in paragraph (1).''

(2) CONFORMING AMENDMENTS.—

(A) Section 2107 is amended by striking subsection (d), by redesignating subsection (e) as subsection (d), and by inserting after subsection (d) (as so redesignated) the following new subsection:

''(e) CROSS REFERENCE.—

''For comparable treatment of long-term lawful permanent residents who ceased to be taxed as residents, see section 877(e).''

(B) Paragraph (3) of section 2501(a) (as amended by subsection (e)) is amended by adding at the end the following new subparagraph:

''(E) CROSS REFERENCE.—

''For comparable treatment of long-term lawful permanent residents who ceased to be taxed as residents, see section 877(e).''

(g) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to—

(A) individuals losing United States citizenship (within the meaning of section 877 of the Internal Revenue Code of 1986) on or after February 6, 1995, and

(B) long-term residents of the United States with respect to whom an event described in subparagraph (A) or (B) of section 877(e)(1) of such Code occurs on or after February 6, 1995.

(2) SPECIAL RULE.—

(A) IN GENERAL.—In the case of an individual who performed an act of expatriation specified in paragraph (1), (2), (3), or (4) of section 349(a) of the Immigration and Nationality Act (8 U.S.C. 1481(a)(1)–(4)) before February 6, 1995, but who did not, on or before such date, furnish to the United States Department of State a signed statement of voluntary relinquishment of United States nationality confirming the performance of such act, the amendments made by this section and section 11349 shall apply to such individual except that—

(i) the 10-year period described in section 877(a) of such Code shall not expire before the end of the 10-year period beginning on the date such statement is so furnished, and

(ii) the 1-year period referred to in section 877(c) of such Code, as amended by this section, shall not expire before the date which is 1 year after the date of the enactment of this Act.

(B) EXCEPTION.—Subparagraph (A) shall not apply if the individual establishes to the satisfaction of the Secretary of the Treasury that such loss of United States citizenship occurred before February 6, 1994.

SEC. 422. INFORMATION ON INDIVIDUALS LOSING UNITED STATES CITIZENSHIP.

(a) IN GENERAL.—Subpart A of part III of subchapter A of chapter 61 is amended by inserting after section 6039E the following new section:

''SEC. 6039F. INFORMATION ON INDIVIDUALS LOSING UNITED STATES CITIZENSHIP.

''(a) IN GENERAL.—Notwithstanding any other provision of law, any individual who loses United States citizenship (within the meaning of section 877(a)) shall provide a statement which includes the information described in subsection (b). Such statement shall be—

''(1) provided not later than the earliest date of any act referred to in subsection (c), and

''(2) provided to the person or court referred to in subsection (c) with respect to such act.

''(b) INFORMATION TO BE PROVIDED.—Information required under subsection (a) shall include—

''(1) the taxpayer's TIN,

''(2) the mailing address of such individual's principal foreign residence,

''(3) the foreign country in which such individual is residing,

''(4) the foreign country of which such individual is a citizen,

''(5) in the case of an individual having a net worth of at least the dollar amount applicable under section 877(a)(2)(B), information detailing the assets and liabilities of such individual, and

''(6) such other information as the Secretary may prescribe.

''(c) ACTS DESCRIBED.—For purposes of this section, the acts referred to in this subsection are—

''(1) the individual's renunciation of his United States nationality before a diplomatic or consular officer of the United States pursuant to paragraph (5) of section 349(a) of the Immigration and Nationality Act (8 U.S.C. 1481(a)(5)),

''(2) the individual's furnishing to the United States Department of State a signed statement of voluntary relinquishment of United States nationality confirming the performance of an act of expatriation specified in paragraph (1), (2), (3), or (4) of section 349(a) of the Immigration and Nationality Act (8 U.S.C. 1481(a)(1)–(4)),

''(3) the issuance by the United States Department of State of a certificate of loss of nationality to the individual, or

''(4) the cancellation by a court of the United States of a naturalized citizen's certificate of naturalization.

''(d) PENALTY.—Any individual failing to provide a statement required under subsection (a) shall be subject to a penalty for each year (of the 10-year period beginning on the date of loss of United States citizenship) during any portion of which such failure continues in an amount equal to the greater of—

''(1) 5 percent of the tax required to be paid under section 877 for the taxable year ending during such year, or

''(2) $1,000,

unless it is shown that such failure is due to reasonable cause and not to willful neglect.

''(e) INFORMATION TO BE PROVIDED TO SECRETARY.—Notwithstanding any other provision of law—

''(1) any Federal agency or court which collects (or is required to collect) the statement under subsection (a) shall provide to the Secretary—

''(A) a copy of any such statement, and

''(B) the name (and any other identifying information) of any individual refusing to comply with the provisions of subsection (a),

''(2) the Secretary of State shall provide to the Secretary a copy of each certificate as to the loss of American nationality under section 358 of the Immigration and Nationality Act which is approved by the Secretary of State, and

''(3) the Federal agency primarily responsible for administering the immigration laws shall provide to the Secretary the name of each lawful permanent resident of the United States (within the meaning of section 7701(b)(6)) whose status as such has been revoked or has been administratively or judicially determined to have been abandoned.

Notwithstanding any other provision of law, not later than 30 days after the close of each calendar quarter, the Secretary shall publish in the Federal Register the name of each individual losing United States citizenship (within the meaning of section 877(a)) with respect to whom the Secretary receives information under the preceding sentence during such quarter.

''(f) REPORTING BY LONG-TERM LAWFUL PERMANENT RESIDENTS WHO CEASE TO BE TAXED AS RESIDENTS.—In lieu of applying the last sentence of subsection (a), any individual who is required to provide a statement under this section by reason of section 877(e)(1) shall provide such statement with the return of tax imposed by chapter 1 for the taxable year during which the event described in such section occurs.

''(g) EXEMPTION.—The Secretary may by regulations exempt any class of individuals from the requirements of this section if he determines that applying this section to such individuals is not necessary to carry out the purposes of this section.''

(b) CLERICAL AMENDMENT.—The table of sections for such subpart A is amended by inserting after the item relating to section 6039E the following new item:

''Sec. 6039F. Information on individuals losing United States citizenship.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to—

(1) individuals losing United States citizenship (within the meaning of section 877 of the Internal Revenue Code of 1986) on or after February 6, 1995, and

(2) long-term residents of the United States with respect to whom an event described in subparagraph (A) or (B) of section 877(e)(1) of such Code occurs on or after such date.

In no event shall any statement required by such amendments be due before the 90th day after the date of the enactment of this Act.

SEC. 423. REPORT ON TAX COMPLIANCE BY UNITED STATES CITIZENS AND RESIDENTS LIVING ABROAD.

Not later than 90 days after the date of the enactment of this Act, the Secretary of the Treasury shall prepare and submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report—

(1) describing the compliance with subtitle A of the Internal Revenue Code of 1986 by citizens and lawful permanent residents of the United States (within the meaning of section 7701(b)(6) of such Code) residing outside the United States, and

(2) recommending measures to improve such compliance (including improved coordination between executive branch agencies).

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Texas [Mr. ARCHER], the gentleman from California [Mr. STARK], the gentleman from Virginia [Mr. BLILEY], and the gentleman from Michigan [Mr. DINGELL] will each be recognized for 22½ minutes; and the gentleman from Pennsylvania [Mr. GOODLING] and the gentleman from Missouri [Mr. CLAY] will each be recognized for 15 minutes.

The Chair recognizes the gentleman from Texas [Mr. ARCHER].

GENERAL LEAVE

Mr. ARCHER. Mr. Speaker, I ask unanimous consent that all Members have 5 legislative days in which to revise and extend their remarks and include extraneous materials on the bill, H.R. 3103.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

Mr. ARCHER. Mr. Speaker, I yield such time as he may consume to the gentleman from Ohio [Mr. HOBSON].

(Mr. HOBSON asked and was given permission to revise and extend his remarks.)

Mr. HOBSON. Mr. Speaker, I rise in support of the bill.

Mr. Speaker, I want to thank the members and staff of the Commerce and Ways and Means Committees for including administrative simplification in the Health Coverage Availability and Affordability Act. This provision is based on legislation that TOM SAWYER, NANCY JOHNSON, and I introduced earlier in this Congress.

We have the most advanced health care services in the world due mainly to our success in using technology. We can use this same technology to improve the way our health care system is run. Our provision removes the barriers that have prevented modern technology from replacing outdated, paper-based health information systems.

Today, the lack of uniform standards for financial and administrative health information is a barrier to modernizing health information systems. Most health plans already transmit data electronically, but the data is nonstandard or incomplete, and cannot be used to coordinate benefits or effectively track fraud and abuse.

Uniform standards for health information would enable the private sector to reduce paperwork (which adds nearly 10 cents to every health care dollar), expose fraud (which is difficult to do in a confusing, disjointed paperwork system), and provide consumers with the information they need to compare health plans and services.

The Health Care Financing Administration [HCFA] is implementing a Medicare transaction system for handling standardized Medicare claims. Under current law, HCFA has the authority to adopt Government standards for health information, and to mandate the use of those standards by the private sector.

Our administrative simplification provision, as it was included in this bill, limits HCFA to adopting standards that already have been developed by a voluntary, consensus process that has included input from the private and public sectors. It establishes a process for the standardization of health data that builds on progress in the private sector.

Our provision was developed over several years in a cooperative effort between the private and public sectors. Political support for our provision is bipartisan and bicameral—it was introduced as H.R. 1766 by Representatives DAVE HOBSON, TOM SAWYER, and NANCY JOHNSON, and as S. 872 by Senators KIT BOND and JOSEPH LIEBERMAN.

Also, as the original author of this provision, I want to clarify that our intention is that health benefits under employee welfare benefit plans would not include hospital or fixed indemnity, specified disease, accident, disability income, dental, and vision benefits.

These provisions and the overall bill respond to the need for health care reform in a responsible way. I encourage Members to vote for the bill.

Mr. ARCHER. Mr. Speaker, I yield 30 seconds to the gentleman from Ohio [Mr. KASICH], the chairman of the Committee on the Budget.

Mr. KASICH. Mr. Speaker, I want to congratulate all of the chairmen on what we are producing here today, which is a fantastic improvement in the lives for all Americans who have been held hostage from changing jobs because of a lack of portability, which we guarantee in this bill, and to give them security in knowing that preexisting conditions that have denied them health insurance or have denied them the ability to be secure in their homes are being removed with this bill.

This is a great day for the American people, a great day for the American family, and we did it without socializing the system. I thank my colleagues for producing this bill.

Mr. ARCHER. Mr. Speaker, I yield such time as he may consume to the gentleman from Georgia [Mr. COLLINS].

(Mr. COLLINS of Georgia asked and was given permission to revise and extend his remarks.)

Mr. COLLINS of Georgia. Mr. Speaker, I rise in full support of this legislation.

Mr. Speaker, the health care reform legislation now under consideration by the Republican-controlled House of Representatives draws a dramatic contrast against the health care reform legislation considered by Congress in 1994 under a Democrat majority.

The legislation of 1994, crafted by President Clinton and introduced by the Democrat leader, Mr. RICHARD GEPHARDT, would have created a new bureaucratic government agency with authority over most of the health care choices each private citizen makes.

This year, however, under a Republican-controlled House, we are considering health care reform legislation that avoids the explosion of government bureaucracy. This legislation is a direct response to the views and concerns expressed by American citizens during the 1994 health care debate when we defeated the Clinton socialistic health care proposal.

This year's reform legislation will provide greater access to health care without increasing government bureaucracy. It will eliminate permanent preexisting condition limitations; ensure greater insurance portability so those who change jobs will have access to coverage; offer greater tax fairness for individuals; provide tax deductible contributions to medical savings accounts targeting those middle-income individuals and families without health care; streamline administrative costs and procedures; combat fraud and abuse in the health care industry; invoke medical malpractice reform that discourages unnecessary litigation currently driving up the cost of health care; and above all preserve the quality and freedom of choice that exists in our current market-based system.

One of the most important and unique components of this health care reform legislation is the creation of medical savings accounts [MSA's]. This provision will allow individuals and families to purchase a high deductible health plan and make tax deductible contributions to MSA's for the purpose of saving money for health care expenditures. In addition, contributions by employers on behalf of their employees will be excludable from taxable income. This proposal will finally provide an ideal way for young individuals and young families just starting out, to obtain affordable, quality health care coverage.

Estimates indicate that at least 1 million people will open medical savings accounts. Approximately 650,000 people who earn between $40,000 and $75,000 per year will choose MSA's; while 120,000 people who earn between $30,000 and $40,000 per year will join. The vast majority of those benefiting from the MSA will be middle-income families who, in today's market, face the most difficult challenge in obtaining coverage.

MSA's create more fairness for small employers and their employees by eliminating barriers to coverage. As a small business owner, I know first hand what kind of limitations small businesses face when trying to establish health care coverage for their employees. Often, providing health care becomes too complicated or too expensive for these employers.

MSA's will be an ideal way for small businesses to assist employees in obtaining health care coverage. MSA's may very well mean the difference between those employees who have no insurance and those that have access to affordable health care.

MSA's will provide the maximum degree of portability for employees. When an employee leaves, he or she will take the MSA to the next job.

MSA's will ultimately reduce the long-term care expenditures of medicare and Medicaid by promoting the purchase of long-term care insurance. The provision will allow individuals to make a tax-free withdrawal for the purposes of paying long-term care insurance premiums. Long-term is among the largest expenditures in entitlement health care programs. Encouraging citizens to purchase coverage in the private markets means reduced costs to the taxpayers.

MSA's will provide the maximum amount of choice for health care consumers. Individuals and families will have the maximum amount of control over the choices they make in their health care. Maximizing the ability of the consumer to choose means increased competition and cost savings for that individual or family purchasing health coverage.

MSA's have a long history of bipartisan support. In 1994, the Democrat party leader, Representative GEPHARDT, endorsed MSA's. In 1994, Senator PAUL SIMON introduced legislation to establish MSA's. In addition, States

have passed State-level legislation that exempt MSA deposits from State-level taxes.

Mr. Speaker, the MSA provision is one of several very important health care reform components of the Health Coverage Availability and Affordability Act. The health care debate began during the last Congress (103d). Today, in the 104th Congress we are fulfilling the commitment to enact common sense health care reform that will provide greater portability and accessibility of health care for all Americans.

Mr. ARCHER. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, today the House considers the Health Coverage Availability and Affordability Act of 1996. This bill, Mr. Speaker, is truly historic. After years of talking about health reform, we are now, with the new Republican majority in this House, going to enact health reform. Most importantly, H.R. 3103 reflects what Americans want in health reform because it addresses the two issues that concern our citizens the most, availability and affordability of health insurance coverage and health care.

A key to increasing the availability of health insurance is insuring portability of coverage if a breadwinner changes jobs. No one should ever say no to a new job simply because he or she fears that the new health insurance company will say no to them. This bill tells workers that they will not have to worry about preexisting conditions limiting their ability to get coverage if they change jobs.

Both to increase the availability and affordability of health care coverage, we establish medical savings accounts. Deductions for MSA's with health insurance protection ought to be an option available to working Americans. MSA's offer Americans the ultimate in portability because, with an MSA, you take the money with you and retain the savings to spend on your health care needs regardless of a change in your employment or life circumstances.

A new study by the Joint Committee on Taxation demonstrates that the M in MSA stands for middle income. The joint committee estimates that 650,000 out of the 1 million people who will be covered by MSA's earn between $40,000 and $75,000 a year while another 120,000 people who will choose MSA's earn below $40,000 per year.

The bill further insures affordability of coverage by raising the deductibility of health insurance for 3.2 million self-employed Americans. At the beginning of this Congress the deduction had expired. Congress increased it to 30 percent last year, and now we increase it to 50 percent.

H.R. 3103 also provides important incentives for Americans to protect their families through the purchase of long-term care insurance, and it allows for accelerated death benefits for those with terminal illnesses such as cancer or HIV. Both of these important measures were part of our Contract With America.

Our bill makes health insurance and medical care more affordable by attacking a key health care cost driver that runs up costs for everyone, and that is fraud and abuse. It is tough on health care crooks by creating new criminal penalties for health care fraud, expanding other penalties and providing the necessary funds for Federal investigator to route out health care crime.

Another cost driver this bill addresses is the current quagmire of paperwork. The bill will make the process cheaper and easier by promoting a common claims form and electronic transmission of this information.

Finally H.R. 3103 undermines one of the major cost drivers, and that is medical malpractice. It gives real reform and will promote health insurance pooling for small employers.

The bill was truly a group effort by four of the House committees with health jurisdiction. I cannot stress enough the leadership provided in developing this joint initiative by the gentleman from Illinois [Mr. HASTERT] and all the chairmen of the committees involved and their subcommittee. I am particularly grateful for the contribution of the bill's chief cosponsor, the Committee on Ways and Means' Subcommittee on Health chairman, the gentleman from California [Mr. THOMAS].

Availability and affordability, two issues important to all Americans; both are the prescription for real achievable private sector health care reform this year. I am confident my colleagues will join me in supporting the Health Coverage Availability and Affordability act of 1996.

Mr. Speaker, I reserve the balance of my time.

Mr. STARK. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, this bill is called the Health Coverage Availability and Affordability Act, but it ain't. Because of the medical savings accounts and other provisions in here, the Republicans have managed through some legislative legerdemain to turn a silk purse into a sow's ear.

The Democratic substitute will, in fact, bring back the Roukema-Kassebaum-Kennedy bill with some technical corrections to make sure that it limits preexisting conditions, and would by far be a better bill, a truly bipartisan bill, one that will pass in the Senate and one that would in fact be signed by the President.

Now, if the Republican intention is to fill up prime time with a bill that they know will pass, it is to me a very sick trick to play on the seniors.

First of all, this bill purports to increase the deduction for self-employed, but really it only does it for 50 percent, and that is in 2003. The Democratic alternative does it at 8 percent, and it does it right up front and pays for it. It is not flimflamming the American public into thinking they are getting something that they are not.

It is also a bad bill because the insurance reforms are weaker. It limits individuals to just one policy and guarantees issue only to small firms of less than 50 people. The rest are out on the street. It spends over $2.5 billion of Medicare money on MSA tax breaks. We should save easy anti-fraud money for Medicare trust fund relief. Not only are the MSA's a bad policy, they are a payoff to the Golden Rule Insurance Company who has contributed almost $1.5 million to Speaker GINGRICH'S political operations.

If that is not bad enough policy, I do not know what is.

This bill actually increases costs in traditional insurance pools. The MSA's, the mean ones, will drive up the rates for most people.

The GOP has mislabeled their bill, I suspect intentionally. The GOP anti-fraud provisions contain 3 pro-fraud loopholes: advisory opinions, harder proof for civil monetary penalties, and they are allowing kickbacks in managed care plans. The CBO, the Republican CBO, says their plans will cost the system a billion dollars.

There is also a payoff to American Family Life. It takes out the Medigap anti-duplication laws, will return us to the days of ripping off seniors by unscrupulous insurance salesmen.

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The payoff to the AMA is in the malpractice caps that reward doctors. I would remind Members that it was released today that there are over 13,000 doctors convicted of sex crimes and other crimes who are still practicing in this country, who will go untouched if the Republicans remove the malpractice caps.

Mr. Speaker, the GOP expatriate language is too weak. We should keep it simple. We should support the Dingell-Spratt-Bentsen substitute, and give the people true portability and true reform.

Mr. Speaker, I reserve the balance of my time.

Mr. ARCHER. Mr. Speaker, I yield 2 minutes to the gentlewoman from Connecticut [Mrs. JOHNSON], the most respected chairman of the Subcommittee on Oversight of the Committee on Ways and Means.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I thank the gentleman, the chairman of the committee, for yielding time to me.

Mr. Speaker, this is a great day or night for Americans. Health security is important to every man, woman, and child. Tonight we take a giant step toward guaranteeing coverage, in spite of preexisting conditions, protecting millions of Americans and their families.

I introduced the first insurance reform bill, and in fact, with our former colleague Rod Chandler, introduced the first legislation to enable small businesses to group together to provide

lower cost insurance for businesses. Tonight we bring a lot of that thinking, 5 years old, to fruition, and for the first time, we are going to put on the President's desk a reform bill that will really directly affect the lives of our constituents and create for them the opportunity to move from job to job, developing their careers, without fear of losing health coverage for their spouse and children.

Twenty-five million workers and dependents are affected by changes in employment every single year; 3.6 million will face job lock. That is 3.6 million workers, but all of their dependents as well. They are the people whose fears will be allayed by tonight's legislation. One hundred and thirty-eight million workers and their dependents are covered by employer plans, and any one of them at any time could need what we do here tonight. This is, indeed, a giant step toward health security for all working Americans.

Underneath that bill, included in it, is the accomplishment of other goals that we have long aspired to. For 5 years we have tried to spread long-term care insurance to protect seniors against the cost of nursing home care, without forcing them to spend down to poverty. This is a remarkable piece of legislation. It is long overdue. It represents the culmination of solid study over 5 years. Mr. Speaker, I urge the Members' support.

Mr. STARK. Mr. Speaker, I yield 3 minutes to the distinguished gentlewoman from Connecticut [Mrs. KENNELLY].

Mrs. KENNELLY. Mr. Speaker, this could have been a great night in this Chamber. In fact, we came very close to having this a great night in this Chamber.

Mr. Speaker, Senator KASSEBAUM and Senator KENNEDY introduced a piece of legislation, very simple, very precise, very direct. What that legislation said was, ''If you lose your job or if you change your job and you have a preexisting health condition, you will not lose your health insurance.''

What happened? Senator KASSEBAUM daily appealed to her colleagues to keep the bill direct and simple. This very afternoon, Senator BRADLEY stood next to Senator KASSEBAUM. He was very much interested, as many of us have been, that if you have a baby you should be allowed to stay in the hospital for 48 hours. What did he say? He said, ''I will not put forth my amendment because it might jeopardize Senator KASSEBAUM's bill.''

Mr. Speaker, did that happen over in this side of the House? It certainly did not. The bill that we have before us tonight has 301 additional pages of insurance changes. As I listened to people talk, and we have talked about this bill all day, I hear some on the majority side say that the additions to the bill have a very definite policy objective; namely, to make health insurance more affordable. How I wish that was true.

However, two of the most controversial riders, tax breaks for medical savings accounts, and an exemption from State insurance laws for certain health plans, could actually make health insurance higher for many, many people, the cost of health insurance. Both of these provisions would promote risk skimming, which puts the healthiest Americans in a separate health care plan. For anyone who knows about insurance, you know when you do not have a decent risk pool, the risk pool does not work.

Mr. Speaker, we have an opportunity tonight to move forward in a bipartisan legislative manner. Senator KASSEBAUM and KENNEDY's bill was put forth here by the gentlewoman from Connecticut, Mrs. ROUKEMA, and many Members of this body. We could take this bill, this simple, precise bill, and have portability for health insurance. That is all we have to do. We do not have to do everything that would just complicate matters. We can help millions of Americans by doing a simple, good bill.

Mr. ARCHER. Mr. Speaker, I yield 1 minute to the gentleman from New York [Mr HOUGHTON], a respected member of the Committee on Ways and Means.

(Mr. HOUGHTON asked and was given permission to revise and extend his remarks.)

Mr. HOUGHTON. Mr. Speaker, I would like to talk on the portability issue. I think it is an important one. I know that a lot of people have talked on it. It will not be the last discussion about this. However, I think it is important. I know a little bit about it, and it is really at the heart of this whole bill.

Mr. Speaker, basically what it does is to free up somebody to work wherever he or she wants. That is not a bad concept. You work for company A and you want to move to company B, but company B does not have any health insurance program. You get a job at company C, but at a far less salary. You would rather take the job at company B. You cannot do it. You cannot help your family.

Under this condition, you must be given an opportunity to have an insurance policy yourself or through the company, irrespective of where you are working or irrespective of the preexisting conditions. It makes a lot of sense, Mr. Speaker. I fully endorse this.

Mr. STARK. Mr. Speaker, I yield 3 minutes to the gentleman from Maryland [Mr. CARDIN].

Mr. CARDIN. Mr. Speaker, I thank my friend, the gentleman from California, for yielding me this time.

Mr. Speaker, let me say to my good friend, the chairman of the Committee on Ways and Means, this bill has certainly changed since it left the Committee on Ways and Means. That is unfortunate, because I know that the chairman agrees with me that we are trying to return power to our States. This bill moves in exactly the opposite direction. By preempting our States in health insurance, which has been a traditional role for State governments to regulate, this bill moves in the wrong direction. It preempts our States without providing adequate Federal protection.

Mr. Speaker, let me just give one example of the impact that this bill will have, if it becomes law, on the State of Maryland. We enacted small market reform in our State. It covers employers that have employees, between 2 and 50 employees. It also covers the association plans, and now also covers our self-employed. The plan is working.

Mr. Speaker, let me just read from a letter that I received from our State officials:

> The reforms went into effect July 1, 1994. . . . The small business community (the Maryland Chamber, Retail Merchants Association, individual businesses) and insurance agents report the reforms have stabilized the market, increased price competition, and increased choice of delivery systems.

The reforms proved so successful to the general assembly that they expanded it to include the self-employed.

Yet, the provisions that are included in this bill would seriously jeopardize our ability to continue that plan in Maryland, for, you see, companies would be able to come under Federal regulation and void the State plan, and therefore, defeat the purpose of the pooling arrangements in our State. That is unfortunate and it is wrong.

Let me give a second example. My State has passed the emergency room care legislation, that uses the ''reasonable lay person'' definition on when that person should be reimbursed for care in an emergency room. We are not waiting for the Federal Government to act on it. The Federal Government has not acted on it. Do not penalize my State by allowing more and more insurance plans to be able to get out from under State regulation and be able to avoid their responsibility to cover emergency room care. That is what this bill will allow to happen. More and more companies will be able to avoid State regulation. That is wrong. It should not happen. We should allow the States to respond.

Let me quote, if I might, from the National Association of Insurance Commissioners:

> Unfortunately, we continue to have grave concerns that subtitle C of title I of H.R. 3160 would significantly erode existing State level insurance reforms. The net effect of the final provisions relating to MEWA's is extremely damaging to States authority to govern their own insurance market.

Mr. Speaker, I do not understand why we are moving in the wrong direction by taking more power, rather than giving our States the ability to control health insurance. The National Association of State legislators opposed those provisions in the bill, and for good reason. I regret that the only option we have is to support the Democratic substitute if we want to deal with preexisting conditions.

Mr. ARCHER. Mr. Speaker, I yield 1 minute to the gentleman from California [Mr. HERGER], another respected member of the Committee on Ways and Means.

Mr. HERGER. Mr. Speaker, I thank the gentleman for yielding time to me.

Mr. Speaker, in 1996, an estimated 3.1 million self-employed Americans will be unfairly denied adequate tax relief for their health insurance costs. Individuals that receive health coverage through their employers do no pay taxes on those benefits while self-employed individuals are only allowed to deduct 30 percent of what they spend on health care insurance.

Mr. Speaker, this mere 30 percent deduction inadequate, discriminatory, and discourages the self-employed from obtaining proper medical coverage and care. While this bill doesn't completely end this inequitable tax treatment of the self-employed, it moves us closer to that goal by increasing the health care deduction for the self-employed to 50 percent.

Mr. Speaker, I urge my colleagues to support the self-employed in this country by adopting this much-needed legislation.

Mr. STARK. Mr. Speaker, I yield 4 minutes to the gentleman from Michigan [Mr. LEVIN].

(Mr. LEVIN asked and was given permission to revise and extend his remarks.)

Mr. LEVIN. Mr. Speaker, I support Kennedy-Kassebaum. This bill before us now is not Kennedy-Kassebaum-plus, it is Kennedy-Kassebaum-minus. In a way, this bill is the story of this session so far. When the Republicans have a chance to do something good, they ruin it by overreaching. They simply cannot resist excess, and they cannot resist turning a bipartisan bill, which Kennedy-Kassebaum is, into a partisan one.

Mr. Speaker, why is this Kennedy-Kassebaum-minus? I think it is very clear, when someone who is covered by group insurance leaves and must have individual insurance, there is going to be less protection for affordability under the bill we have here than Kennedy-Kassebaum, period. It is likely that the individual will pay more.

Second, they have included MSA's, which are likely to draw the healthiest away and hurt everybody else in terms of premiums. Let me just say one thing about MSA's. They are really a potential tax shelter for wealthy people, because if you put money into them, you do not pay Social Security taxes. You indefinitely defer income taxes. And if you keep them until death, you avoid estate taxes. IRA's are structured to avoid that kind of sheltering. What these MSA's, as the Republicans here in the House, once again going to an extreme, what they have done is to promote tax sheltering for very wealthy families.

One last point, and we have made it a number of times, on fraud and abuse. Why make it tougher for the Government to impose civil and monetary penalties in the case of fraud and abuse? Why do that? Why do you require that the proof be recklessness instead of negligence, when the Government relies on the providers, the tens of thousands, to submit accurate bills? Mr. Speaker, I do not understand what pressure group you are reacting to, but it is bad for the public at large.

So for all of these reasons, I urge that we reject this bill. Unfortunately, once again, they have gone much too far. Nothing exceeds like excess, as has been said many years ago. I think we have no alternative but then to vote for the substitute. Let us do Kennedy-Kassebaum, taking care of the self-employed. Let us not go backward. Let us not turn this into a political issue. This reform is long overdue.

Mr. ARCHER. Mr. Speaker, I yield 1 minute to the gentleman from Louisiana [Mr. MCCRERY], a respected member of the Committee on Ways and Means.

(Mr. MCCRERY asked and was given permission to revise and extend his remarks.)

Mr. MCCRERY. Mr. Speaker, medical savings accounts will provide hard-working Americans the freedom to personally manage and even save a portion of their health care dollars. By granting consumers complete control, MSA's allow working men and women and their families to tailor health care spending to their individual needs. This element of personal responsibility will lead to more cost-conscious and cost-efficient spending choices.

MSA's are easily portable from one job to another and provide total freedom when choosing a family's health care provider. In the case of a serious illness or injury, MSA beneficiaries will continue to have comprehensive medical coverage through a high-deductible health plan which meets those costs. Furthermore, this bill helps individuals plan for their future long-term care needs by allowing MSA funds to be used to purchase long-term care insurance or services.

In short, Mr. Speaker, MSA's provide hard-working American families the ultimate in health insurance: choice, flexibility, and portability.

Mr. STARK. Mr. Speaker, I yield 4 minutes to the gentleman from Washington [Mr. MCDERMOTT].

(Mr. MCDERMOTT asked and was given permission to revise and extend his remarks.)

Mr. MCDERMOTT. Mr. Speaker, I wish that we were out here voting on the Kennedy-Kassebaum-Roukema bill, but we are not. HIAA, the Health Insurance Association of America, did not want that bill to come to the floor, and so we have this bill we have before us. This bill was written by, or at least for, the insurance industry.

The first thing in it is data collection. I mentioned that under the rule, they collect data, they have electronic clearinghouses that can shift that information. There is no privacy protection in this bill whatsoever. This is the first time the Federal Government has gotten into collecting health care data, and there are no privacy protections.

But worst about this bill is that it purports to be about portability. Portability means you have insurance, you lose your job, what happens to you? Well, how can you carry your insurance until you get your next job, or what do you do to cover your family? Now, this bill says that, if you were in a company that had 50 people or you had a group insurance and you go out there and you start looking for insurance, the insurance company or the State can decide what they are going to offer you.

Mr. Speaker, we are not going to get the same policy we have now. No one listening to this should think that portability means what I have now I will have tomorrow, because it simply is not so. We give the insurance companies the ability to say, we will give you the average actuarial value policy. What does that mean? It has never been done in the United States. This is a pig in a poke. Anybody who thinks that the insurance companies when they do not have to give you insurance are going to give you the same thing, they are going to jack the price. And you are going to get less benefits, particularly if you have any kind of medical problem.

They are going to medically underwrite you. If you have cancer or heart attack or anything, diabetes, whatever, you suddenly are going to find out you do not have the same benefits you had under your old group policy.

Now, let us say we have a job and we lose it and move to another company. We may get into the next company, but the company that has more than 50 employees has no guarantee that they can go out and buy a policy. There is no guarantee of issue to an employer who has more than 50 people.

Mr. Speaker, all of these proposals fit the insurance company's ability to cherry pick and avoid the sick people and make their choices and find ways to make money. Anything that is in this bill could be done now by the insurance companies. The Republicans have put out there essentially what I say is a guarantee that we can buy a Cadillac in this country. Now, we can pass a bill and say everybody can buy a Cadillac. We guarantee that Cadillac dealerships must issue us the keys to a Cadillac.

Mr. Speaker, why do people not have Cadillacs? They have not got the money to buy Cadillacs. This bill is a fraud because it says, we get portability. But just like a bill that says we get a Cadillac, we would not get one.

Now, if that were not enough, if it were not just the issue of portability, the opportunities for fraud by insurance companies are increased in this bill. We passed a law since I came to Congress that said that insurance companies could not sell a policy to old

people for things that are covered by Medicare. We could not duplicate without saying to the old folks: This policy covers what is under your Medicare. Now, any old folk would say to that: Well, that is stupid. Why should I buy that policy?

So they quit selling those policies. This bill says that an insurance company can go out selling something all over the place that covers what is covered by Medicare. It is simply an opportunity to legalize their fraud.

This is a bad bill. Vote for Dingell, Spratt, and Bentsen.

Mr. ARCHER. Mr. Speaker, I yield 1 minute to the gentleman from Minnesota [Mr. RAMSTAD].

Mr. RAMSTAD. I thank the gentleman for yielding me the time.

Mr. Speaker, last year alone, $31 billion was lost to Medicare fraud and abuse, Medicare and Medicaid fraud and abuse. Everyone here talks about doing something about waste, fraud and abuse in our health care system. This bill finally does something to eliminate these parasites on our health care system.

Mr. Speaker, our bill establishes the Medicare integrity program, which increases the ability of Medicare to prevent payments for fraudulent, abusive or erroneous claims.

We, for the first time, require the Health Care Finance Agency to use state-of-the-art computer software, the same type used by private insurers, and to hire private sector companies with proven track records to prevent fraud and abuse. This will result, according to the CBO, in a net savings of almost $2 billion over the next 6 years.

The other provisions that fight health care fraud and abuse are listed on this chart, Mr. Speaker. I urge approval of this bill to get at waste, fraud, and abuse.

Mr. STARK. Mr. Speaker, I yield myself such time as I may consume.

It is interesting that the previous speaker spoke about parasites I think here to enlighten us about parasites. is the gentleman from Virginia [Mr. MORAN], who will tell us about the Golden Rule Insurance Company, which gave Mr. GINGRICH's political operations over $1.5 million, which is why we are discussing these MSA's.

Mr. Speaker, I yield 3 minutes to the gentleman from Virginia [Mr. MORAN].

Mr. MORAN. Mr. Speaker, as the gentleman from California [Mr. STARK] has explained, I think we know why MSA's are included in this legislation and why the Republican Party wants so much to make them into law. The principal beneficiary of this legislation would be Golden Rule Insurance Co.

All we have to do is to track the campaign contributions to the Speaker and GOPAC and the Republican committee.

Let me explain why the Democrats are not supporting Golden Rule Insurance Co. and their medical savings accounts. In the 1992 annual statement, only 54 cents out of every premium dollar was actually going into medical costs. Imagine. Half of the revenue went into shareholder profits and the like.

Let me explain why the State of Vermont kicked these medical savings account of Golden Rule Insurance Co. out of the State. It is because half of the people in Vermont, 5,000 people have these policies, half of them found that in the tiny writing at the bottom that Golden Rule had excluded whole body parts from coverage. They excluded their arms, their breasts, their backs, their hips, their hands, their legs, their circulatory system. Imagine excluding these things from coverage.

Let me tell my colleagues why the State of Kentucky had so much problem with Golden Rule Insurance Co. Golden Rule Insurance Co. does not want to cover newborns. They will not cover them until they prove that the newborn is healthy. Kentucky passed a law that says you have to cover newborns for the first 30 days of life. Golden Rule sued the State because they do not want to cover newborns for the first 30 days of life.

Mr. Speaker, let me tell my colleagues about some other folks who had specific experience. Carol Schreul of Aurora, IL, Golden Rule rejected her insurance for a brain tumor, $39,000. They would not cover it. They said that she listed her weight as 190 pounds but that it was actually 210 pounds.

Let me tell my colleagues about another Golden Rule policyholder who suffered a stroke, $20,000 in bills. James Anderle was a Milwaukee barber. It turns out that they said he had a preexisting condition, that he had the flu, and that this was a preexisting condition. And so they did not want to cover it.

Claims for $49,000 were denied Harry Baglayan, a self-employed repairman. He underwent bypass surgery. They said that he did not tell them that he had nausea 4 months earlier, and that was a preexisting condition.

I will just quote from the Wall Street Journal, which, it seems to me, probably has a little bit of credibility around these parts. The Wall Street Journal says that they are a sham, that in fact they are most known for cherry picking. In fact, when a claim actually is accepted, they wind up suing the beneficiary and the State. They have piled up $1 billion in assets. It is a sham, Mr. Speaker. We should not include this in our bill.

Mr. ARCHER. Mr. Speaker, I yield myself 15 seconds simply to say that the previous speaker made a very interesting emotional presentation. It just so happens that it has no relevancy to what we are talking about today.

Mr. Speaker, I yield 1 minute to the gentleman from Texas [Mr. SAM JOHNSON].

Mr. SAM JOHNSON of Texas. Mr. Speaker, medical savings accounts are for middle-income America. There is a chart that proves it. Medical savings accounts, therefore, must be part of any health care plan we pass. They are an important option for both employers and employees. They give enhanced portability, preserve consumer choice, allow retirement savings and contain costs.

Medical savings accounts offer all Americans the opportunity to buy a plan that best meets their individual needs.

Mr. Speaker, middle-income Americans are my constituents. They repeatedly tell me that one of the most important things that they want is the ability to choose their own doctor. Medical savings accounts do that. They will allow people to achieve control over their own health care dollars, make it more cost-conscious and bring down the total cost of medical costs for everyone.

Medical savings accounts are good for America. Medical savings accounts offer Americans a freedom they deserve.

Mr. STARK. Mr. Speaker, I reserve the balance of my time.

Mr. ARCHER. Mr. Speaker, I yield 1 minute to the gentleman from Ohio [Mr. PORTMAN].

Mr. PORTMAN. Mr. Speaker, I rise today in strong support of the bill and I do so because I think it will provide greater security to millions of working Americans by eliminating some significant obstacles to health care.

I think this is precisely the kind of health care reform, Mr. Speaker, that the American people have called for. It is targeted reform. It is incremental reform. It makes commonsense improvements to an imperfect system.

Let me give my colleagues an example. This bill helps level the playing field between those who are self-employed and those who work for corporations. The health insurance deduction for the self-employed goes from 30 percent to 50 percent over a 7-year period. With this single step, we are making health care more affordable for 3.2 million Americans, many of those Americans who are now caught in the net, Americans who are now uninsured. That means the mon and pop grocery store down the street. That means that our favorite barber. That means that our local mechanic. All of these people may be self-employed.

In my State of Ohio alone, this enhanced deduction will affect more than 50,000 farm families. It makes sense. Corporations receive a significant deduction, and it is only fair that the self-employed do, too.

□ 1900

Mr. ARCHER. Mr. Speaker, I yield 1 minute to the gentleman from Nevada [Mr. ENSIGN], a respected member of the Committee on Ways and Means.

(Mr. ENSIGN asked and was given permission to revise and extend his remarks.)

Mr. ENSIGN. Mr. Speaker, in southern Nevada, with the fastest-growing senior population in the country, I constantly hear from elderly constituents

about the exorbitant costs of long-term care. People like our parents and grandparents are paying about $40,000 a year for nursing home care. If they do not have the money, Medicaid requires that they lose virtually everything or legally hide everything before they can get help with long-term care from the government.

Currently, there is no provision in the Tax Code that relates to long-term care expenses. Most people incorrectly believe that private insurance will pick up this tab when they need it. But this is simply not the case for 98 percent of long-term care recipients. This bill incorporates the Ensign amendment that treats long-term care expenses as tax-deductible medical expenses. Some of my senior Democratic Ways and Means Committee members have told me they have been trying to do this for over 10 years. Best of all, it is fully paid by making billionaires who renounce their U.S. citizenship for tax purposes pay their fair share. This should have been done years ago, and certainly we should all support this bill with this amendment.

Mr. ARCHER. Mr. Speaker, I yield 1 minute to the gentleman from Nebraska [Mr. CHRISTENSEN], a respected member of the Committee on Ways and Means.

(Mr. CHRISTENSEN asked and was given permission to revise and extend his remarks.)

Mr. CHRISTENSEN. Mr. Speaker, I rise today to speak in favor of a provision that will help senior citizens in my home State of Nebraska, and throughout the country.

What I am referring to are the provisions in this bill that dramatically improve the way we treat long-term care, making long-term care more affordable and accessible.

This bill puts long-term care on a level playing field with other important forms of insurance and provides a much-needed incentive for individuals to take personal responsibility for their long-term care needs.

First, this legislation requires that long-term care insurance be treated like accident and health insurance, meaning that it will generally be excluded from an employee's gross income for tax purposes.

Second, thanks in large part to my colleague Mr. ENSIGN from Nevada, this bill provides that many long-term care expenses will now be deductible.

We as a nation must come together in a bipartisan fashion to put an end to a long-term care system that pulls seniors into poverty and forces taxpayers to step in to bear the burden.

This legislation does just that.

Once again we are doing what we said we would do by ensuring a bright future for our senior citizens.

Mr. STARK. Mr. Speaker, I yield 2 minutes to the gentleman from New York [Mr. RANGEL].

(Mr. RANGEL asked and was given permission to revise and extend his remarks.)

Mr. RANGEL. Mr. Speaker, I think the Republicans should be lauded for attempting at least to pick up the pieces of what has to be a concern to all Americans, and that is inadequate health care for most of our citizens, especially those people who are working and do not have access to insurance. They are not insured by the Federal Government, because they make too much money, and, of course, they do not have enough money to get their own insurance.

But why the Republicans would come in with an insurance plan that allows tax exemptions for people who can afford just to put it in a bank account and if they make certain that it is a high deductible, that is that the only time that they can use it is for catastrophic diseases, then it just seems to me that what we are doing is allowing the insurance companies to cherry-pick and select those people who are healthy and then those people who are not insured by that can come right back and fall on the regular public system that is there.

What we do need is a comprehensive insurance program that really was the one that was initiated before, and perhaps it was too much to consume at one time, but we cannot forget that there are 40 million people out there in the United States that have no insurance at all, and these are the people that are the most vulnerable and these are the people that cannot afford to have these type of savings accounts which are there to protect those who already have.

I think that instead of just selecting those parts of the people that they believe would give political support, that what we have to have in this country is an insurance, a health insurance system where every American, regardless of how much money they have or whether they do not have any at all, can say in this great country that people will not die just because they lack access to health care.

All over we see we are cutting back the public share. If we want to do more in the private sector, let it be fairer.

Mr. ARCHER. Mr. Speaker, I yield myself 1 minute.

I think the debate, Mr. Speaker, has been very curious today. On the one hand, the Democrats accuse us of overreaching, of having too comprehensive a bill. This is from the same people that gave us the unbelievably complex Government takeover of the entire health care system in 1994. It is fascinating. And then they come and say, oh, we are concerned about insurance companies taking a part of the money paid on the premiums and not spending it on health care, but they want to deny medical savings accounts where the individual spends his or her own money without regard to a third-party payer.

There is an enormous inconsistency here, but in a sense it is consistent because in 1994 they wanted to deny choice to the people of this country and now they want to deny choice to the people of this country to have their own medical savings accounts.

Mr. Speaker, I reserve the balance of my time.

Mr. STARK. Mr. Speaker, I yield myself the balance of my time.

I would just suggest that the Republicans would like to spend almost $4 billion on long-term care insurance at the same time they cut $90 billion out of Medicaid, which pays for long-term care for the poorest. It is true that we had a bill that would have provided health insurance to all Americans, and there are 40 million Americans out there uninsured who obviously the Republicans do not give a hoot about. All they care about are the rich, who can enjoy the medical savings accounts.

So if you do not have insurance and your children do not have insurance, the Republicans are doing nothing. If you are very rich or you know some rich people, they get helped by this bill.

The Dingell-Spratt-Bentsen amendment would be the bill to support, which would get us the Roukema-Kennedy-Kassebaum bill, which does all the good things on a bipartisan basis that we need to do and does away with the claptrap that has been added on to this bill with the awful intention of killing it, which to me is cynical, and it is cynical because it is going to hurt the poor and the elderly while it helps the rich, like Ross Perot and the friends of the Republicans. And that is not what this country needs.

We have 40 million people who do not, whose COBRA benefits could protect them; 3½ million who will expire. The Republicans voted against extending it.

Support the Dingell-Spratt-Bentsen amendment.

Mr. ARCHER. Mr. Speaker, I yield the balance of my time to the gentleman from California [Mr. THOMAS], the highly respected, helpful creator of a big part of this bill, the chairman of the health subcommittee of the Committee on Ways and Means.

Mr. THOMAS. Mr. Speaker, I thank the chairman, the gentleman from Texas [Mr. ARCHER], for yielding me this time. I want to compliment him as I want to compliment the chairmen of the other committees, the gentleman from Virginia [Mr. BLILEY] and the gentleman from Pennsylvania [Mr. GOODLING]. It really is exciting, and I am pleased that this new majority for the first time in more than 40 years has a work product on the floor that could not be produced by the former majority.

The Democrats had more than 40 years. In fact, it has been more than 10 years since the last health insurance bill has been on the floor. The Democrats owned Washington in the entire 103d Congress; the Democrats had a majority in the House. They had a majority in the Senate. They had a President. Not one product to deal with the plight of the American worker, so eloquently described by the Democrats

over and over again, on this floor ever came to the floor. We were never provided the opportunity to help. We had the opportunity to hear of the plight of the poor worker just as we did a few minutes ago. The gentlewoman from Connecticut talked about that poor beleaguered person, and I am sure he is and he has been for a long time and he was during the entire time the Democrats were in the majority.

The major committees in the House, not just one committee, the major committees of responsibility have come together and we have produced H.R. 3103. It is not too much, it is not too little, it is just about right for responsible and reasonable health care reform. We have actually accomplished a modest improvement for the self-employed. We moved their deductibility from 30 percent to 50 percent, prospectively. That is really all that we thought was prudent and appropriate.

Criticism from the minority over this? We do not do enough, fast enough. Who was it that left those same self-employed without any protection whatsoever for the entire calendar year of 1994? All of a sudden they want to do something for these people. When they were in control they did absolutely nothing. They allowed the deductibility for health care to lapse. When you were running the place, why were not you more responsible?

H.R. 3103 reforms tort law in the area of medical malpractice. Is it radical? Half the States limit noneconomic damages. Is it controversial? Last March, with 247 votes, 44 Democrats, 23 from the North, 21 from the South, joining the new majority, the responsible Democrats and the Republicans passed medical malpractice reform. We put it in the product liability bill. The exact same language as passed the floor of the House is in this bill. We have put together increased penalties for fraud and abuse. Tougher rules, stiffer penalties. We find it, we fix it, and we make sure that we can fight it. Stiffer penalties, stronger rules. What is wrong with requiring the government to tell people when they ask the government is this OK?

What is wrong with advisory opinions? Apparently, the gentleman from California [Mr. STARK] did not find anything wrong with advisory opinions last June, outside the context of the political responses we have been hearing today. In H.R. 1912, the gentleman from California [Mr. STARK] introduced a bill to deal with health care fraud and abuse. On page 41, the gentleman from California has a provision, subtitled (d), advisory opinions, on kickbacks, and self-referrals.

We also have greater availability and greater affordability of health insurance, you have heard from many of my colleagues in the area of medical savings accounts. We have heard over here from the minority, how horrendous is this provision. Well, is it really? It is choice. It does not say that you must, it says you can. It does not say you shall, it says you may. It is a choice. It is one more choice. Possibly it is a product that people who now cannot find a product in the marketplace will use.

Who are those people? We have heard the profile of those individuals characterized as the healthy and the wealthy. Take a look at, again, the chart that the gentleman from Texas, Mr. SAM JOHNSON, focused on. According to the Joint Tax Committee, 51 percent of the people who are going to find this a useful product are in the $50,000 to $74,000 range, middle class. On the far right of the chart that is $100,000 and above; that is everybody who makes more than $100,000, $200,000, $300,000, $400,000, a million. That is out there less than 12%. That is that enormous group on the other end of the chart. Let us look at the lower end, from $40,000 to $49,000, 13 percent, from $30,000 to $39,000, 11 percent, the vast majority of people who will find this product usable are the middle and the lower middle class.

□ 1915

What is wrong with small employers being able to voluntarily pool their resources so they can save on their health insurance, just like large employers? We begin to make sure that people who more and more need to invest in long-term health care, their cost of the insurance, and the cost of the health care itself, thanks to the gentleman from Nevada, an amendment in the Committee on Ways and Means, will be allowed under the Tax Code. Long overdue, and never done by the Democrats when they were in the majority.

Finally, the heart of the matter: The American worker will no longer have to worry about changing jobs or losing insurance.

H.R. 3103 is a good bill support it.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Virginia [Mr. BLILEY] is recognized for 22½ minutes and the gentleman from Michigan [Mr. DINGELL] is recognized for 22½ minutes.

The Chair recognizes the gentleman from Virginia [Mr. BLILEY].

Mr. BLILEY. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in support of the substitute to H.R. 3103, The Health Coverage Availability and Affordability Act of 1996. During my tenure in Congress, I do not recall the House ever passing a health insurance market reform bill. We are about to take an historic action to change that.

The legislation before you today makes real reforms, and most importantly, it makes health insurance coverage both available—and affordable—for millions of Americans.

The substitute represents a consensus agreement that was developed as a result of the provisions that were reported out of the Commerce Committee, as well as those developed by the Committee on Ways and Means, the Committee on the Judiciary, and the Committee on Economic and Educational Opportunities. It is designed to address the interrelated issues of accessibility and affordability of health insurance coverage.

The provisions of this bill within the jurisdiction of the Commerce Committee are designed to deal with the difficult problem of job lock, or, put more simply, an employee's reluctance to change jobs because of pre-existing condition exclusions in health care coverage. This bill will ensure that individuals who have an opportunity to move to new or better jobs will not have to face limitations in their coverage for pre-existing medical conditions that will affect them or their families. This bill will also assure people in group health plans that they cannot be excluded from coverage, or from renewing their coverage, based on their health status. It provides limits on the period of exclusion for a pre-existing condition and assures that, once covered, the condition will not be excluded from future coverage if the individual meets the requirements of the bill.

The Commerce Committee reported provisions also provide for guaranteed availability of coverage to employees in the small group market. Each insurer that offers coverage in the small group market would have to accept every small employer and every eligible individual within the group.

The bill would also ensure portability of health insurance for qualifying individuals moving from group to individual coverage. This is accomplished by giving States flexibility to achieve individual coverage through a variety of means that include risk pools, group conversion policies, open enrollment by one or more insurers and guaranteed issue.

The bill also contains a number of other provisions which we strongly support. It allows small employers to take advantage of pooling so they can purchase affordable health insurance coverage. It reforms the medical malpractice system which will help contain costs and it provides for new health choices for those who want to purchase medical savings accounts.

It also includes provisions on fraud and abuse and administrative simplification. The General Accounting Office has estimated that fraud and abuse accounts for one out of every ten dollars spent on health care. Regrettably, fraud and abuse not only contributes to the ever-increasing cost of health care, it also leads to a lack of confidence in the health care system and its providers. Providing concrete laws and guidelines and stringent penalties for violations will ensure the continued integrity of the nation's health care system.

The administrative simplification provisions are needed to ensure that there are standards for the transmission of financial and administrative data. Much of this information is currently transmitted in an electronic format. However, there is not a uniform

standard and there are no consistent security standards or safeguards regarding the use of this information.

I urge my colleagues to join me in supporting this bill which will begin to help solve some very real problems for many Americans.

Mr. Speaker, I reserve the balance of my time.

Mr. DINGELL. Mr. Speaker, I yield myself 3 minutes.

(Mr. DINGELL asked and was given permission to revise and extend his remarks.)

Mr. DINGELL. Mr. Speaker, today we choose between the people who carry a lunchbox to work, and the people who carry Gucci briefcases and wear imported loafers.

The people who carry lunchboxes aren't asking for special favors or special treatment. They're not asking for a tax loophole. What they want is very simple. When they change jobs, or if they fall prey to downsizing, or if a loved one contracts cancer or diabetes, they want to be able to buy health insurance. That's all.

I am afraid that this very modest request from the people who carry lunchboxes is going to fall on deaf ears in this House. The majority has instead constructed a monument to the influence industry.

We can pass a bill that makes health insurance portable and prohibits discrimination or restrictions because of pre-existing conditions. This simple bill would help 25 million Americans. Another provision in this bill on the tax deductibility of health insurance for the self-employed would help 3 million Americans.

We could pass that bill, sail it through the Senate, and have it on the President's desk for signature tonight. Instead, we're going to be voting on a Christmas tree bill adorned with ornaments for various special interests. And like a Christmas tree, it's soon going to be put out on the lawn for garbage pickup.

I know whose side I'm on. I'm voting with the people who carry lunchboxes. I urge my colleagues to do the same.

Mr. Speaker, I submit the following material for the RECORD:

HEALTH CARE? YOU COMPARE

H.R. 3103 BASE TEXT

A stripped-down Roukema/Kassebaum bill: no choice of plans for workers who lose their jobs; no guarantees for businesses with more than 50 workers; preempts State laws that protect consumers.

Limits deductibility of health insurance premiums for the self-employed to 50%.

Controversial Medical Savings Accounts.

Controversial medical malpractice law changes.

Controversial repeal of protections for seniors so they won't be ripped off by sale of useless, duplicative health insurance policies.

Controversial provisions overriding state insurance laws.

Controversial provisions making it harder to find and punish wrongdoers.

DINGELL/SPRATT/BENTSEN

A clean Roukema/Kassebaum bill: full portability; protection against discrimination due to preexisting conditions; guaranteed renewal.

Increases deductibility of health insurance premiums for the self-employed from 30% to 80%.

No other controversial provisions to weigh down the bill, slow down the conference, or provoke a Presidential veto.

Keep it simple. Keep it clean. Give the American people what they need.

Support the substitute. Oppose H.R. 3103's base text.

Mr. Speaker, I reserve the balance of my time.

Mr. BLILEY. Mr. Speaker, I yield myself 30 seconds to respond to my good friend, the gentleman from Michigan.

What a difference, my colleagues, 2 years makes. On this very night, the night before we broke for our Easter recess, 2 years ago, I sat over there next to my then chairman, the gentleman from Michigan, and said, ''Mr. Chairman, the President's bill is too heavy. It is too much. It is socialized medicine. We can't move it. We ought to take up the Rowland-Bilirakis bill, bipartisan bill, which was modest, like our bill, and deal with it and mark it up in committee.'' He said ''It can't be done. I am sorry.'' Now he is back. What a difference.

Mr. Speaker, I yield 5 minutes to the gentleman from Florida [Mr. BILIRAKIS] the chairman of the subcommittee.

Mr. BILIRAKIS. Mr. Speaker, I thank the gentleman for yielding me time.

Mr. Speaker, I am pleased to be here today to add my voice to those in favor of health care reform for America's families.

I must say that this moment is both satisfying and, at the same time, deeply ironic. For, now, the House finally has the opportunity to approve health care reforms many of us have advocated for many years. The irony lies in the fact we could have accomplished many of these reforms over 2 years ago if the former leadership had been willing to act and the current administration willing to compromise.

Despite all the political attacks you may hear today—and make no mistake, they are political attacks—health care reform is an idea whose time has come—again and again. The problems we seek to fix today we identified long ago along with many of the solutions contained in this legislation.

Many of you in this Chamber may remember that during the 103d Congress, Congressman Roy Rowland and I introduced consensus health reform legislation. The Rowland-Bilirakis bill was the only true bipartisan bill—but we never got our day in court. Not one vote was ever scheduled on our proposal despite broad support for the provisions contained in the bill.

Despite the great hue and cry in 1994 for reform, my own Commerce Committee did not even schedule a markup on my bill—or any other version of health reform. Today, we have the opportunity to change all that.

We finally have the opportunity to cast a historic vote on a health reform package which contains many of the items advocated by the Rowland-Bilirakis bill in the last Congress.

Like my previous proposal, this legislation will raise deductions for the self-employed, enact provisions on fraud and abuse, promote administrative simplification, establish pooling for small employers, provide for medical malpractice reform, and ensure insurance portability.

To be sure, not all items in this legislation are precisely as we proposed back in 1994. But many of the core items have been subject to bipartisan agreement in the past and should now be viewed in a similar light. I urge my colleagues, on both sides of the aisle, to set aside any remaining differences and pass this bill.

Indeed, it is thus somewhat mystifying when I hear that this bill is somehow too loaded up. And it is a little more than ironic when the main criticism of the previous Rowland-Bilirakis bill was that it didn't do enough.

You can't have it both ways. We have to do something to resolve problems in our health care system now, in this Congress. We never had the chance in 1994.

Health care is too expensive. This bill will help make health care more affordable for millions of families. Access to health care is too restricted—this bill allows policies to be carried from one job to another. Too many people have too few choices with regard to health care—this bill will expand the number of opportunities we all have to secure an effective health care plan for our family.

These are problems we can solve now and which will improve the lives of millions of working Americans. We cannot let this moment pass without passing this bill. I strongly urge my colleagues to support our efforts to improve our Nation's health care delivery system and help make health care in this country both more accessible and affordable.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentlewoman from New Jersey [Mrs. ROUKEMA].

(Mrs. ROUKEMA asked and was given permission to revise and extend her remarks.)

Mrs. ROUKEMA. Mr. Speaker, I am very happy to be here today. Many of my colleagues know that I am the House sponsor of the Kassebaum-Kennedy health insurance reform package. If I had my way, we would be debating and quickly passing a clean version of that legislation.

The portability and the guaranteed issue that it will deliver to 30 million Americans now.

Kassebaum-Kennedy-Roukema is legislation that has been cosponsored in the House by a wide multitude of bipartisan support and in the Senate, Senate Committee on Labor and Resources, it was passed unanimously. It deserves bipartisan support.

The American people want health care reform, and they need it. They are sick and tired of partisan bickering and political gamesmanship. They want results and they want them now.

Unfortunately, I fear the Hastert omnibus bill will inevitably lead to more gridlock and inaction. I fear that, in the end, the American people will not get the common sense reforms that they deserve.

I think it should be noted right here and now that within the last 24 hours, two prominent Republican leaders in the Senate, Senator KASSEBAUM and Senator BENNETT, have confirmed their firm opposition to an omnibus bill. I think we should keep that in mind today.

I expect that if this should be blocked and it should end up in gridlock, I expect that the American people will hold us responsible in November.

Now, do not get me wrong. Some of the reforms that are not part of the Kassebaum-Roukema bill, such as medical malpractice reforms, I have supported in the past and will continue to support. But let us understand and be frank about it. Whether we support them or do not support them, the key components, malpractice, expansion and medical savings account, let us understand and be frank about that, that medical malpractice reform, medical savings account and ERISA expansion are controversial components. They are controversial, they are complex, and they demand individual consideration as individual pieces of legislation.

Mr. Speaker, I again say that we must answer to the American people and pass this legislation in its clean form tonight.

Mr. Speaker, I rise this evening in support of commonsense health insurance reform.

Many of my colleagues know that I am the House sponsor of the Kassebaum-Kennedy health insurance reform package. If I had my way, we would be debating and quickly passing a ''clean'' version of the Kassebaum-Roukema plan today and the portability and guaranteed issue that it presents to 30 million Americans.

Kassebaum-Roukema is legislation that has been cosponsored by 193 House members, and which the Senate Labor and Human Resources Committee approved unanimously.

The American people want healthcare reform. They are sick and tired of partisan bickering and political gamesmanship. They want results and they want them now.

Unfortunately, I fear the Hastert omnibus package will inevitably lead to more gridlock and inaction. And I fear that, in the end, the American people will not get the commonsense reform they deserve.

And it should be noted that within the last 24 hours 2 prominent Republican leaders in the Senate have confirmed their firm opposition to an omnibus bill.

Should that happen, I expect the American people to hold the 104th Congress accountable, as well they should.

Now don't get me wrong. Some of the reforms in H.R. 3103 that are not part of the Kassebaum-Roukema plan—such as medical malpractice reforms—I have supported in the past, and will continue to support in the future.

However, there can be no doubt that certain elements of the underlying bill (such as medical malpractice reform, medical savings accounts, and an ERISA expansion) should be fully debated by the Congress on a case-by-case basis—not wrapped-up into one gigantic package. Each one of these components are complex and controversial and should be properly considered independently.

In the past, I have been a very strong advocate of medical malpractice reforms so that physicians can stop practicing defensive medicine in order to insulate themselves from frivolous lawsuits that only lead to over-utilization of the health care system and higher liability insurance premiums. I will vigorously support these reforms in the future as well.

Nevertheless, I recognize that medical malpractice reform is a very controversial idea that faces serious obstacles in the Senate, and perhaps a veto by President Clinton.

With regard to medical savings accounts, I have some very serious reservations about this idea.

While the notion of empowering individuals to make their own health care decisions has a certain amount of merit, I am concerned that medical savings accounts could, in the long term, serve to ruin the health insurance market.

Medical savings accounts could serve to segregate the population into two groups: Young, healthy people using medical savings accounts and older, sicker people in conventional health plans. If this kind of risk-segmentation happened, the health insurance premiums for older, sicker individuals would skyrocket beyond imagination.

I refuse to support health reform legislation that makes this scenario a reality. Medical savings accounts should be reviewed and debated on their own merit—not as part of some, larger package.

Finally, I want to discuss my concerns about those provisions in the omnibus package that expand the ERISA pre-emption of state insurance laws.

For many years, I served as the ranking minority member of the then House Education and Labor Subcommittee on Labor and Management Relations, which had jurisdiction over ERISA, the Federal law governing employee benefits such as health care or pensions.

The single, most important lesson I learned about ERISA from my time on the subcommittee was this: the more you think you've learned about ERISA and how it works, the more you realize how little you truly know.

I am increasingly of the view that while ERISA as originally devised served a useful purpose, we need a new ERISA for the modern context.

As more and more employers self-insure, thereby receiving a pre-emption from any State insurance rule, regulation or law, employees find themselves at the mercy of their employer's choice of health benefit plan.

For example, New Jersey and other States have enacted laws that require at least 48 hours of hospitalization coverage for women giving birth. These laws are a response to the efforts of managed care networks to discharge women, and their newborn children, within 24 hours of labor and delivery.

When employers self-insure, their employees do not receive the benefit of any of these protections because of the ERISA preemption.

With the expected rapid growth in managed care networks and their enrolles in the future, this trend will only get worse, not better.

Consequently, rather than the significant expansion of the current ERISA as envisioned in H.R. 3103, I believe we need to carefully examine ERISA and devise a new form of this law to meet our current needs.

We should not be considering any ERISA expansion as part of a larger package, where these kinds of issues get lost in the shuffle.

Passing a clean version of the Kassebaum-Roukema plan avoids all of these problems. I hope that we don't let this golden opportunity to slip through our collective fingers.

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Mr. BLILEY. Mr. Speaker, I yield 2 minutes to the gentleman from Iowa [Mr. GANSKE], a valued member of the committee.

Mr. GANSKE. Mr. Speaker, this bill will help fix a health care system that has been beyond the means for many Americans.

Now a worker who wants to pursue his career but cannot change jobs because of an illness in the family would be covered by a new employer's insurance, group-to-group portability. Now an employee who is laid off or between jobs and cannot get individual coverage for his preexisting condition would be able to get coverage, group-to-individual portability. Now the small business employee, whose employer cannot afford to purchase insurance for the firm's five employees because one of them has a chronic illness, would be able to better afford health insurance.

Mr. Speaker, this bill makes it easier for Americans to get and keep health insurance. It is important that this bill includes medical savings accounts. They will return control over health care spending to consumers, save money, and lower health care overutilization. I am pleased that this bill also increases the health insurance deduction for self-employed individuals from 30 percent to 50 percent by the year 2003. While big businesses have been able to deduct all their health care costs, millions of self-employed individuals have been left without a similar benefit. That is not fair. We must give people more incentives and more options to carry health insurance for their families.

The Health Coverage Availability and Affordability Act will also crack down on fraud and abuse, saving millions of dollars. This, too, would keep the cost of your premiums down.

Mr. Speaker, finally, medical malpractice reform will help hold down the cost of defensive medicine and help keep premiums down. If health care is more affordable, more people will have real access to it.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the gentleman from New Jersey [Mr. PALLONE].

Mr. PALLONE. Mr. Speaker, I am so pleased that my colleague, the gentlewoman from New Jersey [Mrs. ROUKEMA] spoke just before me, because basically she pointed out that what we

really need tonight is a clean bill, not loaded down with medical savings accounts and all the other things that are being suggested by the Republican leadership.

Mr. Speaker, the gentlewoman was trying to address portability and preexisting conditions, essentially expand coverage for many people now who cannot get coverage, and also keep health insurance affordable, and she achieves that essentially by saying that if you lose your job or change jobs, the insurance companies still have to provide you with individual coverage. She also limits the situations where the insurance companies can refuse to cover you because of preexisting medical conditions.

This is a very modest bill. We, on the Democratic side, managed to get 172 Members here to cosponsor her bill. In the Senate, there are 54 current cosponsors of the Kassebaum-Kennedy bill, so we know we can move this legislation, and the legislation is good because it is very modest. It basically keeps the insurance pool intact. It does not encourage healthy people to opt out. It does not bring in a lot of new people who are unemployed or who cannot afford insurance or who are critically ill that would increase the costs of health insurance.

But lo and behold, what do we get from the Republican leadership? They throw in the medical savings accounts, and what does that do? It breaks the risk pool. It breaks the insurance risk pool. Essentially what it does is to encourage healthy people and wealthy people to opt out and buy catastrophic coverage and get a tax break to put their money aside and leave everyone else in this risk pool so that they have to pay higher premiums, because it is going to cost more to insure them. It does the very thing, the very opposite, if you will, of what the gentlewoman from New Jersey, Mrs. ROUKEMA, and Senators KASSEBAUM and KENNEDY strove to do.

Mr. Speaker, what will be the ultimate result of increasing the costs of health insurance who remain and do not opt for the medical savings accounts? there will be fewer people insured, fewer people insured.

Mr. BLILEY. Mr. Speaker, I reserve the balance of my time.

Mr. DINGELL. Mr. Speaker, I yield 1½ minutes to the gentleman from New Mexico [Mr. RICHARDSON].

(Mr. RICHARDSON asked and was given permission to revise and extend his remarks.)

Mr. RICHARDSON. Mr. Speaker, the chance for basic bipartisan health care reform may be slipping away, because some have taken a good idea and loaded it up with a lot of gifts to special interests. Why do we not put the American people first for a change?

Mr. Speaker, we all agree there are a few minor changes that we could make to our health care system that would cost the American taxpayer nothing, would offer security to millions of Americans in need of basic health care coverage. I say let us do those things that we can agree on. That is preexisting condition and portability.

We have to stop the unjust practice of denying those with preexisting conditions insurance coverage. Many people who need insurance the most cannot get it because of these preexisting conditions. Another 4 million Americans who have insurance are afraid to leave their jobs, fearing that they never might be insured at another job again.

Mr. Speaker, we should ask ourselves, how many are throwing themselves, begging for a medical savings account? That is for the healthy and for the wealthy. All our constituents are definitely knocking down our doors, demanding us to cut important services like medicare and medicaid and education so that we can spend billions on creating medical savings account.

There are too many controversial malpractice reforms in this bill. Why do we have to load it up? Why can we not do like the other body does and for a change let us say they have taken the right path and pass a bill like Roukema-Kennedy-Kassebaum. That is what we were elected to do. We all said we would do it. Now we have other political agendas that might prevent a good bipartisan health package from being enacted.

Mr. BLILEY. Mr. Speaker, I yield 2 minutes to the gentleman from Georgia [Mr. NORWOOD].

Mr. NORWOOD. Mr. Speaker, I rise today in support of the Health Care Coverage Availability and Affordability Act. In this time of economic insecurity and increasing pressure on America's working-class families, this bill is a common sense approach to health care access that also makes health care more affordable. In 1993, the Clinton administration and the liberals in Congress lined up behind the big government socialized medicine plan. This plan was an utter failure, not because the American people did not want security in their health coverage but because it was the wrong approach, though our Committee on Commerce in the 103d Congress had the right approach with the gentleman from Florida [Mr. BILIRAKIS] and Dr. Rowland of Georgia.

H.R. 3103 takes the right approach in dealing with their anxiety, ensuring that people who change or lose their jobs will have access to health care, regardless of preexisting conditions. This is important and deals with the same issues as the Kassebaum bill. However, while this is a good starting point, it just does not go far enough. Providing portability is important but on its own, it fails to deal with the forces that drive health care costs higher.

Mr. Speaker, it is nonsense to tell the American people that we will increase their access to health care without making health care more affordable. If we do nothing to bring down the cost of health care, we have the same old problem. We will be told that some provisions were included in this bill to kill health care reform. That is bull. Increasing access and reducing health care costs are two sides of the same coin.

This bill attempts to remove the influence of the trial lawyers in medicine by reforming the medical liability system. It gives young people, a large portion of whom do not have coverage, more health care choices. We must pass H.R. 3103.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the gentleman from Massachusetts [Mr. STUDDS].

Mr. STUDDS. Mr. Speaker, if I might have the attention of the distinguished chairman.

Am I correct that his bill prohibits group health plans or insurers offering coverage through group health plans from requiring a participant to pay a premium contribution that is greater than a premium contribution for a similarly situated participant or beneficiary solely on the basis of the health status of the participant or beneficiary?

Mr. BLILEY. Mr. Speaker, will the gentleman yield?

Mr. STUDDS. I yield to the gentleman from Virginia.

Mr. BLILEY. Mr. Speaker, the gentleman is correct.

Mr. STUDDS. Am I further correct that the word ''solely'' in this provision means that there can be no discrimination at all in the setting of premium contribution amounts for a participant on the basis of health status?

Mr. BLILEY. Mr. Speaker, if the gentleman will continue to yield, the gentleman is correct.

Mr. STUDDS. Mr. Speaker, although I am somewhat underwhelmed by both of the propositions before us, I think this is a significant step in the right direction.

Mr. BLILEY. Mr. Speaker, how much time is remaining on both sides?

The SPEAKER pro tempore (Mr. COMBEST). The gentleman from Virginia [Mr. BLILEY] has 11 minutes remaining, and the gentleman from Michigan [Mr. DINGELL] has 12¾ minutes remaining.

Mr. BLILEY. Mr. Speaker, I reserve the balance of my time.

Mr. DINGELL. Mr. Speaker, I yield 1½ minutes to the gentleman from Maryland [Mr. HOYER].

(Mr. HOYER asked and was given permission to revise and extend his remarks.)

Mr. HOYER. Mr. Speaker, I rise in support of the Kassebaum-Roukema-Kennedy legislation. I rise lamenting the fact that we will not take ''yes'' for an answer. Very frankly, the Kennedy-Kassebaum-Roukema bill was bottled up in the Senate until the heat got so high recently that the Republican in the Senate who then publicly admitted holding up the bill said no, let it go forward.

Mr. Speaker, all of us in a bipartisan way agree that we ought to preclude

preexisting conditions being an impediment to our citizens getting insurance. All of us believe that people ought not to be locked into their jobs because they do not have portability of health care security through their insurance. All of us believe that in a bipartisan way. That is what the gentlewoman from New Jersey [Mrs. ROUKEMA] was saying. That is what Senator KASSEBAUM is saying from Kansas. But we are having trouble taking yes for an answer.

Mr. Speaker, I personally believe that the medical savings account, although superficially appearing to provide some options, in fact will increase the cost for those who are less healthy and less wealthy. That is not just a fancy phrase. I think it is reality.

In addition, as my colleague, the gentleman from Maryland [Mr. CARDIN] expressed when he spoke on Ways and Means, our State is very concerned about precluding it from making determinations. In fact, we are stopping States from having the flexibility that our Republican colleagues say they ought to have.

Mr. BLILEY. Mr. Speaker, I yield 2 minutes to the gentleman from Florida [Mr. STEARNS], a distinguished member of the committee.

(Mr. STEARNS asked and was given permission to revise and extend his remarks.)

Mr. STEARNS. Mr. Speaker, I rise in support of the Archer/Bliley bill because I believe the issue of genetic privacy is of tremendous importance. I introduced H.R. 2690, the Genetic Privacy and Nondiscrimination Act of 1995. My bill would ban discrimination based on a person's genetic profile.

I wish to acknowledge my colleague and good friend Representative JOE KENNEDY who is helping me on the other side of the aisle. He and I are working together on this bill.

With new forms of genetic testing able to reveal an individual's likelihood of contracting a number of diseases, the possibility arises that employers and health insurers could use that information to discriminate.

This is a civil rights issue. People who are already at risk due to their genetic makeup shouldn't have to worry about the additional hardship of losing their job or health insurance.

Like a companion bill introduced by Senators MARK HATFIELD and CONNIE MACK, H.R. 2690 would also ban the disclosure of genetic information by anyone without the written authorization of the individual. This safeguard would protect the privacy of individuals who would rather their genetic information be kept private.

I am pleased that I was able to add a portion of my bill to the Archer-Bliley bill.

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Genetic testing has proved effective in certain cases, and it can be argued that the detection of a gene or a certain genetic characteristic will not necessarily result in the onset of a particular illness. So, we have an ambiguity here. We have an opportunity where somebody could have a defect which somebody would interpret different ways which would prevent them from having good health care insurance.

Genetic testing is moving along, as we all know, and it raises many ethical and legal and social questions relating to access to genetic testing, insurability and employability, and we need to make this confidential. The purpose of the Genetic Privacy Act, which I have provided, is to establish some guidelines concerning disclosure and use of genetic information with the goal of balancing the rights of the individuals against the needs of society.

Mr. DINGELL. Mr. Speaker, I yield 1½ minutes to the distinguished gentleman from New Jersey [Mr. MENENDEZ].

(Mr. MENENDEZ asked and was given permission to revise and extend his remarks.)

Mr. MENENDEZ. Mr. Speaker, I rise in support of the substitute which gives us an opportunity to pass a reform we know will be signed by the President.

In the last Congress we saw the demise of comprehensive health care reform, and those who objected to that initiative said that it was too much. We ended up with nothing. Hundreds of thousands of New Jerseyans and millions of Americans continued to languish in the insecurity of no health care coverage.

Today we can address one major concern of millions of working Americans, the fear of moving from job to job because of the possible loss of comprehensive health insurance. We can eliminate the condition referred to as job lock and free up opportunities for working men and women to seek new employment.

We also have an opportunity to provide necessary protection for those Americans with preexisting illnesses who are trapped in a job solely because of their inability to become insured if they leave their position. We have the opportunity to eliminate the discriminatory practice of denying continued health care to people with diabetes and other illnesses for which insurance coverage has been nearly impossible to obtain.

But the committee's bill contains provisions which are unacceptable to the President, the Senate and which, if included, may end any hope of enacting even modest health care reform, and I hope this is not the cynical reason behind the bill.

Twenty-five percent of my constituents have no health care insurance whatsoever. If we have to enact health care reform one step at a time, so be it. But let us take the first step today by insuring more people, liberating them in their choices through the adoption of the Democratic substitute.

Mr. BLILEY. Mr. Speaker, I yield 1½ minutes to the gentleman from Pennsylvania [Mr. FOX].

Mr. FOX of Pennsylvania. Mr. Speaker, I rise to support the Archer-Bliley bill, which will be the antidote to the problem we have in the United States of making sure we have sufficient coverage for all Americans.

As my colleagues know, the United States spends far more per capita on health care than any other major Nation in the world. But yet despite the rising costs of health care, millions of Americans are without health insurance and millions more expected to join the ranks of the uninsured.

The solution to the problem, I believe, Mr. Speaker, is in fact contained in H.R. 3103. The reforms before us here tonight in the House reform current health care insurance practices to make health insurance more available and more affordable.

The bill encourages insurance companies to provide coverages to the workers who change from one-employer provided plan to another. It gives the portability everybody wants. They lose their job and move to a job without coverage. It allows small employers to join together to purchase group health insurance for the first time, to do so for their employees, and allows self-employed individuals, Mr. Speaker, to deduct increasing percentages of their health insurance premiums from their income taxes.

This is an idea whose time has arrived, and I would ask for my colleagues to support this legislation for those reasons, but still a few more. It allows organizations such as trade associations and chambers of commerce to voluntarily associate to purchase health insurance which would be available to all member organizations. Further, it provides incentives to encourage individuals and their employers to make tax-deductible contributions in lieu of health insurance premiums.

Finally, Mr. Speaker, it increases penalties for fraud.

Mr. DINGELL. Mr. Speaker, I yield 1½ minutes to the distinguished gentleman from Ohio [Mr. BROWN].

Mr. BROWN of Ohio. Mr. Speaker, three years ago the insurance industry spent $100 million to kill comprehensive health care reform . How many of these companies are ominously silent on this Gingrich special interest health care bill.

One politically active insurance company located in Indiana would benefit handsomely under the Gingrich plan thinks to a special interest giveaway larded onto the Republican bill. Medical savings accounts will enrich a select group of high-end catastrophic providers, skim the well-off and the healthy out of the insurance pool, and increase costs for everyone left behind.

This Gingrich special interest plan is a bill written by the insurance companies, of the insurance companies, and for the insurance companies. Approximately 40 million Americans are without health care and without health insurance. A majority of these Americans are from working families, working hard, paying their taxes, playing by

the rules. They need our help in this Chamber tonight.

Mr. Speaker, pass the Dingell substitute. Defeat the Gingrich special interest bill.

Mr. BILILEY. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Georgia [Mr. KINGSTON].

Mr. KINGSTON. Mr. Speaker, I find it appalling that the Democrats would bring in this special interest thing. The integrity of the debate; is it possible to have a honest debate any more at all?

I mean if my colleagues want to talk about special interests, read yesterday's Hill newspaper article. The American Trial Lawyers just gave $2.2 million to candidates last year, 94 percent going to Democrats opposed to this bill because it has tort reform. My colleagues want to talk special interests? Weigh on in, because my colleagues are the ones who are in the pocket of the American trial bar.

Let us get to the real issue here. Medical savings accounts gives choice to Americans. It takes it away from our Washington bureaucrat command and control allies and puts it in the hands of the American public where it belongs. That is what our constituents want, and once they start making their own decisions on health care, they are going to decide a whole lot of other things, like they may need somebody else to represent them in Congress.

I think it is important to also know that our colleagues are standing one more time against small businesses by opposing legislation that would allow pet stores and clothing stores and barber shops to pool together and buy their insurance as a group.

Mr. DINGELL. Mr. Speaker, I yield 1½ minutes to the distinguished gentleman from Vermont [Mr. SANDERS].

Mr. SANDERS. Mr. Speaker, I thank the gentleman for yielding me the time.

Mr. Speaker, more women in the United States are injured and killed through domestic violence than by automobile accidents, muggings, and rapes by strangers combined. Domestic violence is a terrible plague in American society.

Given that reality, it is an absolute outrage that a number of insurance companies deny health insurance to women who have been battered and who have been victims of domestic violence. These insurance companies argue that domestic violence is a preexisting condition and that it might not be profitable for them to insure these women. Under these conditions women are being abused twice, first by their batterers and, secondly, by the insurance companies who refuse to insure them and their families.

Mr. Speaker, I am delighted that both the Republican and Democratic health care bills before us tonight include an amendment which I offered which would once and for all put an end to this outrage. Women who are battered are entitled to health insurance just like anyone else.

Mr. BLILEY. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from California [Mr. COX], chairman of the Republican Policy Committee.

Mr. COX of California. Mr. Speaker, I would just like to thank my colleague from Vermont. My understanding of his remarks is that he is pleased with the bill because it includes provisions that will make sure that domestic violence is covered, that it is not excluded from our protections as a preexisting condition.

That is my understanding. Is that correct?

Mr. SANDERS. Mr. Speaker, will the gentleman yield?

Mr. COX of California. I yield to the gentleman from Vermont.

Mr. SANDERS. Included both in the Republican bill and the Dingell bill as well, yes.

Mr. COX of California. I thank the gentleman for pointing out that additional salutary impact of this legislation.

There is something else in this legislation that I would like to highlight, in addition to the fact that it will solve the problems that we have all agreed need to be solved on preexisting conditions and on portability of coverage. That is reducing costs in the way that the Congressional Budget Office has told us is the most effective way possible.

A September 1993 Office of Technology Assessment report said that a ceiling on noneconomic damages in medical lawsuits is the best way that we can get a grip on costs. Earlier in this session we have devoted our attention to this issue, and this Congress has, by overwhelming bipartisan vote, approved this kind of health care liability reform that, I want to point out, is also included in this bill and provides a very solid reason for voting for it.

One of the key elements is what in California we call MICRA. It is health care cost control that we have had in place for many, many years. It was passed by a Democratic legislature, signed by a Democratic governor. It is bipartisan in this Congress, as well. I was very pleased to be the Member who offered this legislation in the first session of Congress and to see the strong bipartisan support that it won.

We do have too many frivolous lawsuits, and, as a matter of fact, we can through this proven technique, already a law in California, control them for the benefit of every single individual insured person in America. Driving down health care costs this way is very, very important.

Mr. DINGELL. I yield 1½ minutes to the distinguished gentleman from Massachusetts [Mr. OLVER].

Mr. OLVER. Mr. Speaker, I thank the gentleman for yielding me the time.

Mr. Speaker, among the many provisions, hundreds of pages of provisions which the insurance industry added to the Kennedy-Kassebaum bill that passed the Senate with, God forbid, bipartisan support, the most insidious of those provisions are those that provide for the medical savings accounts because they would set off a chain reaction.

First, they encourage the healthy and particularly the wealthy who can afford the high deductibles of MSA's to opt out of their current insurance pool. That shrinks the insurance pool needed to keep premiums more affordable for everybody.

Next, that is injury to hard-working middle-income people left behind in the pool because they are going to see their premiums go up, they are going to have to make up the loss of the healthiest and wealthiest.

And, finally to add insult to injury, the same middle-income workers paying higher premiums will also be paying taxes to replace the tax breaks handed to those who can afford these accounts.

Mr. Speaker, that is wrong, and I urge my colleagues to support the substitute which is a clean Kennedy-Kassebaum-Roukema bill. It is real reform with several clean good steps toward real health insurance reform. It eliminates the denials for preexisting conditions when someone changes jobs, it eliminates some of the job lock which keeps people from changing jobs due to fear of losing their insurance, and it reduces the burden on the self-employed by raising their health insurance deduction to 50 percent.

Mr. BLILEY. Mr. Speaker, I have only one speaker left, and I reserve the balance of my time. I understand I have the right to close.

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Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentlewoman from Connecticut [Ms. DELAURO].

Ms. DELAURO. Mr. Speaker, we have a real opportunity tonight to do something for the working families in this country. The American public is clamoring for health care relief. It is one of the fundamental concerns of the people of this country. People in this Nation are frightened that they will lose their jobs, that they will lose their health care, that they will be denied health insurance because of a preexisting condition that they may have or that their children may have.

Mr. Speaker, the Kassebaum-Kennedy-Roukema bill takes a first step toward addressing these problems. It is a good bill, it is a bipartisan bill. It addresses the needs of the American people. Do not load up the bill with politically contentious issues that are designed to kill this bill, this opportunity for health care reform. It is wrong. It is not what the people of this Nation have sent us here to do. It is not what our jobs are about.

Mr. Speaker, the authors of this bill have asked for a clean bill, not to be loaded up. Mrs. KASSEBAUM earlier

today said, ''I think there are some who, by design, would like to see problems.'' The Washington Times today says that ''Riders Imperil Health Care Reforms,'' and it says that ''House and Senate Republicans said they planned to add a series of controversial provisions to a popular health insurance reform bill, clouding chances for quick passage.''

The gentleman from Virginia [Mr. BLILEY] himself has said that, ''If you load up the wagon, it is heavier to pull.'' Do not sacrifice health care reform. Do not sacrifice the American public for special interests tonight. It is wrong to do that. We have a golden opportunity to do something, not for the Golden Rule Insurance Co., but for the American people, for the working families of this country who deserve to have relief from the perils of a disastrous illness. Vote against this bill, vote for the Democratic substitute.

Mr. DINGELL. Mr. Speaker, I yield 1½ minutes to the distinguished gentleman from California [Mr. FAZIO].

Mr. FAZIO of California. Mr. Speaker, when President Clinton stood here a few months ago and announced his support for a bill that had been authored by Senator KASSEBAUM and the gentlewoman from New Jersey, Mrs. ROUKEMA, to be joined by the gentlemen from Massachusetts, Senator TED KENNEDY, and JOSEPH KENNEDY, the country was ecstatic. They were convinced for the first time we would actually do something about the need to make health insurance portable and to prevent prior conditions from making insurance either unavailable or unaffordable to many people.

Tragically, we are here tonight debating a bill that goes far beyond that consensus, that moves us into conflict on issues like MSAs, that are a pure giveaway to a gentleman from Indiana named Mr. Rooney, who legitimate insurance salesmen in my district claim they would never sell policies for.

We have watered down portability, we have limited the ability to prevent prior conditions from being remedied in this legislation, because we have taken an approach that does not really give people what they have been told they will get. They will pay more if there are fortunate enough at all to be able to continue to have health coverage. They are not going to be able to keep the kind of plan they have had. This proposal ensures they will pay more.

Tragically, in the process of making this bill difficult to pass and sign, we have not done enough to help small business people who need 80 percent, if not 100 percent, deductibility, and we have weakened consumer protections and gutted State law.

Please oppose this bill and support the substitute.

Mr. Speaker, I offer my strong support for the Democratic substitute.

The Republican bill is loaded down with special interest amendments like MSA's political paybacks for the Golden Rule Insurance Co.

These paybacks mean everyone else will have to pay more for their insurance.

The Democratic substitute will help tens of millions of Americans keep their health insurance when they switch jobs, regardless of their condition.

The Democratic substitute addresses several fundamental problems.

If an employee who has been covered for at least 18 months switches or loses his or her job, that employee could buy insurance without exclusions for pre-existing medical conditions.

Workers will no longer be locked into jobs or prevented from starting their own businesses for fear of losing their own coverage.

The substitute also contains an increase in the deductibility of health insurance for the self-employed.

Greater deductibility serves two important goals.

First, greater deductibility increases affordability. Increasing deductibility will help millions of farmers, small businesses, and other working families afford the high cost of health care insurance.

Second, greater deductibility ensures greater fairness in our tax code. Corporations have long enjoyed full deductibility for their health insurance costs. It is time to narrow the gap between Wall Street and Main Street.

This substitute represents legislation that we can pass today and that the President would sign tomorrow. It has received wide bipartisan support, both here in the House and in the other body.

Let us not miss this opportunity to enact health care insurance reform that will benefit millions of hard-working Americans.

I urge a yes vote on this substitute.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Massachusetts [Mr. MARKEY] to conclude debate on this side.

Mr. MARKEY. Mr. Speaker, it is with sorrow and frustration that I rise to oppose this bill. Reform of our health care system is long overdue. The fact that some 40 million Americans do not have health insurance is an absolute disgrace, and it is high time that we do something about it. Last week the Committee on Commerce unanimously approved legislation that would have provided at least some relief to millions of hardworking American families by ending job lock and limiting the use of preexisting condition clauses.

It was a good first step. It was incremental, to be sure. It would have guaranteed that health care was affordable, but at least it would have been accessible. It was modest, and for that reason I had hoped that a large majority of Members from both sides of the aisle could support it.

Mr. Speaker, my mother always says that a half a loaf is better than none, and I supported that bill, even though it was really only a couple of slices. I know the American people want the whole loaf. Unfortunately, the leadership has taken a couple of good, wholesome slices of health insurance reform and slapped a whole lot of extraneous junk food on top, creating a health care hoagie of medical savings accounts, caps on medical malpractice awards, and other unhealthy additives. These anchovies and olives and onions are sure to tickle the taste buds of a very few special interests, but cause heartburn for millions of consumers.

Barry Goldwater's old words can be twisted here this evening, because now the Republican Party believes that extremism and the defense of special interests is no vice. ''The American Medical Association wants it, we will just toss it into this bill.''

Barbara Tuchman wrote a very famous book back in the early 1980's, entitled the ''March of Folly'', basically chronicling throughout the ages the mistakes.

Mr. BLILEY. Mr. Speaker, it is with pleasure that I yield the balance of my time to the gentleman from Illinois [Mr. HASTERT], the chief deputy whip, a gentleman who has worked tirelessly on this legislation.

The SPEAKER pro tempore (Mr. COMBEST). The gentleman from Illinois [Mr. HASTERT] is recognized for 4½ minutes.

Mr. HASTERT. Mr. Speaker, I thank the chairman of the Committee on Energy and Commerce for yielding time to me. As a matter of fact, Mr. Speaker, I thank all of those chairmen of the committees who have worked together to make this bill possible, and the subcommittee chairmen, and I would be remiss if I did not thank the staff of the combined committees, who did an excellent job in working together to make sure that this bill was successful.

Mr. Speaker, I have heard a lot of outrageous statements from the other side of the aisle tonight, and even one from our side of the aisle. But it questions me, it wonders me, I guess you would say, who are those special interests that everybody is talking about? Is it the small businessman who needs to have the ability, the deductibility; that if he has a small business and wants to get his employees covered, 85 percent of which are people who work today and do not have insurance and end up in situations with one family member that works for a small business, that we give them the ability to pool that and take it to the marketplace with the same advantages that big business gets? Is that a special interest?

Is it a special interest for a family who wants to get health care and make choices of their own, instead of having an HMO or a doctor or an insurance company tell them, is that the special interest they talk about?

Maybe, Mr. Speaker, there are some dinosaurs still in this Congress that do not want to have change, some dinosaurs that still want to have big Federal health care take care of everything, and take over everything, and if they cannot have it their way, then they are going to do the very minimum, the very minimum to cover the ladies and gentleman of this country and the families of this country.

Mr. Speaker, we have traveled a long road in a short period of time with this

reform bill. For that, I applaud the cooperation of everybody. It must be noted that with this legislation, we have succeeded where previous Congresses have failed, and we have put together reforms in the health care delivery system that will help people today. Our legislature will lower the cost of health care insurance while making it more available and affordable to middle-income American families.

Who among our critics will deny that health insurance is too expensive? Who among our critics will deny that American families should have more control over their health care spending? Who among our critics will deny that patients deserve more health care dollars than bureaucrats and trial lawyers? I have listened with intent interest, and the charges of some of the members of the minority party are just outrageous.

They claim our bill does too much, that it goes too far, and that it is too ambitious for this Congress. This claim, coming from proponents of the President's ill-conceived centralized, federalized health care scheme, can only be seen as a farce. I contend that the President's first health care bill was far too big. The Kennedy approach now advocated by the President is just too small. Our health care plan is just right for the American family.

Our colleagues in the other body deserve a great deal of credit for trying to remove the barriers created by preexisting conditions. It is a needed reform, and it is contained in our bill. This bill gives people who lose or change jobs the insurance that they can keep their health insurance when they need it most.

One other misstatement of fact. The Senate has not passed the Kennedy bill. It has only moved out of committee. Only yesterday the letter comes out of the Senate that the leadership in the U.S. Senate approves of our bill. They ratify our bill. They commend us for doing these things, for doing more for the American people.

I have to say that a letter from the small business groups in this country says that this is the right thing to do for the American working people, for those people who have to carry a lunch bucket to work. It gives them choice, it gives them coverage, and Mr. Speaker, the time has come to pass this legislation. I ask for its approval.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Pennsylvania [Mr. GOODLING] will be recognized for 15 minutes, and the gentleman from Missouri [Mr. CLAY] will be recognized for 15 minutes.

The Chair recognizes the gentleman from Pennsylvania [Mr. GOODLING].

Mr. GOODLING. Mr. Speaker, I yield myself 4½ minutes.

(Mr. GOODLING asked and was given permission to revise and extend his remarks.)

Mr. GOODLING. Mr. Speaker, today this House of the people has a historic opportunity to cast their vote for landmark legislation designed to address the health insurance concerns expressed by the people.

For nearly three decades the American people have looked to Congress to improve private health insurance accessibility, affordability, and accountability. Unfortunately, until this point, efforts to nationalize health care have deprived our people of the added security that would result from the commonsense and bipartisan elements of targeted health insurance reform contained in the measure we are now considering. These elements, such as health insurance portability, renewability, and pooling for small employers, have been long debated and included in various legislative proposals offered by the members of the Economic and Educational Opportunities Committee and many others.

These needed well-targeted reforms did not advance in the last Congress because of the failed efforts by the President to promote his government-run health care plan. The American people were not fooled—the elements of the President's plan proved too costly, too bureaucratic, and would have led to health care rationing. However, our efforts here today give evidence that we are seriously taking President Clinton at his word which was given in his State of the Union address last year, ''Let's do it step by step; let's do whatever we have to do to get something done'' in regard to incremental health insurance reform.

That is why the legislation before us is deliberately more modest in scope. Rather than trying to create a new health care system, the Health Coverage Availability and Affordability Act seeks to build on those elements of the Nation's employment-based system that work well—namely the fully insured and self-insured group health plans under ERISA—while at the same time making the important changes to the current system which are needed.

The changes called for by the American people, like the people who have spoken at my town meetings in York, PA, include helping end job-lock for employees seeking new employment by limiting preexisting condition restrictions under the new employer's plan and eliminating such restrictions for those who maintain continuous health insurance coverage. This proposal, like the bill reported by our Committee, does that and more.

In addition, an employer would not be able to exclude new workers from their company health plan simply because that worker or a member of his or her family may have a serious health condition. Such individuals would have to be permitted to enroll and be able to choose a benefit package under the plan. If family coverage is offered under a group health plan, spouses who lose other coverage and newborns would have to be allowed to be enrolled.

Smaller businesses have also expressed concern that insurers not be able to drop their coverage because of the health status of their employees. The legislation addresses this concern by prohibiting insurers and multiple employer plans from failing to renew health insurance coverage because of adverse claims experience or other reasons. Smaller employers and their employees would also have an expanded choice of health insurance coverage because of provisions in the bill allowing employers to choose their coverage from among all of the products offered by insurers and HMO's participating in the small group market.

I believe these changes reflect the kind of important reforms the American public expect of us. But we must also help those who have no coverage at all. The problem of the uninsured is primarily one of small businesses that cannot afford to buy insurance for their workers.

The many witnesses who spoke at our committee's hearings stressed that making health insurance more affordable was the key to making it more available to the American worker and his or her family. Therefore, the legislation contains provisions that will help achieve the goal of expanding coverage to the nearly 34 million individuals in working families who now do not have health insurance coverage. It does this by clarifying the ERISA law to allow employers, especially smaller employers, to form multiple employer plans through the associations that represent the Nation's trades and businesses and by allowing employers and employees to choose and negotiate for the type of coverage they need and can afford.

In 1974, Congress enacted the Employee Retirement Income Security Act or, as it came to be known, ERISA. In doing so, Congress shaped and put into place the cornerstone of our country's employee benefits law. More importantly, it laid the foundation upon which employers and negotiated multiemployer plans have been able to successfully provide benefits to workers and their families, including pensions, health, and other benefits. As Dr. Richard Lesher, president of the U.S. Chamber of Commerce, has testified, ''Our membership is convinced that preservation of ERISA is a critical step on the road to significant health care reform. We support H.R. 995 [the bill reported by the Committee] as it builds upon ERISA by including needed insurance market reform.''

This is one issue on which employers and unions agree. For example, Mr. Robert Georgine, chairman of the National Coordinating Committee for Multiemployer Plans, stated in testimony that:

> ''Given this reality [that there will be no employer mandate] the next best approach is a policy that encourages an expansion of voluntary, employment-based coverage without imposing additional costs on existing health plans.* * * H.R. 995 [the bill reported by the Committee] takes this approach. We are pleased that the bill uses ERISA as its vehicle.''

By utilizing the time-tested features contained in ERISA, the provision under subtitle C, like those under H.R. 995, build upon the successes produced by private sector innovation and market competition.

Under subtitle C of the bill, multiple employer plans could self-insure or fully insure, gaining all of the advantages this entails including economies-of-scale and lower costs. Small employers who now do not have access to coverage, or cannot afford it, would be automatically eligible for more affordable health coverage through the plans sponsored by their business and trade associations. Together with other provisions of the bill, such as the increase in the deduction of health insurance costs for the self-employed, this legislation will unleash small employers into a more competitive health insurance marketplace, thus enabling them to secure more affordable health coverage in the same manner as do larger employers.

Subtitle C also brings more accountability to the health insurance market. The Department of Labor inspector general, Mr. Charles Masten, testified that this is necessary and important legislation to stop health insurance fraud perpetrated by bogus unions and other illegitimate operators. Legitimate plans will be made accountable and fraudulent schemes will be halted when these provisions are enacted.

In sum, subtitle C and the other provisions of the Health Coverage Availabilty and Affordability Act present this Congress with perhaps its best opportunity since the passage of ERISA to expand access to affordable health insurance for many American families.

The measure is superior to other bills in either body in regard to protecting the American worker and his family and offering the opportunity for true portability of health insurance coverage, by increasing the likelihood that the mobile worker's next employer will also be offering a health plan. The fact that small employers strongly support the pooling provisions in the bill is testament to the vast potential multiple employer plans have for expanding coverage and reducing the cost-shifting from the uninsured to the insured worker that currently takes place.

The House bill is also more protective under its portability provisions. The bill would allow a 60-day lapse in coverge before portability protection for preexisting conditions would be interrupted while other bills would allow only a 30-day lapse in coverage to terminate an employee's portability protection. The House bill has also been crafted carefully to be both more protective and administrable with regard to the evidence employees must give to received portability credit for prior coverage. It is anticipated that under the House bill most group health plans would utilize the simpler portability rule which credits employees with period of prior coverage for purposes of reducing a new 12-month preexisting condition period without requiring a demonstration that the prior coverage actually covered the preexisting condition—a potentially lengthy and costly determination.

The House bill has also been carefully drawn to avoid issues that made the Clinton plan so controversial such as provisions requiring group health plans to include particular forms or types of benefit.

In sum, the provisions of the Health Coverage Availability and Affordability Act represent the best opportunity in decades for American workers and their families to gain increased access to more affordable and accountable health insurance coverage. I urge my colleagues to vote for this workable responsible targeted health insurance reform bill. The American people will thank you for the increased security they will have when you make history by passing this landmark health coverage legislation.

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Mr. CLAY. Mr. Speaker, I yield myself 3 minutes.

(Mr. CLAY asked and was given permission to revise and extend his remarks.)

Mr. CLAY. Mr. Speaker, I rise in opposition to H.R. 3103. The Republican leadership is passing up a golden opportunity today to pass a realistic, bipartisan health reform bill. Instead of bringing to the floor the Roukema-Kassebaum-Kennedy bill, the leadership is bringing up for consideration H.R. 3103. This bill is so weighted down with complex, controversial, and special interest provisions that it could doom health reform for 1996.

Members will have a chance, however, to vote for sensible, bipartisan health reform legislation today. The democratic substitute is the Roukema bill, and I urge my colleagues to support it.

The Nation cries out for the reasonable, constructive approach of the Roukema bill. Democrats and Republicans should unite behind this bill. It has broad bipartisan support in both Houses of Congress. The President has said he will sign it.

The House Republican leadership is on the verge of dashing the hopes of millions of people. They are on the verge of blocking the modest legislative objectives of a large, bipartisan group of Members in the House and Senate.

Mr. SPEAKER, included in H.R. 3103 is a proposal to exempt self-funded, multi-employer health plans, or MEWA's, from State law. This proposal is opposed by the National Conference of State Legislatures and the National Association of Insurance Commissioners.

The large, self-funded health plans created by this bill would be financial disasters waiting to happen. There is a reason Congress delegated responsibility for regulating MEWA's to the States in 1983. While many legitimate, successful MEWA's exist, the MEWA business continues to attract unscrupulous operators and to experience an inordinate failure rate.

Considering the fraud and abuse that has long been associated with MEWA's, it is incredible that the bill would grandfather existing MEWA's. The bill would immediately exempt large, existing MEWA's—the good, the bad, and the ugly—from State solvency and insurance laws. Having obtained this instant ''Good Housekeeping Seal of Approval,'' unscrupulous and inadequately financed operators could begin preying on the public—one step ahead of the Labor Department which might still be reviewing their application for a Federal certificate.

The bill's solvency standards are inadequate to the task assigned to the Labor Department to regulate hundreds of multistate, multiemployer health plans enrolling up to as many as 20 million people. Consumers could find very little standing behind a Federal MEWA if it should get into financial trouble.

This bill is an ironic example of legislative forum shopping; it greatly expands Federal authority over the private sector. The Federal Government for the first time would be in the business of chartering and regulating the solvency of privately run, national health plans.

Perhaps nothing the Republicans have passed during the 104th Congress would increase Federal financial exposure more than this bill's MEWA provision. It would only be a matter of time before a large, multistate MEWA would go under, leaving consumers with millions of dollars in unpaid medical bills.

And to whom will these angry, aggrieved consumers turn when this happens? Their State insurance regulator? No. Consumers will turn to the Labor Department and Members of Congress for relief. And, as with the savings and loans insolvencies of the 1980's, the urge and political pressure to bail out these MEWA's and protect constituents will be irresistible.

Finally, considering the hostility, not to mention the appropriations riders and budget cuts, that has met Labor Department regulatory activity during this Congress, it is almost certain that the Labor Department will be a weak regulator.

Do you want the Federal Government to assume responsibility for regulating large, multistate health plans whose insolvencies could expose the Federal Government to multimillion-dollar bailouts—especially in an era of Federal Government downsizing, anti-regulating zeal, and diminishing budgets?

Mr. Speaker, this bill brings market fragmentation to an even higher plain. It carves up the multiemployer plan market, treating large plans differently than small plans, old plans differently than new plans, single industry plans differently than multiindustry plans, plans in one State differently than plans in another.

Its exemptions, its exceptions to the exemptions, and its loopholes to the exceptions to the exemptions—never mind the bill's grandfathering of scoundrels along with the saints—makes this bill look like swiss cheese and smell like limburger.

Finally, the United States has an extremely fragmented health insurance market. This bill would make it worse. The expansion of self-funded plans would greatly exacerbate market fragmentation.

The bill's expansion of the ERISA preemption to self-funded multiemployer plans, and the cost savings associated with not having to comply with State solvency and insurance rules, will make being a Federal MEWA an extremely attractive option for existing multiemployer plans and trade association plans that currently offer

fully insured products to their members. Many of these plans would seek to become federally chartered self-funded MEWA's. And, many employers that now offer an insured product to their employees—through Blue Cross-Blue Shield, for example—will transfer their coverage to these Federal MEWA's.

These Federal, self-funded MEWA's will siphon healthier, younger groups from traditional insurance markets and, as a consequence, will undermine those markets as well as State health reform initiatives. As healthier groups exit the insurance market, premiums will rise, forcing some individuals to drop coverage. In addition, shrinkage in the size of insurance markets means a shrinkage in both a State's insurance premium tax base and high risk pool assessment base; H.R. 3103 would cost States millions and millions of dollars in lost revenues—revenues which States use to finance high risk pools for the uninsured. This bill will make it more difficult for States to maintain and expand their efforts to expand coverage to the uninsured. That would be a travesty.

I urge Members to oppose H.R. 3103 and to support the Democratic substitute.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS,
Washington, DC, March 28, 1996.

Hon. NEWT GINGRICH,
Speaker of the House, Washington, DC.

DEAR MR. SPEAKER: I am writing to comment upon the ''Health Coverage Availability and Affordability Act of 1996'', H.R. 3160, adopted by the House Rules Committee yesterday and scheduled for a vote by the full House of Representatives today. As you are aware, over the last few weeks, the National Association of Insurance Commissioners' (NAIC) Special Committee on Health Insurance (the ''NAIC Committee''), together with the National Conference of State Legislatures (''NCSL''), has provided comments upon H.R. 995, H.R. 3063 and H.R. 3070.

We appreciate the legislation's extension of portability reforms to self-funded health care plans governed by the Federal Employee Retirement Income Security Act (''ERISA''); the NAIC has long called for these reforms and federal intervention in this area is laudable. We also appreciate certain clarification that were made to provisions in the bills adopted by the committees of jurisdiction relating to state flexibility and the Medicare anti-duplication prohibitions. However, as detailed below, we continue to have serious concerns with the bill's provisions relating to multiple employer welfare arrangements (''MEWAs'').

We commend the additional clarifications made within Title 1, Subtitle D, Section 192, relating to ''State Flexibility to Provide Greater Protection''. The bill contains further limits on the scope of its preemption than were contained in H.R. 3063 and H.R. 3070. The legislative now states that it does not preempt those state laws ''that related to matters not specifically addressed'' in the bill. The bill also specifically saves several areas of state laws. We appreciate this enhanced state flexibility. We do, however, remain concerned about the absence of a broader construction clause explicitly saving from preemption any state laws that are not inconsistent with the bill and which provide greater beneficiary protection. In the absence of such a clause, the bill might be construed to ''preempt the field'' of any state law that touches upon any area minimally mentioned in the bill, even if the bill's provisions were not intended to preempt such state law. Since this a new area of federal intervention, we urge caution and care in the final crafting of preemption language.

We also appreciate the significant strides made in refining the range of health insurance policies which are not to be considered duplicative for the purposes of the application of the new Medicare anti-duplication provisions. We would appreciate the opportunity to clarify the states' remaining jurisdiction concerning health insurance policies governed by these provisions (possibly within legislative history) and to provide technical comments. We would like to commend you for tightening the consumer protections in these provisions from the earlier provisions adopted by amendment in committee.

We reiterate the concerns raised in our letter of March 18, 1996 to Chairmen Archer and Bliley concerning the long term care insurance related provisions within the legislation.

Unfortunately, we continue to have grave concerns that Subtitle C of Title 1 of H.R. 3160 would significantly erode existing state-level insurance reforms. The net effect of the final provisions relating to MEWAs is extremely damaging to states' authority to govern their own insurance market. The final language contains many layers of savings for, and exemptions from, state laws. This maze clouds the picture. Upon close examination of the multiple tiers of provisions, the bill preempts state laws governing health insurance, including those governing MEWAs, in all but a small number of states.

In sum, the changes made to Subtitle C do not represent a significant improvement from those contained within H.R. 995. We therefore remain opposed to most of the provisions contained within Subtitle C of Title I of the bill and reiterate the prior concerns expressed by the NAIC Committee on this topic. (See Joint NAIC Committee/NCSL letter dated March 5, 1996 to Representative William Goodling).

In addition, the bill still preempts state rating laws applicable to association plans thereby creating an unlevel playing field between these plans and other insured plans. Market fragmentation will thereby worsen and costs within the insured market could spiral. With respect to association plans, the bill also preempts state mandated benefit laws which have been enacted by the states.

The state budgetary impact of the bill is still likely to be significant. The bill only allows states to apply premium taxes to newly-formed or newly operating arrangements. Any arrangement that can argue they were already ''operating'' in a state cannot be taxed on a level playing field with state-regulated insurers. This provision thus promotes unfair competition and could significantly diminish state premium tax income.

The bill strips states of their oversight responsibility over a significant class of MEWAs. We question whether states could in good conscience accept responsibility for MEWA activities by asking the U.S. Department of Labor, pursuant to the option in the bill, for the authority to enforce the inadequate federal standards set forth in the bill. While gaps and ambiguities in federal law have led to some enforcement difficulties, this should be addressed by clarifications in federal law, not by the sweeping preemption of state regulatory authority over MEWAs proposed through H.R. 3160.

Thank you for your consideration of our comments. We look forward to continuing to work together on legislation to promote portability and availability of health insurance. Please feel free to call Kevin Cronin, the NAIC's Acting Executive Vice President and Washington Counsel at (202) 624–7790, with any questions you may have.

Sincerely,

BRIAN K. ATCHINSON,
President, NAIC,
Superintendent, Maine Bureau of Insurance.

NATIONAL CONFERENCE OF STATE LEGISLATURES,
Washington, DC, March 27, 1996.

Hon. JOHN JOSEPH MOAKLEY,
Ranking Member, Committee on Rules,
U.S. House of Representatives, Washington, DC.

DEAR REPRESENTATIVE MOAKLEY: On behalf of the National Conference of State Legislatures, I would like to share our thoughts on H.R. 3160, pending health insurance reform legislation. NCSL supports efforts to extend portability to individuals covered by ERISA plans and to establish minimum federal standards for insured plans. We are pleased that Title I, Subtitles A and B, build on the foundation for reform built by states over the last several years. We have been assured that the intent of Subtitles A and B is to continue to support state regulation and innovation in the small group and individual markets. We are pleased that changes have been made since the mark-up of H.R. 3070 and H.R. 3103, to provide additional clarity with regard to the ability of states to exceed the federal standards, established in the bill. We continue to have some concerns. For example, Section 103(b)(1) that states, ''. . . A group health plan, and an insurer or HMO offering health insurance coverage in connection with a group health plan, may not require a participant or beneficiary to pay a premium or contribution which is greater than such premium or contribution for a similarly situated participant or beneficiary *solely* on the basis of the health status of the participant or beneficiary.'' NCSL is concerned that state rating laws that prohibit or restrict the use of health status in a manner different than prescribed in the bill, may be preempted. For example, in cases where plans that include a rating component in addition to health status, state rating reforms may not apply. We hope to work with you to obtain additional clarity.

While we support the thrust of Subtitles A and B of Title I, NCSL opposes Subtitle C and urges you not to include these provisions in the House health insurance reform bill. Subtitle C fails to recognize the traditional role of states in the regulation of insurance and the important contributions state legislators have made in increasing accessibility and portability of health insurance and addressing fraud and consumer protection issues with regard to Multiple Employer Welfare Associations, by eliminating state authority to oversee Multiple Employer Welfare Associations (MEWAs). Instead, Subtitle C: (1) creates incentives for the establishment of federally regulated MEWAs, moving more individuals out of the reach of state insurance regulators and the protections those regulators provide; (2) permits some MEWAs to operate without receiving full federal approval; and (3) expands the Department of Labor's (DOL) authority over employer solvency and MEWAs, but fails to authorize funds for expanding DOL staff to perform these functions. NCSL opposes this preemption of state authority and the deregulation of MEWAs.

The MEWA provisions of H.R. 3160 would: (1) disrupt the existing health insurance market, undermining existing state efforts to improve access to health care and adversely affecting insurance premiums overall, and (2) make it easier for unscrupulous individuals to commit fraud under the protective umbrella of this proposed federal law which fails to provide adequate protections

for plan participants. NCSL supports and encourages the development of public and private purchasing cooperatives and other innovative ventures that permit individuals and groups to negotiate affordable health care coverage on the same basis as large groups. We also believe that these entities should and must be regulated and that consumers must be protected. Work remains to be done at both the state and federal government levels to strike a reasonable balance for MEWAs. NCSL urges you to retain the state role in regulating MEWAs.

States have made tremendous progress in reforming the small group insurance market. Since 1990 at least, 43 states have enacted laws that require carriers to renew coverage guaranteed renewal); 37 states have enacted laws that require carriers to offer coverage to small groups regardless of the health status of their employees or previous claims experience (guaranteed issue); and 45 states limit pre-existing condition waiting periods and require carriers to give individuals credit for previous coverage. In addition, similar efforts are underway in a number of states with respect to the individual insurance market. Since 1991 at least, 16 states have enacted guaranteed renewal; 11 states have enacted guaranteed issue; and 22 states have limited pre-existing condition waiting periods. Twenty-four states have established state high-risk health insurance pools that enrolled over 100,000 individuals last year. Finally, states are continuing to work with MEWAs to strike a balance between reasonable state regulations, plan flexibility and consumer protection.

NCSL joins the many other groups in urging you to move forward without further delay on these incremental, but important steps toward health reform. NCSL looks forward to working with you and your colleagues in the future as we work together toward expanding health care access and affordability.

Sincerely,

WILIAM POUND,
Executive Director.

Mr. CLAY. Mr. Speaker, I reserve the balance of my time.

Mr. GOODLING. Mr. Speaker, I yield such time as he may consume to the gentleman from Indiana [Mr. BUYER].

(Mr. BUYER asked and was given permission to revise and extend his remarks.)

Mr. BUYER. Mr. Speaker, I rise in support of the bill to open access and make health care affordable.

Mr. Speaker, today, with the passage of this bill, H.R. 3103, we will be expanding health care coverage to millions of Americans. After years of discussing how best to bring reform to our health care system, this bill brings meaningful incremental health care reform. H.R. 3103, the Health Care Coverage Availability and Affordability Act, addresses two crucial needs in our health care system—access and affordability.

First, let's review our current situation. Eighty-five percent of the population has health insurance, mostly through their employer. The uninsured, approximately 39 million Americans, today are not poor and are not elderly. The poor are covered by Medicaid; the elderly are covered by Medicare. Of the uninsured, 47 percent were employed full time; 38 percent worked part-time; 16 percent were unemployed. If incentives can be created in the market so more employed individuals can get affordable coverage and those between jobs can get coverage; then, the number of uninsured individuals will go down. Meaning millions of Americans will be covered by medical insurance.

Furthermore, many individuals cannot get coverage due to pre-existing conditions or because it is too expensive. Many businesses cannot get coverage because one of the employees or a dependent of an employee has a pre-existing condition. Employees are discouraged from changing jobs or starting their own businesses because they cannot get coverage due to a pre-existing condition.

H.R. 3103 will help create incentives so more individuals receive affordable insurance. First, it addresses the problems of access and affordability. Under H.R. 3103, group health plans (large employer plans, insurers, health maintenance organizations) are prohibited from imposing a pre-existing condition exclusion that exceeds 12 months for conditions that were diagnosed or treated within the previous 6 months on individuals that move from one group plan to another group plan. Pre-existing conditions would not affect newborns, adopted children, or pregnancy. Health insurance providers must reduce previous condition exclusion periods for an individual who enrolls in another program by the amount of time the individual was covered by a group health plan, health insurance, and HMO or Medicaid. Health insurance providers may not deny coverage to individuals in group health plans because of (1) a medical condition, (2) claims experience, (3) receipt of treatments for a medical condition, (4) medical history, (5) evidence of insurability or (6) disability.

H.R. 3103 also ensures portability of health insurance for those moving from group coverage to individual coverage, such as someone leaving a large employer to start a business. Many States, including Indiana, have addressed this issue. Under H.R. 3103, States are given the flexibility to address this problem such as by risk pools, or conversion policies, open enrollment periods, guaranteed issue, or any means that a State sees fit. However, for those State's that have not acted adequately, an insurer or HMO issuing individual health insurance coverage would have to offer an insurance policy equal to the average acturial value of the plans offered in the individual market by that insurer. The insurer would be prohibited to decline to issue coverage based on health status.

One of the key provisions of the bill allows small employers to voluntarily form groups for the purpose of self-insuring or providing health care coverage. Associations, like the NFIB or the Farm Bureau, would be able to band their members together for health insurance purposes and be treated like large multi-state employers. The regulatory structure that enables General Motors or IBM or AT&T to offer health insurance coverage, will now exist for the local hardware store, the corner grocer, and the farmer to purchase affordable health care coverage.

Voluntary health insurance associations are not new. In northwest Indiana a group of businesses have banded together to gain market clout to buy health care coverage for their employees. Typically, the employers in the alliance enjoy savings of 10 percent to 40 percent and can access 11 different health plans. H.R. 3103 should make their task easier and the bill should encourage other entities to band together to get access to affordable health insurance.

These provisions address the regulatory side of health insurance. By themselves, they make this bill worthy of support, but H.R. 3103 does not stop at insurance reform. It includes noteworthy tax relief as well.

First, H.R. 3103 increases the health insurance deduction for self-employed individuals from 30 percent to 50 percent by the year 2003. In 1995, Congress made this deduction permanent and raised it from 25 percent to 30 percent. We need to take care of the entrepreneurial spirit of America which lies in small business. This bill will increase the deduction to 50 percent. As large employers get a complete write-off of health insurance expenses, this bill brings an element of tax fairness to the system.

The bill also extends the medical expense tax deduction to include long-term care services that are curing or rehabilitative in nature, or are maintenance and personal care required by the chronically ill. This should give some relief to taxpayers who need long-term care. In additon, benefits paid out under life insurance ''accelerated death benefits'' contracts would not be treated as taxable income to the terminally or chronically ill beneficiary.

H.R. 3103 also includes Medical Savings Accounts. Individuals covered by a high deductible health insurance plan or their employer could make tax deductible contributions to a medical savings account. Funds could only be used for qualified medical expenses and disbursements for non-medical reasons would be treated as taxable income and subject to an additional 10 percent penalty. MSAs are true portability. The account belongs to the individual and is under the individual's control. This is a creative solution to provide more affordable insurance coverage and greater choice.

Finally, H.R. 3103 addresses fraud. Recent studies estimate that fraud costs consumers 5 to 10 percent of ever health care dollar spent. This is literally billions of dollars and leads to higher costs and higher premiums. It authorizes the Secretary of Health and Human Services and the Attorney General to jointly establish a national program to combat health care fraud. Under Medicare, the Secretary of HHS is required to establish a program to encourage individuals to report suspected fraud and abuse in the Medicare Program. Individuals who have been convicted of felonies relating to health care fraud or controlled substances would be excluded from Medicare and State health care programs for a minimum of 5 years. Criminal penalties would be revised and enhanced.

H.R. 3103 is a good bill with much needed reform. It goes beyond simple portability and addresses access, affordability, and choice. Once enacted, it will mean that someone today without insurance has a better chance of getting it and affording it tomorrow.

Mr. GOODLING. Mr. Speaker, I yield 4½ minutes to the gentleman from Illinois [Mr. FAWELL], who has spent probably hundreds of hours putting this legislation together and guiding us in committee.

Mr. FAWELL. Mr. Speaker, I thank the gentleman for yielding me this time.

Mr. Speaker, I rise to enthusiastically support H.R. 3160. The bill includes key small business health insurance reform that was in H.R. 995, reported by the Economic Opportunities

Committee: It gives small employers the right to form groups for the purpose of self-insuring or fully insuring and thereby gain access to affordable health care with the economies of scale that large employers and union plans have had for years under ERISA.

The problem of the uninsured is predominately a problem of small business lacking access to affordable insurance. Eighty-five percent of the 40 million uninsured are in families with at least one employed worker, the majority of whom work in a small business. Small businesses face health insurance premiums 30 percent higher than larger companies due to higher administration costs, and an additional 30 percent more due to costly State mandated coverages.

Small business people—through the National Federation of Independent Business—call this reform ''A remarkable advancement for small businesses over current law * * * a massive improvement''. Here's what NFIB says. I am going to be quoting from a letter from them.

NFIB is seeking to correct a basic unfairness in our health care system. Big business is allowed to buy health insurance under a different set of rules than small business. Because of ERISA, large self-insured businesses are exempted from State law in their health plans while small business is stuck with State insurance coverage mandates . . . and other forms of regulation. This inequity between big business and small business in large part explains why the premiums of corporate America are going down, while small business premiums are going up.

H.R. 3160 would stop this unfairness by allowing small firms to band together across State lines to purchase health insurance with nearly the same exemption from State law that big business has. Small employers will be able to cut their premiums by as much as a third. The legislation give(s) small firms almost every advantage they lack in purchasing health insurance today,

As I have indicated, big business has all of these advantages.

Achieving this is NFIB's highest health reform priority. Any substitute that does not directly address this inequity between big and small business is unacceptable to the more than 600,000 members of NFIB.

Of course, NFIB is but one of dozens of employer groups that support this approach. It is backed by the Chamber of Commerce, National Association of Manufacturers, National Association of Wholesalers, the National Restaurant Association, the National Retail Federation, the church groups, and many others, and I might also add, by labor unions that understand how valuable this type of legislation is.

A recent editorial in the Chicago Tribune entitled ''Free the Health Insurance Market'' expressed it this way:

''Freed of the need to offer 50 different policies, an organization such as the National Restaurant Association could arrange with an insurer to offer a basic policy to all its members. Without mandating coverage or capping premiums—two odious features of President Clinton's failed reform plan—the (bill) spurs the private insurance market to absorb a good portion of the Nation's 41 million uninsured, the vast majority of whom either have jobs or have a jobholder in he family.''

Unless we do something there by the way, what good is portability?

Mr. Speaker, many of the Governors had concerns about the original H.R. 995 as introduced last year. I am pleased to report that we worked very closely with many of them over the past year, and have addressed their concerns. Several changes were made that are acceptable to the Governors and the employer community.

Let me ask this one question, and think about it: Who benefits from this legislation? The people who cut your hair, serve you at restaurants, repair your car, clean your clothes—the millions of people working in small businesses all over America and who produce most of our new jobs.

I urge my colleagues to vote no on the substitute and vote yes on final passage of H.R. 3160. Allow employees of small businesses the same kind of access to affordable health care as that available to employees of large businesses.

SECTION-BY-SECTION ANALYSIS OF PROVISIONS RELATING TO ERISA GROUP HEALTH PLANS CONSIDERED BY THE COMMITTEE ON ECONOMIC AND EDUCATIONAL OPPORTUNITIES IN THE HEALTH COVERAGE AVAILABILITY AND AFFORDABILITY ACT OF 1996

TITLE I—INCREASED AVAILABILITY AND PORTABILITY OF HEALTH PLAN INSURANCE COVERAGE

Subtitle A—Coverage Under Group Health Plans

Sec. 101. Portability of coverage for previously covered individuals, and

Sec. 102. Limitation on preexisting condition exclusions; no application to certain newborns, adopted children, and pregnancy.

Group health plans, insurers, and health maintenance organizations would be prohibited from imposing a preexisting condition exclusion that exceeded 12 months for conditions for which medical advice, diagnosis, or treatment was received or recommended within the previous 6 months prior to becoming insured. In the event that the individual was a late enrollee, the preexisting condition exclusion could not exceed 18 months.

Preexisting condition exclusions or limitations could not be applied to newborns and adopted children so long as these individuals become insured within 30 days of birth or placement for adoption. Pregnancy could not be treated as a preexisting condition. In addition, genetic information could not be considered a preexisting condition, so long as treatment of the condition to which the information was applicable had not been sought during the 6 months prior to becoming covered.

Group health plans, insurers, and health maintenance organizations (HMOs) would be required to credit periods of qualified previous coverage toward the fulfillment of a preexisting condition exclusion period when an individual moves from one source of group health coverage to another. Specifically, a preexisting condition limitation period would be reduced by the length of the aggregate period of any qualified prior coverage. Prior coverage would not have to be credited toward a preexisting condition limitation period if the individual experienced a break in qualified group coverage of more than 60 days. (Qualified group coverage means any period of coverage of the individual under a group health plan, health insurance coverage, Medicaid, Medicare, military health care, the Indian Health Service, state health insurance coverage or state risk pool, and coverage under the Federal Employee Health Benefits Program (FEHBP).) A waiting period for any coverage under a group health plan (or for health insurance coverage offered in connection with a group health plan) would not be considered a break in coverage.

Presentation of a certification of prior coverage would establish an individual's eligibility for credit against a preexisting condition limitation period. Group health plan administrators, insurers, HMOs, and state Medicaid programs would be required to provide such certifications of coverage upon request of the individual.

In determining whether an individual has met qualified coverage periods, a group health plan, insurer, or HMO offering group coverage could elect one of two methods. Under the first, it could include all periods, without regard to the specific benefits offered during the period of prior coverage. Under the second, it could look at periods of prior coverage on a benefit-specific basis and not include as a qualified coverage period a specific benefit unless coverage for that benefit was included at the end of the most recent period of coverage. Entities electing the second method would have to state prominently in any disclosure statements concerning the plan or coverage and to each enrollee at the time of enrollment or sale that the plan or coverage had made such an election and would have to include a description of the effect of this election. Upon the request of the plan, insurer, or HMO, the entity providing the certification would have to promptly disclose information on benefits under its plan. It could charge the reasonable cost for providing this information.

Sec. 103. Prohibiting exclusions based on health status and providing for enrollment periods.

This section provides for availability of coverage. The bill would ensure that employees and their dependents could not, based on health status, be excluded from enrolling in their group health plan and being continually enrolled. Health status is defined to include, with respect to an individual, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), or disability.

Group health plans would be required to provide for special enrollment periods for eligible individuals who lose other sources of coverage if certain conditions were met. An individual would have to be allowed to enroll under at least one benefit option if: (1) the employee (or dependent) had been covered under another group health plan at the time coverage was previously offered, (2) that this was the reason for declining enrollment, (3) that the individual lost their coverage as a result of certain events (loss of eligibility for coverage, termination or employment, or reduction in the number of hours of employment), and (4) the employee requested such enrollment within 30 days of termination of the coverage.

In the event that a group health plan provided family coverage, the plan could not require, as a condition of coverage of a beneficiary or participant in the plan a waiting period applicable to the coverage of a beneficiary who is a newborn, an adopted child or child placed for adoption, or a spouse, at the time of marriage, if the participant has met any waiting period applicable to that participant. The bill defines timely enrollment as being within 30 days of the birth, adoption,

or marriage if family coverage was available as of that date.

Renewability requirements apply to certain arrangements to assure continued access of employers to health coverage to offer their employees. A group health plan which is a multiemployer plan, a multiple employer health plan (as defined in section 704 of ERISA), and a multiple employer welfare arrangement (providing medical care) may not deny an employer whose employees are covered under such a plan or arrangement continued access to the same or other coverage under the terms of such plan or arrangement other than (1) for nonpayment of premiums or contributions, (2) for fraud or other intentional misrepresentation of material fact by the employer, (3) for noncompliance with material plan or arrangement provisions, (4) because the plan or arrangement is ceasing to offer any coverage in a geographic area, (5) for failure to meet the terms of an applicable collective bargaining agreement, to renew a collective bargaining or other agreement requiring or authorizing contributions to the plan, or to employ employees covered by such an agreement, (6) in the case of a plan or arrangement to which subparagraph (C), (D), or (E) of section 3(40) of ERISA applies, to the extent necessary to meet the requirement of such subparagraph, or (7) in the case of a multiple employer health plan (as defined in section 701(4) of such Act), for failure to meet the requirements under part 7 of ERISA for exemption under section 514(b)(6)(B) of such Act. It is not included that anything in this section be construed to preclude any such plan or arrangement from establishing employer contribution requirements or group participation requirements not otherwise prohibited by this Act.

Sec. 104. Enforcement.

The above provisions would be enforced through penalties assessed through the Internal Revenue Code (IRC), Employee Retirement Income Security Act (ERISA), or through civil money penalties assessed by the Secretary of Health and Human Services (HHS). The Secretaries of Treasury, Labor, and HHS would be required to issue regulations that are nonduplicative and in a manner that assures coordination and nonduplication in their activities as provided for under this Act.

Enforcement through ERISA. Sections 101, 102, and 103 of Subtitle A (and the definitions under Subtitle D insofar as they are applicable to such sections) are deemed to be provisions of Title I of the Employee Retirement Income Security Act of 1974 (ERISA) for purposes of applying the enforcement, fiduciary and other provisions of such title. The Secretary of Labor would only apply the sanctions under ERISA to an insurer or HMO that was subject to state law (within the meaning of section 514(b)(2)(A)) in the event that the Secretary determines that the state has not provided for enforcement of the above provisions of the Act. Sanctions would not apply in the event that the Secretary of Labor established that none of the persons against whom the liability would be imposed knew, or exercising reasonable diligence, would have known that a failure existed, or if the noncomplying entity acted within 30 days to correct the failure. In no case would a civil money penalty be imposed under ERISA for a violation for which an excise tax under the COBRA enforcement provisions under the Internal Revenue Code was imposed or for which a civil money penalty was imposed by the Security of HHS.

Enforcement through the IRC. IRC enforcement would be done through the Consolidated Omnibus Budget Reconciliation Act (COBRA) health insurance continuation provisions (section 4980B). In general, a noncomplying plan would be subject to an excise tax of $100 per day per violation. Penalties would not be assessed in the event that the failure was determined to be unintentional or a correction was made within 30 days. For purposes of applying the COBRA enforcement language, special rules would apply: (1) no tax could be imposed by this provision on a noncomplying insurer or HMO subject to state insurance regulation if the Secretary of HHS determined that the state had an effective enforcement mechanism; (2) in the case of a group health plan of a smaller employer that provided coverage solely through a contract with an insurer or HMO, no tax would be imposed upon the employer if the failure was solely because of the product offered by the insurer or HMO; and (3) no tax penalty would be assessed for a failure under this provision if a sanction had been imposed under ERISA or by the Secretary of HHS with respect to such failure.

Enforcement through Civil Money Penalties. A group health plan, insurer, or HMO that failed to meet the above requirements would be subject to a civil money penalty. Rules similar to those imposed under the COBRA penalties would apply. The maximum amount of penalty would be a $100 for each day for each individual with respect to which a failure occurred. In determining the penalty amount, the Secretary would be required to take into account the previous record of compliance of the person being assessed with the applicable requirements of the bill, the gravity of the violation, and the overall limitations for unintentional failures provided under the IRC COBRA provisions. No penalty could be assessed if the failure was not intentional or if the failure was corrected within 30 days. A procedure would be available for administrative and judicial review of a penalty assessment.

The authority for the Secretary of HHS to impose civil money penalties would not apply to enforcement with respect to any entity which offered health insurance coverage and which was an insurer or HMO subject to state regulation (within the meaning of section 514(b)(2)(A) of ERISA) by an applicable state authority if the Secretary of HHS determined that the state had established an enforcement plan. In no case would a civil money penalty be imposed under this provision for a violation for which an excise tax under COBRA or civil money penalty under ERISA was assessed.

Subtitle B—Certain Requirements for Insurers and HMOs in the Group and Individual Markets

Part 1. Availability of Group Health Insurance Coverage

Sec. 131. Guaranteed availability of general coverage in the small group market.

This section provides for guaranteed availability of general coverage in the small group market. Each insurer or HMO that offered general coverage in the small group market in a state would have to: (1) accept every small employer in the state that applied for such coverage; and (2) accept for enrollment every eligible individual who applied for enrollment during the initial enrollment period in which the individual first became eligible for coverage under the group health plan. No restriction based on health status could be placed on the ability of an eligible individual to enroll.

The small group market is generally defined as employer groups with more than 2 and less than 51 employees. An eligible individual is one in relation to the employer as determined: (1) in accordance with the terms of the plan; (2) as provided by the insurer or HMO under rules which would have to be applied uniformly; and (3) in accordance with applicable state laws. Special rules would apply to network plans and HMOs to ensure that this guaranteed availability provision did not lead to capacity problems. In addition, such entities would not have to enroll a small group whose employees worked or lived outside the entity's service area. Insurers and HMOs could deny enrollment to an eligible small group in the event that the group failed to meet certain minimum participation or contribution requirements that were consistent with state law.

Sec. 132. Guaranteed Renewability of group coverage.

This section provides for guaranteed renewability of group coverage. If an insurer or HMO offered health insurance coverage in the small or large group market, the coverage would have to be renewed or continued in forced at the option of the employer. (An insurer or HMO could modify the coverage offered to a group health plan so long as the modification was effective on a uniform basis among group health plans with that type of coverage.) Exceptions to the guaranteed renewability requirement would apply in the event that the employer failed to pay the premiums, committed fraud, violated the participation rules, or moved outside the service area. In addition, guaranteed renewability would not apply if: (a) the insurer or HMO ceased to offer any such coverage in a state (or in the case of a network plan, in a geographic area); (b) in the event that the insurer or HMO uniformly terminated offering a particular type of coverage and provided adequate notice and the opportunity to elect other health insurance being offered in that market; and (c) in the event that the entity discontinued offering all health insurance coverage in the small or large group market or in both markets in a state, provided for adequate notice. In the last instance, such an entity could not reenter the market it left for at least 5 years.

Subtitle C—Affordable and Available Health Coverage Through Multiple Employer Pooling Arrangements

Sec. 161. Clarification of duty of the Secretary of Labor to implement provisions of current law providing for exemptions from State regulation of multiple employer health plans.

Sec. 161, Subsection (a). Rules governing state regulation of multiple employer health plans.

This subsection adds a new Part 7 (Rules Governing State Regulation of Multiple Employer Health Plans) to Title I of ERISA, as follows:

''Sec. 701. Definitions.

This section defines the following terms: insurer, fully-insured, medical care (as under current law), multiple employer health plan, participating employer, sponsor, and state insurance commissioner.

''Sec. 702. Clarification of duty of the Secretary of Labor to implement provisions of current law providing for exemptions from State regulation of multiple employer health plans.

This section clarifies the conditions under which multiple employer health plans (MEHPs), non-fully-insured multiple employer arrangements providing medical care, may apply for an exemption from certain state laws. The exemption process is contained in current ERISA law, which also contains restrictions on the ability of states to fully regulate such entities. Specifically, existing section 514(b)(6)(A)(ii) of ERISA provides that in the case of such a partly insured or fully self-insured arrangement, any law of any State which regulates insurance may apply only ''to the extent not inconsistent with other parts of ERISA.'' However, under section 514(b)(6)(B), the Department of Labor (DOL) may issue an exemption from

state law with respect to such self-insured arrangements.

''Section 702 clarifies that only certain legitimate association health plans and other arrangements (described below) which are not fully insured are eligible for an exemption and thereby treated as ERISA employee welfare benefit plans. This is accomplished by clarifying the duty of the Secretary of Labor to implement the provisions of current law section 514(b)(6)(B) to provide such exemptions for MEHPs. Under section 514(a) of ERISA, States are preempted from regulating employee welfare benefit plans, but an exception is made under section 702 to allow states to enforce the conditions of an exemption granted a MEHP.

''Section 702 further sets forth criteria which a self-insured arrangement must meet to qualify for an exemption and thus become a MEHP. The Secretary shall grant an exemption to an arrangement only if: (1) a complete application has been filed, accompanied by the filing fee of $5,000; (2) the application demonstrates compliance with requirements established in sections 703 and 704 below; (3) the Secretary finds that the exemption is administratively feasible, not adverse to the interests of the individuals covered under it, and protective of the rights and benefits of the individuals covered under the arrangement, and (4) all other terms of the exemption are met (including financial, actuarial, reporting, participation, and such other requirements as may be specified as a condition of the exemption).

''The application must include the following: (1) identifying information about the arrangement and the states in which it will operate; (2) evidence that ERISA's bonding requirements will be met; (3) copies of all plan documents and agreements with service providers; (4) a funding report indicating that the reserve requirements of section 705 will be met, the contribution rates will be adequate to cover obligations, and that a qualified actuary (a member in good standing of the American Academy of Actuaries or an actuary meeting such other standards the Secretary considers adequate) has issued an opinion with respect to the arrangement's assets, liabilities, and projected costs; and (5) any other information prescribed by the Secretary. Exempt arrangements must notify the Secretary of any material changes in this information at any time, must file annual reports with the Secretary, and must engage a qualified actuary.

''Section 702 also provides for a class exemption from section 514(b)(6(A)(ii) of ERISA for large MEHPs that have been in operation for at least five years on the date of enactment. An arrangement qualified for this class exemption if: (1) at the time of application for exemption, the arrangement covers at least 1,000 participants and beneficiaries, or has at least 2,000 employees of eligible participating employers; (2) a complete application has been filed and is pending; and (3) the application meets requirements established by the Secretary with respect to class exemptions. Class exemptions would be treated as having been granted with respect to the arrangement unless the Secretary provides appropriate notice that the exemption has been denied. It is expected that the standards applicable to entities eligible for a class exemption will be no less protective than if an individual exemption were granted to such an entity.

''Sec. 703. Requirements relating to sponsors, board of trustees, and plan operations.

This section establishes eligibility requirements for MEHPs. Applications must comply with requirements established by the Secretary. Applications must demonstrate that the arrangement's sponsor has been in existence for a continuous period of at least 5 years and is organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for a least annual meetings, as a trade association, an industry association, a professional association, or a chamber of commerce (or similar business group, including a corporation or similar organization that operates on a cooperative basis within the meaning of section 1381 of the IRC) for purposes other than that of obtaining or providing medical care. Also, the applicant must demonstrate that the sponsor is established as a permanent entity, has the active support of its members, and collects dues from its members without conditioning such on the basis of the health status or claims experience of plan participants or beneficiaries or on the basis of the member's participation in the MEHP.

''Section 703 also requires that the arrangement be operated, pursuant to a trust agreement, by a ''board of trustees'' which has complete fiscal control and which is responsible for all operations of the arrangement. The board of trustees must develop rules of operation and financial control based on a three-year plan of operation which is adequate to carry out the terms of the arrangement and to meet all applicable requirements of the exemption and Title I of ERISA. The rules also require that all employers who are association members be eligible for participation under the terms of the plan. Eligible individuals of such participating employers cannot be excluded from enrolling in the plan because of health status as required under section 103 of the Act (nor be excluded by purchasing an individual policy of health insurance coverage for a person based on their health status). The rules also stipulate that premium rates established under the plan with respect to any particular participating employer cannot be based on the claims experience of the particular employer.

''In addition to the associations described above, certain other entities are eligible to seek an exemption as MEHPs under section 514(b)(6)(B) of ERISA. These include (1) franchise networks (section 703(b)), (2) certain existing collectively bargained arrangements which fail to meet the statutory exemption criteria (section 703(c)), and (3) certain arrangements not meeting the statutory exemption criteria for single employer plans (section 703(d)). (Section 709 of ERISA, added by Section 166, also makes eligible certain church plans electing to seek an exemption.)''

''Sec. 704. Other Requirements For Exemption.

''Section 704 requires a MEHP to meet the following requirements: (1) its governing instruments must provide that the board of trustees serves as the named fiduciary and plan administrator, that the sponsor serves as plan sponsor, and that the reserve requirements of section 705 are met; (2) the contribution rates must be adequate, and (3) any other requirements set out in regulations by the Secretary must be met.''

''Sec. 705. Maintenance of Reserves.

''Section 705 requires MEHPs to establish and maintain reserves sufficient for unearned contributions, benefit liabilities incurred but not yet satisfied and for which risk of loss has not been transferred, expected administrative costs, and any other obligations and margin for error recommended by the qualified actuary. The minimum reserves must be no less than 25% of expected incurred claims and expenses for the year or $400,000. The Secretary may provide additional requirements relating to reserves and excess/stop loss coverage and may provide adjustments to the levels of reserves otherwise required to take into account excess/stop loss coverage or other financial arrangements.''

''Sec. 706. Notice Requirements for Voluntary Termination.

''Section 706 provides that, except as permitted in section 707, a MEHP may terminate only if the board of trustees provides 60 days advance written notice to participants and beneficiaries and submits to the Secretary a plan providing for timely payment of all benefit obligations.''

''Sec. 707. Corrective Actions and Mandatory Termination.

''Section 707 requires a MEHP to continue to meet the reserve requirements even if its exemption is no longer in effect. The board of trustees must quarterly determine whether the reserve requirements of section 705 are being met and, if they are not, must, in consultation with the qualified actuary, develop a plan to ensure compliance and report such information to the Secretary. In any case where a MEHP notifies the Secretary that it has failed to meet the reserve requirements and corrective action has not restored compliance, and the Secretary determines that the failure will result in a continuing failure to pay benefit obligations, the Secretary may direct the board to terminate the arrangement.''

''Sec. 708. Additional Rules Regarding State Authority.

Under section 708(a), a state which certifies to the Secretary that it provides guaranteed access to health coverage may elect to opt out of the MEHP provisions outlined above and deny a MEHP the right to offer coverage in the small group market (or otherwise regulate such MEHP with respect to such coverage), except as described below. A state is considered to provide such guaranteed access, if (1) the state certifies that at least 90% of all state residents are covered by a group health plan or otherwise have health insurance coverage, or (2) the state has, in the small group market, provided for guaranteed issue of at least one standard benefits package and for rating reforms designed to make health insurance coverage more affordable. In states without such guaranteed access, MEHPs could offer coverage in the small group market in the state as long as they meet the standards set forth in Part 7. For purposes of item (2) above and the similar provision under section 162 of the bill, it is intended that states that have achieved very high levels of health insurance coverage through means such as tax-preferred status for entities required to provide guaranteed issue, community-rated coverage be considered to meet the requirement under (2) regardless of how long a state law requiring such has been in effect.

''Section 708(b) provides a limited exception to the above described state opt out for certain large, multi-state arrangements. The state opt out (described in item (2) in the above paragraph) does not apply to new and existing MEHPs that meet the following criteria: (1) the sponsor operates in a majority of the 50 states and in at least 2 of the regions of the country; (2) the arrangement covers or will cover at least 7,500 participants and beneficiaries; and (3) at the time the application to become a MEHP is filed, the arrangement does not have pending against it any enforcement action by the state. In addition, the state opt out (described in items (1) and (2) in the above paragraph) does not apply in a state in which an arrangement meeting the MEHP standards operates on March 6, 1996, to the extent a state enforcement action is not pending against such an entity at the time an application for an exemption is made. The above two exceptions do not apply to any state which, as of January 1, 1996, either (1) has enacted a law providing for guaranteed issue of

fully community rated individual health insurance coverage offered by insurers and HMOs, or (2) requires insurers offering group health coverage to reimburse insurers individual coverage for losses resulting from their offering individual coverage on an open enrollment basis. Regulations may also apply certain limitations to single industry plans.

''Under section 708, a state could assess new association-based MEHPs (former after March 6, 1996) nondiscriminatory state premium taxes set at a rate no greater than that applicable to any insurer or health maintenance organization offering health insurance coverage in the state. MEHPs existing as of March 6, 1996 would remain exempt from state premium taxes; however, if they expand into a new state, the state could apply the above rule.

Section 162. Affordable and Available Fully-Insured Health Coverage Through Voluntary Health Insurance Associations.

This section adds a new subsection (d) to section 514 of ERISA which provides for the establishment of Voluntary Health Insurance Associations (VHIAs). Under this section, a VHIA is defined as a multiple employer welfare arrangement, maintained by a qualified association, under which all medical benefits are fully-insured, under which no employer is excluded as a participating employer (subject to minimum participation requirements of an insurer), under which the enrollment requirements of section 103 of the Act apply, under which all health insurance coverage options are aggressively marketed, and under which the health insurance coverage is provided by an insurer or HMO to which the laws of the state in which it operates apply.

The term qualified association means an association in which the sponsor of the association is, and has been (together with its immediate predecessor, if any) for a continuous period of not less than 5 years, organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose, as a trade association, an industry association, a professional association, or a chamber of commerce (or similar business group), for substantial purposes other than that of obtaining or providing medical care (within the meaning of section 607(1) of ERISA), is established as a permanent entity which receives the active support of its members and meets at least annually, and collects dues without conditioning such dues on the basis of the health status or claims experience of plan participants or beneficiaries or on the basis of participation in a VHIA.

Section 162 sets forth the preemption rules applicable to VHIAs. This provision would preempt two types of state laws and leave unaffected any other applicable state law not otherwise preempted under current law (i.e., section 514 of ERISA). The first type of law preempted is a law which might otherwise preclude an insurer or HMO from setting premium rates based on the claims experience of the employers participating in a VHIA (without varying the premium rates of a particular employer on the basis of the employer's own experience). As a result of this provision, a qualified association could form a VHIA and offer health insurance coverage and establish and distribute plan costs in a manner similar to that permitted under current law for self-insured plans. This will empower employees and employers to form groups to more effectively and cost-efficiently purchase fully-insured health insurance coverage.

Section 162 also preempts a second type of State law that requires health insurance coverage in connection with group health plans to cover specific items or services consisting of medical care (but does not preempt laws prohibiting the exclusion of specific diseases). This will enable employers and employees to establish health insurance packages which include benefits which they want and which they can afford.

Under this section, a state which certifies to the Secretary that it provides ''guaranteed access''' to health coverage may deny a VHIA the right to offer coverage in the small group market (or otherwise regulate such VHIA with respect to such coverage), except as described below. A state is considered to provide such guaranteed access if (1) the state certifies that at least 90% of all state residents are covered by a group health plan or otherwise have health insurance coverage, or (2) the state has, in the small group market, provided for guaranteed issue of at least one standard benefits package and for rating reforms designed to make health insurance coverage more affordable. In a state without such guaranteed access, VHIAs could offer coverage in the small group market in the state as long as they meet the standards for such entities.

This section also provides a limited exception to the above described state opt out for certain large, multi-state arrangements. The state opt out (described in item (2) in the paragraph above) does not apply to VHIAs that meet the following criteria: (1) the sponsor operates in a majority of the 50 states and in at least 2 of the regions of the country; (2) the arrangement covers or will cover at least 7,500 participants and beneficiaries; and (3) under the terms of the arrangement, either the qualified association does not exclude from membership any small employer in the state, or the arrangement accepts every small employer in the state that applies for coverage.

In addition, the state opt out (described in items (1) and (2) in the paragraph two paragraphs above) does not apply in a state in which an arrangement operates on March 6, 1996 and under the terms of the arrangement, either the qualified association does not exclude from membership any small employer in the state, or the arrangement accepts every small employer in the state that applies for coverage.

The above exceptions for multi-state plans and existing plans do not apply to any state which, as of January 1, 1996, either (1) has enacted a law providing for guaranteed issue of fully community rated individual health insurance coverage offered by insurers and HMOs, or (2) requires insurers offering group health coverage to reimburse insurers offering individual coverage for losses resulting from their offering individual coverage on an open enrollment basis.

Sec. 163. State authority fully applicable to self-insured multiple employer welfare arrangements providing medical care which are not exempted under new part 7.

This section clarifies the scope of ERISA preemption to make clear the authority of states to fully regulate non-fully-insured MEWAs which are not provided an exemption under new Part 7 of ERISA.

Sec. 164. Clarification of treatment of single employer arrangements

This section modifies the treatment of certain single employer arrangements under the section of ERISA that defines a MEWA (section 3(40)). The treatment of a single employer plan as being excluded from the definition of MEWA (and thus from state law) is clarified by defining the minimum interest required for two or more entities to be in ''common control'' as a percentage which cannot be required to be greater than 25%. Also a plan would be considered a single employer plan if less than 25% of the covered employees are employed by other participating employers.

Sec. 165. Clarification of treatment of certain collectively bargained arrangements.

This section clarifies the conditions under which multiemployer and other collectively-bargained arrangements are exempted from the MEWA definition, and thus exempt from state law. This is intended to address the problem of ''bogus unions'' and other illegitimate health insurance operators. The provision amends the definition of MEWA to exclude a plan or arrangement which is established or maintained under or pursuant to a collective bargaining agreement (as described in the National Labor Relations Act, the Railway Labor Act, and similar state public employee relation laws). (Current law requires the Secretary to ''find'' that a collective bargaining agreement exists, but no such finding has ever been issued). It then specifies additional conditions which must be met for such a plan to be a statutorily excluded collectively bargained arrangement and thus not a MEWA. These include:

(1) The plan cannot utilize the services of any licensed insurance agent or broker to solicit or enroll employers or pay a commission or other form of compensation to certain persons that is related to the volume or number of employers or individuals solicited or enrolled in the plan.

(2) A maximum 15 percent rule applies to the number of covered individuals in the plan who are not employees (or their beneficiaries) within a bargaining unit covered by any of the collective bargaining agreements with a participating employer or who are not present or former employees (or their beneficiaries) of sponsoring employee organizations or employers who are or were a party to any of the collective bargaining agreements.

(3) The employee organization or other entity sponsoring the plan or arrangement must certify annually to the Secretary the plan has met the previous requirements.

(4) If the plan or arrangement is not fully insured, it must be a multiemployer plan meeting specific requirements of the Labor Management Relations Act (i.e., the requirement for joint labor-management trusteeship under section 302(c)(5)(B)).

(5) If the plan or arrangement is not in effect as of the date of enactment, the employee organization or other entity sponsoring the plan or arrangement must have existed for at least 3 years or have been affiliated with another employee organization in existence for at least 3 years, or demonstrate to the Secretary that certain of the above requirements have been met.

Sec. 166. Treatment of church plans.

This section adds a new section 709 to ERISA permitting church plans to voluntarily elect to apply to the Department of Labor for an exemption under section 514(b)(6)(B) and in accordance with new ERISA Part 7. An exempted church plan would, with certain exceptions, have to comply with the provisions of ERISA Title I in order to receive an exception from state law. The election to be covered by ERISA would be irrevocable. A church plan is covered under this section if the plan provides benefits which include medical care and some or all of the benefits are not fully insured.

Sec. 167. Enforcement provisions relating to multiple employer welfare arrangements.

This section amends specific provisions of ERISA to establish enforcement provisions relating to the multiple employer elements of the bill: (1) a civil penalty applies for failure of MEWAs to file registration statements under section 169 of the bill; (2) the section provides for State enforcement through Federal courts with respect to violations by multiple employer health plans, subject to the existence of enforcement agreements described in section 168 below; (3) willful misrepresentation that an entity is an exempted

MEWA or collectively-bargained arrangement may result in criminal penalties; (4) the section provides for cease activity orders for arrangements found to be neither licensed, registered, or otherwise approved under State insurance law, or operating in accordance with the terms of an exemption granted by the Secretary under new part 7; and (5) the section provides for the responsibility of the fiduciary or board of trustees of a MEHP to comply with the required claims procedure under ERISA.

Sec. 168. Cooperation between Federal and State authorities.

This section amends section 506 of ERISA (relating to coordination and responsibility of agencies enforcing ERISA and related laws) to specify State responsibility with respect to self-insured Multiple Employer Health Plans and Voluntary Health Insurance Associations. A State may enter into an agreement with the Secretary for delegation to the State of some or all of the Secretary's authority to enforce provisions of ERISA applicable to exempted MEHPs or to VHIAs. The Secretary is required to enter into the agreement if the Secretary determines that delegation to the State would not result in a lower level or quality of enforcement. However, if the Secretary delegates authority to a State, the Secretary can continue to exercise such authority concurrently with the State. The Secretary is required to provide enforcement assistance to the States with respect to MEWAs.

Sec. 169. Filing requirements for multiple employer welfare arrangements offering health benefits.

This section amends the reporting and disclosure requirements of ERISA to require MEWAs offering health benefits to file with the Secretary a registration statement within 60 days before beginning operations (for those starting on or after January 1, 1997) and no later than February 15 of each year. The section also requires MEWAs providing medical care to issue to participating employers certain information including summary plan descriptions, contribution rates, and the status of the arrangement (whether fully-insured or an exempted self-insured plan).

Sec. 170. Single annual filing for all participating employers.

This section amends ERISA's section 110 (relating to alternative methods of compliance with reporting and disclosure requirements) to provide for a single annual filing for all participating employers of fully insured MEWAs.

Sec. 171. Effective date; transitional rule.

This section provides that, in general, the amendments made by this title are effective January 1, 1998. In addition, the Secretary is required to issue all regulations needed to carry out the amendments before January 1, 1998. The section provides for transition rules for self-insured MEWAs in operation as of the effective date so that those applying to the Secretary for an exemption from State regulation are deemed to be excluded for a period not to exceed 18 months unless the Secretary denies the exemption or finds the MEWAs application deficient, provided that the arrangement does not have pending against it an enforcement action by a state. The Secretary can revoke the exemption at any time if it would be detrimental to the interests of individuals covered under the Act.

Subtitle D—Definitions; General Provisions

Sec. 191. Definitions; scope of coverage, and

Sec. 192. State flexibility to provide greater protection.

In addition to providing definitions of terms used in this title of the Act, this subtitle provides that, subject to the ERISA savings clause below, nothing in Subtitle A, B, or D should be construed to preempt state laws: (1) that relate to matters not specifically addressed in such subtitles, (2) that require insurers or HMOs to impose a limitation or exclusion of benefits relating to the treatment of a preexisting condition period for a period that is shorter than the applicable period provided under such subtitles; (3) that allow individuals, participants, and beneficiaries to be considered to be in a period of previous qualifying coverage if such individual, participant, or beneficiary experiences a lapse in coverage that is greater than the 60-day periods provided for under sections 101 and 102, or (4) that, in defining ''preexisting condition'' to have a look-back period that is shorter than 6 months. The ERISA savings clause states that, except as provided specifically in subtitle C, nothing in this Act shall be construed to affect or modify the provisions of section 514 of ERISA (relating to federal preemption of state laws relating to employee benefit plans).

Sec. 193. Effective Date.

In general, except as otherwise provided for in this title, the provisions of this title would apply with respect to: (1) group health plans and health insurance coverage offered in connection with group health plans, for plan years beginning on or after January 1, 1998; and (2) individual insurance coverage issued, renewed, in effect, or operated on or after January 1, 1998.

The Secretaries of HHS, Treasury, and Labor would be required to issue regulations on a timely basis as may be required to carry out this title.

Sec. 194. Rule of Construction.

Nothing in this title or any amendment made thereby may be construed to require the coverage of any specific procedure, treatment, or service as part of a group health plan or health insurance coverage under this title or through regulation.

Mr. CLAY. Mr. Speaker, I yield 3 minutes to the gentleman from Texas, Mr. GENE GREEN.

Mr. GENE GREEN of Texas. Mr. Speaker, I would like to thank my colleague and ranking member from Missouri for yielding me the time.

Mr. Speaker, I rise in opposition to H.R. 3103, and a little background. I was honored to serve 20 years in the Texas legislature, Mr. Speaker, and work for many of those years with the statehouse members to beef up and strengthen our State health insurance regulation laws so that people who buy group insurance would know what they are purchasing. Here today I see this bill would actually abolish that protection, not only in the State of Texas, but State legislatures all over the country have worked for many years to provide and strengthen State oversight of these laws.

Mr. Speaker, yesterday I asked the Committee on Rules to make in order my amendment striking the preemption of these multiple employer welfare arrangements, also known as the MEWA insurance laws, because what happens now is in all of our States, we regulate them. This bill will take away that State regulation and move it to Washington to definitely a universal national standard developed and implemented from Washington and will replace these carefully crafted local State insurance laws that meet the needs of our local States and not necessarily what is from Washington.

Mr. Speaker, that is right. The majority of the Republicans want to move the regulation of these insurance laws from the States to an agency led by what one of my Republican colleagues said in his turn were Communists.

We hear a lot of rhetoric from the other side about giving more power to the States, and yet in this issue the Republicans want to take away the States' authority to regulate these health plans and give it to the Federal Government. While we have heard about local control rhetoric so much, the House Republicans want to expand the authority of the Department of Labor with these regulations.

In his own estimates, Secretary Reich will have to develop 26 new regulations to deal with the federalization of multiple employer welfare arrangements. The Federal Government got out of this business of regulating MEWA's in 1983 because the States were better equipped to deal with the high instances of fraud on the local level. But now we see this bill will preempt those States rights, and what will it mean to the average American family. State statutes requiring that certain benefits covered by health insurance policies may no longer apply.

Again, let me give an example from the State of Texas. In 1973 we changed the law that required insurance policies in Texas have to cover newborn infants. Up until then, a newborn infant had to survive 14 days before the group insurance policy would cover them. That was a mandated benefit, and this bill would possibly take that away unless the Department of Labor somehow says, OK, we are going to have this minimum benefit. This protection would be no longer available, at least on the local level, that the States have decided need to be provided to the purchasers of insurance.

Unlike block grants, States have tested and successfully regulated MEWA's, and there is no compelling reason or need to preempt State authority in this area.

Mr. CLAY. Mr. Speaker, I yield 3 minutes to the gentleman from New Jersey [Mr. ANDREWS].

(Mr. ANDREWS asked and was given permission to revise and extend his remarks.)

Mr. ANDREWS. Mr. Speaker, I would like to thank the gentleman from Missouri [Mr. CLAY], the ranking member, for yielding me this time.

Mr. Speaker, there are two sets of ideas before the House tonight. There is a set of ideas on which there is disagreement, whether we should limit the amount people can recover if they are a victim of malpractice; whether or not people should have medical savings accounts; whether or not there should be pooling arrangements for small businesses. There is legitimate disagreement about those things.

Then there is another set of ideas on which there is virtual unanimous agreement, broad consensus that we should make it illegal to say you cannot deny someone an insurance policy

because they have been sick, and that people should be able to take their insurance from job to job.

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Mr. Speaker, logical people would say that we put aside the things on which we cannot agree and debate about them and try to refine them and deal with them another day and then we take the things on which we do agree and pass them so we can send them to the President of the United States and make them law.

But we are not going to do that. What we are going to do tonight in the bill that is before us is take a lot of controversial provisions and maybe pass them out of here and send them to a conference that will, in likelihood, I believe they will wither on the vine and die.

Now, this is not just another cynical example of the cynical exercise of how politics is practiced in our country. It is more than that. It has a lot to do with real people in real families and their real lives.

Mr. Speaker, the American people understand this. A woman with breast cancer, a man who has had a triple bypass heart operation, a shipyard worker who has had asbestosis can be denied health insurance coverage now because the have been sick. If the substitute offered by the gentlewoman from New Jersey [Mrs. ROUKEMA] does not pass tonight, they can still be denied that coverage. We need to make it illegal, illegal for an insurance company in this country to say to that woman with breast cancer of that man with asbestosis or that person who has had the triple bypass operation that, we are not going to sell you a policy or that we are going to charge you the Moon and the stars to buy the policy. A unanimous vote in a Senate committee said they agreed with that. Dozens of Republicans and Democrats, if not hundreds around here, have said they agree with that. The President of the United States has said he would sign that. But unless the Roukema substitute passes, we are not going do do that.

Do the right thing tonight. Vote ''yes'' on the Roukema substitute and ''no'' on this bill.

Mr. CLAY. Mr. Speaker, I yield 2 minutes to the gentleman from New York [Mr. ENGEL].

Mr. ENGEL. Mr. Speaker, I thank the ranking member for yielding me this time.

Mr. Speaker, this bill ought to be defeated. We should be considering a clean version of the Kennedy-Kassebaum-Roukema health reform bill, and I would say that the reason we are not considering a clean version of the Kennedy-Kassebaum-Roukema health reform bill is because the Republican leadership really does not want to see health care reform come into law.

They really want to see it defeated. But, quite frankly, they do not have the guts to say it. So they are weighing this bill down with all kinds of extraneous things that do not belong in the bill, knowing full well that this will kill the bill.

The Senate is going to pass a clean version. The President has said he will sign a clean version, and yet what we are doing today is a political charade. We are not passing a clean version, we are deliberately not passing the version the Senate is passing, and we know that the President will not agree.

So it is a charade. And, again, the Republican leadership does not have the guts to say the truth. You know, the gentleman from Texas [Mr. DELAY], the Republican whip, had it right before, when he said on the House floor, and I quote the gentleman from Texas from his speech on the House floor, ''This is blatant politics and blatant hypocrisy.'' Except he was wrong in directing it to me and the Democrats. It seems to me the blatant, as the gentleman from Texas [Mr. DELAY] said, ''blatant politics and blatant hypocrisy'' is on the part of the gentleman from Texas [Mr. DELAY] and the Republican leadership because they do not have the guts to say we are against health care reform; instead, they are just weighing down this bill with a bunch of nonsense.

We believe that portability ought to become law. We believe that preexisting conditions is not a reason to deny people health care coverage. The Roukema bill does that. The Roukema bill will pass. The Roukema bill has the votes to pass, yet what they are doing is making it impossible for the Roukema bill to pass, and that to me is, quote, as the gentleman from Texas [Mr. DELAY] says, ''blatant politics and blatant hypocrisy.''

Mr. GOODLING. Mr. Speaker, I yield 1 minute to the gentlewoman from Kansas [Mrs. MEYERS].

(Mrs. MEYERS of Kansas asked and was given permission to revise and extend her remarks.)

Mrs. MEYERS of Kansas. Mr. Speaker, I rise in strong support of H.R. 3103 because it allows small employers to form Multiple Employer Health Plans [MEHPs] which can cross State lines. Small businesses operate closer to the bottom line than larger businesses, and are often unable to obtain coverage at any price. They pay higher premiums if they do obtain coverage, and cannot count on stable premiums.

MEHPs can self insure, in which case they would be required to register and maintain substantial capital reserves—a minimum of $400,000 or 25 percent of the expected claims—whichever was higher.

MEHPs would allow small employers to band together around the country, thereby avoiding expensive State-mandated benefits. Right now, small businesses pay up to 30 percent more in premiums than big businesses that can make use of ERISA exemptions.

The substitute does not allow small employers to form MEHPs across State lines.

I urge my colleagues to support 3103.

Mr. GOODLING. Mr. Speaker, I yield 1 minute to the gentleman from North Carolina [Mr. BALLENGER].

Mr. BALLENGER. Mr. Speaker, I thank the gentleman for yielding this time to me.

Mr. Speaker, I rise in strong support of H.R. 3103, and want to address the provisions relating to medical savings accounts for MSA's.

During the debate over the President's health care reform package during the 103d Congress, we saw that Americans view choice as fundamental to our health care system. By allowing people the chance to choose a high-deductible health insurance plan and to place the premium savings into a personal savings account, we are providing a way for people to manage their health care expenses. This plan would be used to cover major health costs while the savings account would cover routine and preventive care.

Under this bill, individuals could deposit up to $2,000 per year and could save, in the account, what they didn't use. Any withdrawals from the account for non-medical expenses would be taxable and subject to an early withdrawal penalty of 10 percent. Also, MSAs would allow patients to choose their own doctors and participate in their own care. These accounts belong to the individual and are portable during a job change.

Employers are currently able to offer MSA-like plans. However, unlike other traditional plans, the Government does not allow these plans to be tax deductible. MSAs should receive equal treatment, because recent studies indicate that these plans reduce the health care costs for employers by around 12 percent compared to traditional plans. This cost reduction directly enables employers to maintain quality health benefit plans to their employees at no additional charge. As we look for market-oriented ways to contain the costs of health care, MSAs should be viewed as an attractive option.

Mr. CLAY. Mr. Speaker, I yield 2 minutes to the gentleman from Indiana [Mr. ROEMER].

(Mr. ROEMER asked and was given permission to revise and extend his remarks.)

Mr. ROEMER. Mr. Speaker, I wish for once Members of Congress would put themselves in the shoes of hard-working Americans, whether those shoes are loafers or construction boots, and then Americans would work together to reform in a simplistic and bipartisan commonsense way our health care system.

Now, we have two choices tonight: We can either support H.R. 3103, a convoluted measure that is highly controversial, with all kinds of special-interest provisions that will never become law, or we can support a bipartisan provision from Senator KENNEDY, Senator KASSEBAUM, and the gentlewoman from New Jersey [Mrs. ROUKEMA].

There is a bipartisan approach, a commonsense approach to provide

portability, to provide health care for workers who lose their jobs. Let me give an example of why this is important. IBM has laid off 40,000 people; AT&T 40,000 people. These people are hard workers. They have children that may have diabetes or leukemia. And now health insurance companies can say, ''We don't want to cover you anymore.'' If you vote for the Roukema Bill, the Kennedy-Kassebaum bill, you will allow these hard-working Americans to take their insurance with them and to not let the insurance companies be prejudiced against these people.

Vote for our children. Vote for our hard-working people in America, and vote for commonsense bipartisanship.

Mr. GOODLING. Mr. Speaker, I yield 1 minute to the gentleman from Michigan [Mr. KNOLLENBERG].–

Mr. KNOLLENBERG. Mr. Speaker, I rise in strong support of H.R. 3103 and commend my colleague, the gentleman from Illinois [Mr. FAWELL] for his efforts in bringing this legislation, which is badly needed, to the floor.

H.R. 3103 is not about big insurance companies or some Government takeover, as some would suggest. It is about providing coverage for millions of uninsured, and it allows them to get it on an accessible and affordable basis.

H.R. 3103 is about providing insurance to those millions of people that are currently unable to get insurance. For too long this system has stacked the deck against small business. Big businesses, such as GM, IBM, I just heard, have had the luxury of providing employees insurance through self-insuring, while small businesses lack the resources to self-insure. This bill directly addresses the inequality by allowing small businesses to join together to self-insure.

Mr. Speaker, Kassebaum-Kennedy is a Cadillac coverage program, one size fits all, without affordability. I urge my colleagues to vote for H.R. 3103.

Mr. GOODLING. Mr. Speaker, I yield 1 minute to the gentleman from Florida [Mr. WELDON].

Mr. WELDON of Florida. Mr. Speaker, I thank the gentleman for yielding me this time.

I rise in strong support of this bill for a variety of different reasons, probably chief of which is that it will allow many small employers to pool their resources together and purchase health care benefits in bulk.

This is an advantage the has been held by large corporations for many years and has been denied small businesses, and, as a consequence of that, those small businesses have to pay a much higher premium and they therefore choose not to provide coverage.

I would like to also additionally briefly address the issue of medical savings accounts. We have heard a lot of discussion about how bad these supposedly are, but I would assert that if medical savings accounts were available to the employees that work for Members of the minority, the majority of their employees would select medical savings accounts because medical savings accounts truly give the health care consumer the freedom to choose how to spend their health care dollars. It has been shown repeatedly that they over and over save a considerable amount of money. One of the biggest problems in our health car system is the third-party payer system.

Mr. CLAY. Mr. Speaker, I yield the balance of my time to the gentleman from New York [Mr. OWENS].

(Mr. OWENS asked and was given permission to revise and extend his remarks.)

Mr. OWENS. Mr. Speaker, the Dingell-Kennedy-Kassebaum substitute is a modest but significant step forward for health care. I rise in support of the substitute.

It is good that we are here addressing problems such as portability or increased deductibility for small businesses and preexisting condition discrimination. These small steps forward are important, but the American people should not be misled.

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The noble goal of universal health care, health care for all Americans, is not being discussed tonight. The administration bill in the 103d Congress was striving to help Americans join the other civilized, industrialized nations and provide health care for the 43 million Americans who are not covered with any health care plan.

This bill moves us no closer to health care for everybody. Looming over all of us in our present health care system is the dangerous threat to the Medicaid entitlement. That is not being discussed, but the Medicaid entitlement is America's beachhead for universal health care. Even if we pass the highly desirable Kennedy-Kassebaum-Dingell substitute, we will be taking a giant step backward if we throw away the Medicaid entitlement within a few weeks.

The American people must not be swindled. Two actions are needed. Tonight we have to pass the substitute, and we also have to make certain that in the future, the next few weeks, we deny the Governors, the majority Republicans in this body, the opportunity to roll back the clock to destroy 30 years of good health care by eliminating the Medicaid entitlement. The Medicaid entitlement is absolutely necessary for the 43 million Americans who are not covered. The hope for those 43 million lies in keeping the Medicaid entitlement and expanding it.

This was the noble goal of the administration's bill in the 103d Congress. It was very difficult because they were looking to close that gap. It was very difficult because the 103d Congress proposal by the administration was attempting to have America join the other civilized industrialized nations for universal health care.

Mr. GOODLING. Mr. Speaker, I yield 1 minute to the gentleman from Delaware [Mr. CASTLE].

Mr. CASTLE. Mr. Speaker, I am proud to be an original cosponsor of H.R. 3103. Approximately 17 percent of our nonelderly population does not have health care insurance coverage in the United States of America. This very important piece of legislation decreases that rank of the uninsured, that 17 percent, by making health insurance more readily available and affordable. Many things we should have done many years ago: Guaranteeing the portability of health insurance for workers changing or leaving jobs, limiting the ability of insurers to use preexisting conditions to deny health insurance coverage, making health insurance more affordable by reforming malpractice laws and cracking down on fraud and abuse, and several other measures which are here.

This focused reform bill compliments the efforts of States to expand health insurance coverage within their borders rather than superseding them.

I would like to say a word or two about those who argue that this would kill Kassebaum-Kennedy. This bill does not kill what our colleagues in the Senate have accomplished. This bill builds upon the sound principles to expand availability contained in Kassebaum-Kennedy, but also addresses affordability, which is not addressed in that bill.

Mr. Speaker, I encourage all of us to support this excellent piece of legislation.

Mr. GOODLING. Mr. Speaker, I yield 30 seconds to the gentleman from Illinois [Mr. FAWELL].

Mr. FAWELL. Mr. Speaker, I think all one can say, I would just compliment the leadership on this side of the aisle. I would like to point out, too, that you will notice that no one, no one on this side of the aisle, criticized the legislation that that side is pushing. Yet I think it is fair to say we have had an abundance of criticism from that side.

We are simply asking that small employers have the rights that mid-sized and large employers have had for a long time, and that is to be able to self-insure. They preempt state law. You have heard it say there are 138 million people today under the ERISA law.

Mr. DEFAZIO. Mr. Speaker, I rise in opposition to H.R. 3103, the so-called ''Health Coverage Availability and Affordability Act,'' and in support of the Democratic substitute.

We all agree that the American system of health care is in dire need of an overhaul. Health care costs are skyrocketing out of control. Having doubled in the last decade, they're far beyond the reach of any American who's uninsured and can't afford exorbitant insurance premiums. Four million Americans lost health insurance between 1988 and 1994. Millions more are just a pinkslip away from losing all of their health care coverage.

There are provisions in H.R. 3103 that I support. I agree that it is high time Congress acts to correct some of the more egregious practices of insurance companies. Denying insurance to individuals because of pre-existing conditions, genetic information, or a history of

domestic violence is outrageous. It is a good start to ban these practices.

I've supported legislation that would correct these policies. I've authored legislation that would prohibit using domestic violence as a risk factor. I've also co-sponsored the Kennedy-Kassebaum-Roukema health care reform bill, which has the support of Senate Republicans and Democrats as well as the President.

The Democratic substitute would replace H.R. 3103 with language from the Kennedy-Kassebaum-Roukema bill. This bill would expand access to health insurance for Americans by increasing portability and limiting insurance companies' ability to deny coverage because of pre-existing conditions. The political consensus for the Kennedy-Kassebaum-Roukema bill means that it could become law in a matter of weeks.

But H.R. 3103 embraces controversial, divisive policies that doom any chance of insurance reform and minimal health security for the American people.

As a long-time advocate of fiscal responsibility, I must oppose the provisions in this bill establishing generous Medical Savings Accounts [MSAs]. The MSAs would result in a significant loss of taxpayer dollars without a substantial revenue offset. Under this bill, individuals could deposit up to $2,000 annually and families up to $4,000 in tax-free MSAs. The Joint Committee on Taxation has estimated that this provision alone would cost the U.S. taxpayers approximately $2 billion. This flies in the face of the deficit reduction goals to which this Congress purports to aspire.

The Republican leadership counters that the bill contains budgetary savings to offset the revenue loss from MSAs. This assertion is laughable and cynical. The budgetary savings are achieved through ''reforms'' in the Medicare program—the health plan for America's senior citizens. This is the same Medicare program that the Republicans claim is in such a dire financial crisis.

Any savings achieved through Medicare reforms should be used to shore up the Medicare trust fund. Failing that, these savings should be used to lower deductibles and increase benefits for Medicare beneficiaries. It makes no sense to use this savings to offset a tax break for the limited number of individuals who can afford MSAs.

Individuals who choose to open MSAs will likely be healthier, wealthier and younger than average. Unfortunately, the majority of the Medicare population is among the older and sicker and would not benefit from MSAs. The Republican leadership's bill would, therefore, steal money from Medicare recipients to pay for tax breaks for healthier Americans.

Ironically, H.R. 3103 would also remove state oversight and replace it with Federal regulation to advantage insurance companies. This would be a severe blow to the States' rights movement. For the past year we have heard Republicans disparage the role of the Federal Government. Yet, under this legislation, the Republican leadership conveniently tosses aside this argument in favor of Federal supremacy over insurance coverage. This legislation preempts existing state insurance reforms and State regulation of self-funded multiple employer plans [MEWAs].

In Oregon, local leaders have developed a series of health care initiatives with the active support of insurers, consumers and the business community. H.R. 3103 could seriously jeopardize these reforms, as well as reforms already enacted in other States.

Every American should have lifetime access to quality, affordable health care. All of our major economic competitors have adopted comprehensive health care reforms. Surely the United States of America, the greatest industrial power on Earth, can adopt the minimal protections in the Kennedy-Kassebaum-Roukema bill.

If you truly want to bring some relief to our constituents, I urge my colleagues to support the Democratic substitute which would replace the controversial Republican leadership's proposal with the language in the Kennedy-Kassebaum-Roukema bill.

Mr. CLINGER. Mr. Speaker, I rise in strong support of the ''Health Coverage Availability and Affordability Act of 1996.'' This legislation takes very practical, needed steps to ensure working Americans that they will always have access to health insurance regardless of their health, their family's health, or their employer. H.R. 3103 will ensure Americans portability and renewability of their health coverage while eliminating the fear of losing coverage because of pre-existing condition limitations when changing or losing a job.

I am particularly pleased to see provisions in the bill that set tough policies to combat health care fraud and abuse. Recent studies estimate that overcharging, double billing, and charging for services not rendered to patients cost consumers up to 10 percent of every health care dollar spent. This results in both higher health care costs and insurance premiums for everyone.

Under H.R. 3103, penalties for defrauding the Government through Federal health care programs, such as Medicare and Medicaid, will be stiffened. Furthermore, the bill will require the Secretary of Health and Human Services and the Attorney General to jointly establish a national health care fraud and abuse control program to coordinate Federal, State and local law enforcement to combat fraud with respect to health plans.

In addition, the ''Health Coverage Availability and Affordability Act of 1996'' will require the Secretary of Health and Human Services to exclude from Medicare and State health care programs for a minimum of 5 years individuals and entities who have been convicted of felony offenses relating to health care fraud; require the Secretary to provide beneficiaries with an explanation of each item or service for which payment was made under Medicare; and require the Secretary to establish a program to encourage individuals to report suspected fraud and abuse in the Medicare program.

I firmly believe that the fraud and abuse provisions in H.R. 3103 are long overdue and represent a serious effort to reduce fraudulent activity, which drives up the cost of health care for everyone. The Government Reform and Oversight Committee, which I chair, has held several hearings on this very issue, and I feel strongly that we need to act now to crack down on health care fraud and abuse.

Also, as a representative of a largely rural district, I am pleased to see provisions in H.R. 3103 that will allow small businesses to join together to form purchasing cooperatives. This provision exempts small businesses from certain State insurance regulations—an exemption that big business now enjoys. This change will make health insurance affordable for small businesses who cannot afford it at the present time—a problem that is particularly noticeable in rural areas. Some predict that small employers will be able to cut their business premiums by as much as a third, even while paying State premium taxes, which is provided for under the bill. This provision will certainly increase access to quality health care to rural individuals.

Again, I urge my colleagues to support this sensible, responsible approach to health care reform.

Mr. GILMAN. Mr. Speaker, I rise in strong support of H.R. 3103, the Health Coverage Availability and Affordability Act and urge my colleagues to support this well intentioned bill.

As one of the Republican cosponsors of the Roukema/Kassebaum/Kennedy portability measure, I am acutely aware of the need for Congress to approve a health coverage measure which will ensure working people and families that they will always have access to health insurance regardless of their health, their family's health, or their employer. Accordingly, I commend my colleague, Representative ROUKEMA, for her efforts in the House to bring this portability measure before the House today.

Similarly, I am pleased that the House will have an opportunity to make a good bill better. In addition to making health insurance more available to all Americans, H.R. 3103 makes it more affordable and provides more choices.

H.R. 3103 will provide incentives to encourage individuals, and their employers, to make tax deductible contributions—in lieu of health insurance premiums—to a specialized savings account [MSA] to be used at a later date for health expenses; it increases penalties for fraud and abuse of the federally-funded health care system; and allows self employed individuals and small businesses to voluntarily associate to purchase health insurance which would be available to all member organizations.

All of these provisions mentioned above will help our Nation's farmers, self-employed, and small business entrepreneurs to provide health insurance for their families and employees.

Though H.R. 3103 may not be a perfect bill it does provide important health insurance reforms that will ensure broad health coverage for our constituents.

Furthermore, this measure is a step in the right direction. I look forward to working further with my colleagues on health care reform measures which will protect those Americans who currently do not have health insurance coverage.

I urge my colleagues to support H.R. 3103.

Mr. STENHOLM. Mr. Speaker, in an effort to keep health insurance reform moving through the legislative process, I rise with some reservation to support H.R. 3103, the Health Coverage Availability Act of 1996.

My record clearly reflects my strong support of health insurance reform. In addition to efforts on rural health issues and system-wide reform, I have worked for many years to make health insurance both accessible and affordable for millions of underserved Americans, many of whom reside in the 17th District of Texas. In one very recent example, I heard from a constituent who has been employed since 1954, working the last 10 years with her sister in a bookkeeping and secretarial business. At one point, she had hospitalization insurance, but the price of the policy continually

increased to the point that she finally had to drop it because she could no longer afford it. She now worries about the health and economic vulnerability of her situation.

While this legislation does not specifically address all of her needs, I believe certain provisions such as portability of health insurance, limitation on pre-existing conditions, increased tax deductibility for the self-employed, and guaranteed availability of insurance for small employers, are definitely steps in the right direction.

Because the Senate has taken the lead on a health insurance reform bill which the President has pledged to sign, I must express my concerns about the political ramifications of loading this bill down with some of the more controversial issues that have been included here today. I recall just a few years ago, during a similar health care debate, when my friends on the other side of the aisle were criticizing Democrats for ''overreaching'' on health care reform proposals. Now, I fear we are back to square one.

Like many Members of this body, I would like to see additional health care reforms, including reforms to develop rural health networks and preserve rural health services. Facing political reality, however, I realize that this might not be the proper vehicle to achieve these goals.

I am also concerned that rather than promoting the goals of greater health insurance access and affordability, some provisions in this bill may have the reverse impact in the long run because sufficient safeguards were not added to the provisions. For example, I have strongly supported small employer pooling arrangements with effective certification and solvency standards, as well as protections to ensure that the pool is large enough to manage risk. However, I am worried that the pooling section of this legislation fails to meet those concerns.

I am especially concerned that the bill we are considering today includes provisions and changes which were made after the Committees of jurisdiction reported out their components of the bill.

While I am not convinced that this House bill meets many of my concerns, I do believe that these issues can be worked out in conference. Therefore, in the spirit of keeping the process moving forward, I intend to vote yes on final passage. It is my hope that we not let another opportunity to achieve some type of bipartisan health care reform pass us by, simply because we again overreach the boundaries of consensus. That is why I am cautiously supporting H.R. 3103, with the hope that the conference committee will inject bipartisan commonsense into the process and develop a health insurance reform bill that will get a Presidential signature.

After all, without both a congressional majority and a Presidential signature, my constituents in the 17th district, or Americans anywhere else, will receive no benefit from this political exercise. In the final analysis, I would hope that the ultimate goal for us all is weighed not in political, special interest terms, but in terms of caring for the health needs of our un- and under-insured populations.

Mr. HORN. Mr. Speaker, there has been a campaign of misinformation about this legislation. Americans have been told that this bill would deny them continued health insurance coverage for alternative medical treatments. This is untrue.

This bill does not deal with health insurance coverage for alternative medical treatments. This is an issue that must be addressed by the States. H.R. 3103 only requires that each State implement a mechanism to ensure individual coverage.

This bill does increase choices for health care delivery systems by providing for medical savings accounts. With these accounts, Americans can utilize their health care dollars for whatever treatment fits their needs. That is the way to ensure that alternative medical treatments remain available for anyone who wants them.

Mr. FRANKS of Connecticut. Mr. Speaker, H.R. 3103, the Health Care Coverage Availability and Affordability Act will ensure that Americans have access to health care coverage. More importantly, however, the bill will insure that people do not lose their insurance coverage when they switch jobs.

During the March 17th hearing this subcommittee held on insurance reform I stated that I had worked for both small businesses and for Fortune 500 companies. During my tenure in the business world I saw first hand the concern of individuals who have worked hard and suddenly found themselves without employment or insurance coverage. These individuals worry about how they will make their insurance payments to COBRA. COBRA benefits are supposed to cover individuals during periods of unemployment, but without a job how can the individual keep up his or her COBRA payments. They can't, so they simply slip through the cracks in our insurance industry. These are the individuals that we must be most concerned with.

This same scenario can be applied to the self employed. Should a self-employed individual's company fail, what would happen during the period of unemployment. I have recently reintroduced legislation I sponsored during the 103d Congress. My bill would allow us to look at the situation I just described in a similar fashion to the way in which we look at unemployment compensation, with the exception that the employer will not have to contribute. While a person is employed, why not have that person make contributions to an uninsurance trust. The employee would be able to contribute money to the trust and then access it during periods of unemployment. We also need this kind of return.

The bill before us today brings about much-needed reform to the insurance industry in this country. It addresses such important issues as portability and pre-existing conditions. Individuals will no longer have to remain in a job they do not like in order to maintain insurance coverage. Under this bill if an individual changes jobs his or her insurance coverage will follow. Also, according to this bill insurance companies will no longer be able to deny coverage to individuals with pre-existing conditions.

H.R. 3103 addresses the problem of medical malpractice as well. The bill establishes uniform standards for health care liability suits brought in court. Malpractice lawsuit awards are capped at $250,000 for non-economic damages and $250,000 or three times the non-economic damages for punitive damages. This capping of damages will aid in driving down health care costs.

This bill will allow organizations, like trade associations, to voluntarily associate to purchase health care insurance. This insurance would then be available to all member organizations. The voluntary association organizations for the purpose of buying health insurance will allow them to increase their purchasing power, thus allowing them to purchase insurance at a significant savings.

The bill provides relief for self-employed individuals by allowing them to deduct increasing percentages of their health insurance costs from their income taxes. This provision, like many of the others contained in this bill, will make the purchasing of health insurance more affordable. This is especially important for self-employed individuals because all too often they fall through the cracks in our health insurance industry.

Penalties for fraud and abuse of the federally funded health care system are increased under this legislation. Overcharging, double billing, and charging for services not rendered has become too prevalent. These types of fraud cost consumes 5 to 10 percent of ever health care dollar. This results in higher health care costs as well as higher in insurance premiums.

Finally the bill allows for the establishment of medical savings accounts, MSA's. MSA's will bring about changes to health insurance. These accounts will place the consumer in charge of his or her health care. The consumer will have total control over his or her health care. This will allow the consumer to spend his or her health care dollars as he or she wants.

Mr. Speaker, the legislation before us takes important steps toward reforming the health insurance industry in this country. I applaud this legislation and look forward to its passage. Thank you and I yield back the balance of my time.

Mr. OXLEY. Mr. Speaker, I rise today in support of the Health Coverage Availability and Affordability Act of 1996. This bill includes provisions I have long supported on paperwork reduction.

I am pleased to see that today, the House will have the opportunity to vote on these and other needed reforms. Legislation aimed at making health insurance more available and affordable while reducing administrative paperwork is long overdue. While President George Bush introduced similar legislation in 1992, the then Democrat-controlled Congress blocked its consideration. It was not until the defeat of President Clinton's nationalized health care system that a consensus coalesced around these market-based reforms.

Currently, excessive paperwork, redtape, and duplicative administrative costs add nearly 10 cents to every health care dollar spent in the United States. In response to this concern I introduced legislation during the 102d Congress, along with our former colleague, Alex McMillan, to reduce these unnecessary costs through the establishment of uniform health claims and electronic billing standards.

Following this first ever free-standing bill on billing simplification, my Ohio colleague, DAVE HOBSON, took up the cause, improving upon our efforts. Congressman HOBSON's work has been integral in the promotion of the benefits of a uniform electronic billing system.

Mr. Speaker, I support the passage of the Health Care Coverage Availability and Affordability Act. American working families need and deserve the flexibility and cost-saving measures this bill provides.

Mr. PARKER. I want to congratulate the many Members who have been instrumental

in bringing to the floor this important health care reform legislation.

In the 103d Congress, a number of us worked diligently on a similar, incremental package that would have corrected many identifiable problems in our health care delivery system.

Unfortunately, we never had an opportunity to vote on such a measure.

Today, however, I am pleased that we will finally be able to tell our constituents that help is on the way—changes will be made to address many of their health care concerns.

The passage of this legislation will assure people that they can change jobs and obtain group health insurance coverage through a new employer, without pre-existing condition limitations.

For those individuals who are between jobs and have been unable to obtain coverage due to a pre-existing condition, this bill will make it possible for them to do so.

For small employers, new pooling arrangements and an increased deduction for health insurance premiums will make it easier for them to purchase insurance coverage for their employees.

For individuals and families, medical savings accounts will now be available that allow them to control their own health care decisions and costs.

And for the many States like my own that provide health care coverage for uninsured high-risk individuals, this bill will clarify the tax-exempt status of State-established health insurance risk pools.

Currently, such risk pools are not automatically exempt from Federal income taxes.

This bill provides the necessary legislative fix to assist States in making much-needed medical insurance available to uninsurable residents.

Of course this bill, like the proposal I worked on in the last Congress, also includes provisions addressing such important needs as administrative simplification, fraud and abuse elimination, and medical malpractice reform.

In closing, we are taking the critical first steps toward a health care delivery system that is more accessible and affordable.

H.R. 3103 establishes a strong foundation on which future reforms in our health care delivery system can be based.

We should not let this opportunity to improve the Nation's health care system slip away once again.

Mr. CONYERS. Mr. Speaker, medical malpractice is a widespread and serious problem in our society. Studies have established that it is the third leading cause of preventable death, second only to those deaths associated with cigarette smoking and alcohol abuse. More than 1.3 million hospitalized Americans, or nearly 1 in 25, are estimated to be injured annually by medical treatment, and about 100,000 such patients, or 1 in 400, die each year as a direct result of such injuries.

Unfortunately, in federalizing this state law matter, the Republican proposals would absolutely decimate the protections the states have provided for against medical malpractice and other forms of misconduct. A summary of these provisions follows:

A. Statute of Limitations/§ 281—Prohibits victims from bringing any state health care liability action more than two years after an injury is discovered or five years after the negligent conduct that caused the injury first occurred. Such a proposed new federal statute of limitations takes no account of the fact that many injuries caused by medical malpractice or faulty drugs often take years to manifest themselves. Thus under the proposal, a patient who is negligently inflicted with HIV-infected blood and develops AIDs six years later would be forever barred from filing a medical malpractice or product liability claim.

B. $250,000 Cap on Non-economic Damages/§ 282(a)(1)—Caps the award of non-economic damages in medical malpractice actions at $250,000. The bulk of data indicates that dollar caps do not provide significant savings. Using information derived from a 1992 GAO study, the ABA's Special Committee on Medical Professional Liability found that state tort reform proposals ''have not had any measurable impact on overall health [care] costs'' and that personal health care spending had doubled between 1982 and 1990, regardless of the type of ''reforms'' adopted. A 1986 GAO study on the impact of specific tort changes on medical malpractice claims revealed that claims and insurance costs continue to rise despite state-adopted limits on victim compensation.

Even the total elimination of malpractice costs would provide only negligible savings to the health care system. According to separate reviews by the U.S. Department of Health and Human Services and CBO, the total amount of *all* liability premiums paid in the United States represents less than 1% of the Nation's health care costs. And factoring in the costs of so-called ''defensive medicine'' would not result in any significant additional savings to the health care system, according to both the CBO and the Congressional Office of Technology Assessment.

An additional concern with caps on non-economic damages is that they could unfairly penalize those victims who suffer the most severe injury and are most in need of financial security. Although harder to scientifically measure, non-economic damages compensate victims for real losses—such as loss of sight, disfigurement, inability to bear children, incontinence, inability to feed or bathe oneself, or loss of a limb—that are not accounted for in lost wages. And non-economic damage caps have been found to have a disproportionately negative impact on women, minorities, the poor, the young, and the unemployed; since they generally have less wages, a greater proportion of their losses is non-economic.

C. Joint and Several Liability/§ 282(a)(2)—Eliminates the state doctrine of joint and several liability for non-economic damages. This will allow wrongdoers to profit at the expense of innocent victims, rather than forcing tortfeasors to allocate liability among themselves, as has traditionally been the case under state law. And since women, minorities, and the poor generally earn less wages, such limitations on non-economic damages could have a disproportionately negative impact on these groups.

D. Limits on Punitive Damages/§ 282(b)—Caps punitive damage awards at the greater of $250,000 or three times economic damages; limit the state law standard for the award of punitive damages to intentional or ''consciously indifferent'' conduct; allow a bifurcated proceeding to determine issues relating to punitive damages; and completely ban punitive damages in the case of drugs or other devices that have been approved by the FDA or any other drug ''generally recognized as safe and effective'' pursuant to FDA-established conditions.

These proposed limitations raise a number of concerns. Arbitrary caps on punitive damages may provide unjustified windfalls to the few tortfeasors responsible for blatant and wanton medical misconduct. (In fact, studies have shown that only 265 medical malpractice punitive awards were awarded in the United States in the 30 years between 1963 and 1993.) By insulating grossly negligent conduct, the proposed new federal standard for establishing punitive damages comes close to criminalizing tort law. Permitting defendants to bifurcate proceedings concerning the award of punitive damages may well lead to far more costly and time-consuming proceedings, again working to the disadvantage of injured victims. And banning punitive damages for FDA-approved products is likely to have a disproportionate impact on women, since they make up the largest class of victims of medical products.

E. Periodic Payments/§ 282(c)—Grants wrongdoers the option of paying damage awards in excess of $50,000 on a periodic basis. This provision would apply not only to future economic damages realized over time, such as lost wages, but to non-economic losses, like the loss of a limb, that are realized all at once. Also, in contrast to many state law periodic payment provisions, the Republican proposal does not seek to protect the victim from the risk of nonpayment resulting from future insolvency by the wrongdoer or to specify that future payments should be increased to account for inflation or to reflect changed circumstances.

F. Collateral Source and Subrogation/§ 282(d)—In most states under the collateral source rule, a victim is able to obtain compensation for the full amount of damages incurred, and his or her health insurance provider is able to seek subrogation in respect of its own payments to the victim. This ensures that the true cost of damages lies with the wrongdoer while eliminating the possibility of double recovery by the victim. The Republican proposal would turn this system on its head by allowing tortfeasors to introduce evidence of potential collateral payments owing from the insurer to the victim. This could have the effect of shifting costs from negligent doctors to the health insurance system in general and taxpayers in particular, resulting in increased health premiums paid by workers and businesses.

Another problematic feature of Republican malpractice proposals has been their one-sided, anti-victim nature. For example, their proposal allows States to enact more restrictive caps and damage limitations, but not permit the states freedom to grant victims any greater legal rights. Their proposals also ignore a number of complex legal issues. For example, in the state law context, various damage caps have been held to violate state constitutional guarantees relating to equal protection, due process, and rights of trial by jury and access to the courts; and these very same concerns are likely to be present at the federal level. And by layering a system of federal rules on top of a two-century-old system of state common law, the Republican proposals will inevitably lead to confusing conflicts, not only within the federal and state courts, but between federal and state courts.

I urge opposition to these proposals which would harm victims and insulate wrongdoers from liability.

Mr. NEAL of Massachusetts. Mr. Speaker, one lesson that both Democrats and Republicans learned from the health care reform debate in the 103d Congress is that retaining access to affordable health insurance is an anxiety that plagues most American families.

We exhausted the health care debate a few years ago in this Congress searching for ways to do it all—to make health care cheaper, better, and more accessible for everyone. And though we didn't pass health care reform legislation at that time, the fact that we are here today talking about limiting pre-existing condition exclusions and making health insurance portable—two consensus issues that Democrats and Republicans both support—is proof that our efforts did not fail.

I'd like to take a moment today to applaud our President for choosing to act upon America's health care concerns, and for having the courage to bring the issue of health care reform to the forefront of our national agenda.

The United States, and Massachusetts in particular, is home to the best quality health care in the world, and it is our job as Members of this House to make quality care available to Americans. The pre-existing condition limits and portability provisions in this bill meet this goal.

We also have a unique opportunity today to make health insurance more affordable to the self-employed by increasing the deductibility of health insurance premiums. Under current law, the self-employed are allowed a 30 percent deduction. The bill before us today gradually increases the deduction to 50 percent and 50 percent is not phased in until 2003.

The Democratic substitute addresses this issue in a more sensible and equitable manner. The Democratic substitute would increase the deduction to 50 percent in 1997 and 80 percent in 2002. Affordability is the greatest barrier to expanding health coverage. Increasing the deduction to 50 percent in 1997 will help make insurance affordable to those who lack coverage. Now, the self-employed may be able to fit into their budget the cost of health insurance.

Equity in the tax code should be one of our primary focuses. Corporations are allowed to deduct 100 percent of the cost of providing health insurance. Narrowing the gap between corporations and the self-employed restores greater tax equity.

Self-employed businesses range in spectrum from family farms to sole practitioners. These businesses are a vital part of our economy. We need to make health care affordable for them.

I urge you to support the Democratic substitute which tackles the issues where there is agreement and will make a difference in the health care of Americans.

Mrs. VUCANOVICH. Mr. Speaker, it took many years of debate, and thousands of town hall meetings, but by George, I think we've got it.

Congress has finally stepped up to the plate to ensure that Americans are able to obtain health insurance. Too many Americans are shut out of health care insurance because of preexisting conditions, or because they change jobs. With one swing of the bat in the first inning of the game, we have successfully completed a ''Triple A''—much better than a triple play. The bill provides ''A''-vailability, ''A''-ffordability and ''A''-ccountability. It helps employees who try to obtain health insurance, employers who try to provide health insurance, and the bill tackles the high cost of health care.

It makes good on promises by raising the health deduction for self-employed to 50 percent by the year 2003, provides citizens the opportunity to contribute to Medical Savings Accounts, and allows individuals to deduct long-term care expenses.

The House Committees' team has made the advancement up to third base, and it's up to the rest of us to take it home. I urge my colleagues and teammates to support this historic bill.

Mr. CUNNINGHAM. Mr. Speaker, today I rise in support of Health Coverage Availability and Affordability Act, H.R. 3103, particularly the provisions which will provide small employers with the ability to reduce health insurance costs through the formation of multiple employer arrangements [MEWAs]. H.R. 3103 will bring affordable health care to millions of Americans who currently are uninsured, and will also provide greater assurance that those who already have health coverage will not lose it when they change jobs.

Without the small employer pooling provisions, any incremental health reform measure only addresses the problem of security for those who currently have health insurance. However, by providing small business with the same tools that are already available to large corporations in obtaining health coverage, we can also help the problem of the uninsured.

Eighty-five percent of the forty million uninsured are persons in families with at least one employed worker, and the majority of these workers are employed in small businesses. As small business becomes a larger portion of the economy, more and more people will find themselves employed by smaller companies. Thus, if we are ever going to make health coverage affordable for the uninsured, it is imperative that we provide small business with the same opportunities that already are available to large corporations for keeping health costs down.

Small employer pooling arrangements must operate uniformly across state lines, just like large employer arrangements do currently. We must provide a market-oriented, 21st century solution to the problem of the uninsured.

I urge you to vote in favor of H.R. 3103 to increase health care security and affordability for American workers.

Mr. LAZIO of New York. Mr. Speaker, I rise today in proud support of H.R. 3103, the Health Coverage & Affordability Act of 1996, of which I am a cosponsor.

This is a day which I have been looking forward to since I first took office over 3 years ago. Today, we are taking a long overdue step to provide real, substantive change to our health care system which will help working class families across America, and in my home district of Long Island.

For far too long, many Americans have worried that losing a job or having a preexisting condition would jeopardize the portability of their health insurance.

Because of this bill, workers will continue to have coverage if they change or lose their job—even with preexisting conditions. General Accounting Office [GAO] statistics show that 12 million workers with employer-based insurance leave their jobs every year, and millions more lose their jobs. H.R. 3103 would benefit up to 25 million Americans per year, including those who face job-lock, by eliminating the preexisting condition exclusions for persons with prior health insurance coverage.

An important feature of H.R. 3103 will eliminate discrimination based on genetic information. This would allow thousands of men and women to undergo genetic testing needed to preserve their health without fear of losing their health insurance or not being able to acquire it. This protection is essential for the women of Long Island, where instances of breast cancer are among the highest in the country. With H.R. 3103 in place, these women can be tested for BRCA–1, a gene linked to the disease, without fear of losing the insurance needed to meet their medical needs.

As a result of our efforts today, health care will become more affordable. H.R. 3103 tackles the problem created by rampant fraud and lawsuit abuse that drives up the cost, and will increase penalties for those who commit fraud and abuse. Importantly, this bill also increases the health insurance deduction for self-employed individuals from 30 percent to 50 percent by 2003, and allows taxpayers to make tax-deductible contributions to a medical savings account.

I urge my colleagues to support this bill and these reforms which will ease some of those worries of families who are already being squeezed by high taxes and falling wages by ensuring availability, affordability, and accountability to those who receive health care through their jobs. The American people deserve this and we owe it to them to pass it by a wide bi-partisan margin.

Mr. KLECZKA. Mr. Speaker, Americans will today witness firsthand an overt effort by the Republican leadership to sink a much-needed piece of legislation for the sake of preserving their cozy relationship with special-interests. A perfectly good insurance reform bill introduced by Senators KENNEDY and KASSEBAUM and Representative ROUKEMA in the House has been loaded with extra, controversial provisions that will make it difficult, if not impossible, to pass into law.

While modest, the original bill could help 21 million Americans by waiving the pre-existing condition exclusions for individuals who have had continuous health coverage. As many as 4 million people who are currently ''locked'' into their jobs for fear of losing needed health coverage for themselves or their family would benefit from the bill's national portability standards.

Yet, despite the fact that this bill will benefit 25 million Americans, Republicans in the House do not support it. In the Ways and Means Committee, the Kennedy-Kassebaum-Roukema bill did not receive one Republican vote. Apparently, 25 million hard-working Americans are not enough to convince the GOP that we need this legislation. Evidently,

unless it has the blessing of the Health Insurance Association of America it is not worth voting for.

Why else would these Members condition their support for insurance reform on adding ''sweeteners'' like medical liability provisions that limit the legal rights of malpractice victims? Why do we need to permit insurance companies to sell Medicare beneficiaries unnecessary and costly policies that duplicate benefits they already have?

The Republican bill (H.R. 3103) includes other items that will likely meet strong opposition in the Senate, namely, controversial provisions that effectively limit the ability of States to enact health care reforms by pre-empting existing state regulations on multi-employer health plans. Already, a large percentage of employers are exempt from state reforms under the ERISA. With this provision, Congress takes even more health plans out of states' reach.

This add-on is especially puzzling since it flies in the face of the States' rights argument we have been hearing over and over from the Republicans. They want to block grant Medicaid, welfare, public housing, senior employment programs and other Federal initiatives and let the states administer and regulate them. Why not health care reform? Their own argument that the states can do things better and more efficiently than the Federal Government is contradicts this new policy.

As one of only four Democrats that cast their vote in favor of the Ways and Means insurance reform legislation, I strongly support providing my constituents with health coverage they can take from job to job. But, I differ from my Republican colleagues in one important respect. Not only do I support it—I also want it to pass. This final version of the bill bends over backwards so far to please so many special interests that it severs the spine that holds it together and paralyzes the legislative process.

Mr. Speaker, I support the clean Democratic substitute, which is identical to the original Kennedy-Kassebaum-Roukema bill and I urge my colleagues to do likewise.

The SPEAKER pro tempore (Mr. COMBEST). All time for debate has expired.

AMENDMENT IN THE NATURE OF A SUBSTITUTE OFFERED BY MR. DINGELL

Mr. DINGELL. Mr. Speaker, as the designee of the minority leader, under the rule, and on behalf of myself and my two colleagues, the gentleman from South Carolina [Mr. SPRATT] and the gentleman from Texas [Mr. BENTSEN], I offer an amendment in the nature of a substitute.

The SPEAKER pro tempore. The Clerk will designate the amendment in the nature of a substitute.

The text of the amendment in the nature of a substitute is as follows:

Amendment in the nature of a substitute offered by Mr. DINGELL:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Health Insurance Reform Act of 1996''.

TITLE I—HEALTH CARE ACCESS, PORTABILITY, AND RENEWABILITY

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SUBTITLE B—INDIVIDUAL MARKET RULES

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SUBTITLE F—MISCELLANEOUS PROVISIONS

Sec. 191. Health coverage availability study.
Sec. 192. Effective date.
Sec. 193. Severability.

SEC. 100. DEFINITIONS.

As used in this title:

(1) BENEFICIARY.—The term ''beneficiary'' has the meaning given such term under section 3(8) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(8)).

(2) EMPLOYEE.—The term ''employee'' has the meaning given such term under section 3(6) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(6)).

(3) EMPLOYER.—The term ''employer'' has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(5)), except that such term shall include only employers of two or more employees.

(4) EMPLOYEE HEALTH BENEFIT PLAN.—

(A) IN GENERAL.—The term ''employee health benefit plan'' means any employee welfare benefit plan, governmental plan, or church plan (as defined under paragraphs (1), (32), and (33) of section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002 (1), (32), and (33))) that provides or pays for health benefits (such as provider and hospital benefits) for participants and beneficiaries whether—

(i) directly;

(ii) through a group health plan offered by a health plan issuer as defined in paragraph (8); or

(iii) otherwise.

(B) RULE OF CONSTRUCTION.—An employee health benefit plan shall not be construed to be a group health plan, an individual health plan, or a health plan issuer.

(C) ARRANGEMENTS NOT INCLUDED.—Such term does not include the following, or any combination thereof:

(i) Coverage only for accident, or disability income insurance, or any combination thereof.

(ii) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act).

(iii) Coverage issued as a supplement to liability insurance.

(iv) Liability insurance, including general liability insurance and automobile liability insurance.

(v) Workers compensation or similar insurance.

(vi) Automobile medical payment insurance.

(vii) Coverage for a specified disease or illness.

(viii) Hospital or fixed indemnity insurance.

(ix) Short-term limited duration insurance.

(x) Credit-only, dental-only, or vision-only insurance.

(xi) A health insurance policy providing benefits only for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(5) FAMILY.—

(A) IN GENERAL.—The term ''family'' means an individual, the individual's spouse, and the child of the individual (if any).

(B) CHILD.—For purposes of subparagraph (A), the term ''child'' means any individual who is a child within the meaning of section 151(c)(3) of the Internal Revenue Code of 1986.

(6) GROUP HEALTH PLAN.—

(A) IN GENERAL.—The term ''group health plan'' means any contract, policy, certificate or other arrangement offered by a health plan issuer to a group purchaser that provides or pays for health benefits (such as provider and hospital benefits) in connection with an employee health benefit plan.

(B) ARRANGEMENTS NOT INCLUDED.—Such term does not include the following, or any combination thereof;

(i) Coverage only for accident, or disability income insurance, or any combination thereof.

(ii) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act).

(iii) Coverage issued as a supplement to liability insurance.

(iv) Liability insurance, including general liability insurance and automobile liability insurance.

(v) Workers compensation or similar insurance.

(vi) Automobile medical payment insurance.

(vii) Coverage for a specified disease or illness.

(ix) Short-term limited duration insurance.

(x) Credit-only, dental-only, or vision-only insurance.

(xi) A health insurance policy providing benefits only for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(7) GROUP PURCHASER.—The term ''group purchaser'' means any person (as defined under paragraph (9) of section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(9)) or entity that purchases or pays for health benefits (such as provider or hospital benefits) on behalf of two or more participants or beneficiaries in connection with an employee health benefit plan. A health plan purchasing cooperative established under section 131 shall not be considered to be a group purchaser.

(8) HEALTH PLAN ISSUER.—The term ''health plan issuer'' means any entity that is licensed (prior to or after the date of enactment of this Act) by a State to offer a group health plan or an individual health plan.

(9) HEALTH STATUS.—The term ''health status'' includes. with respect to an individual, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), or disability.

(10) PARTICIPANT.—The term ''participant'' has the meaning given such term under section 3(7) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(7)).

(11) PLAN SPONSOR.—The term ''plan sponsor'' has the meaning given such term under section 3(16)(B) of the Employee Retirement

Income Security Act of 1974 (29 U.S.C. 1002(16)(B)).

(12) SECRETARY.—The term ''Secretary'', unless specifically provided otherwise, means the Secretary of Labor.

(13) STATE.—The term ''State'' means each of the several States, the District of Columbia, Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

Subtitle A—Group Market Rules

SECTION 101. GUARANTEED AVAILABILITY OF HEALTH COVERAGE.

In General.—

(1) NONDISCRIMINATION.—Except as provided in subsection (b), section 102 and section 103—

(A) a health plan issuer offering a group health plan may not decline to offer whole group coverage to a group purchaser desiring to purchase such coverage; and

(B) an employee health benefit plan or a health plan issuer offering a group health plan may establish eligibility, continuation of eligibility, enrollment, or premium; contribution requirements under the terms of such plan, except that such requirements shall not be based on health status (as defined in section 100(9)).

(2) HEALTH PROMOTION AND DISEASE PREVENTION.—Nothing in this subsection shall prevent an employee health benefit plan or a health plan issuer from establishing premium; discounts or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(b) APPLICATION OF CAPACITY LIMITS.—

(1) IN GENERAL.—Subject to paragraph (2), a health plan issuer offering a group health plan may cease offering coverage to group purchasers under the plan if—

(A) the health plan issuer ceases to offer coverage to any additional group purchasers; and

(B) the health plan issuer can demonstrate to the applicable certifying authority (as defined in section 142(d)), if required, that its financial or provider capacity to serve previously covered participants and beneficiaries (and additional participants and beneficiaries who will be expected to enroll because of their affiliation with a group purchaser or such previously covered participants or beneficiaries) will be impaired if the health plan issuer is required to offer coverage to additional group purchasers.

Such health plan issuer shall be prohibited from offering coverage after a cessation in offering coverage under this paragraph for a 6-month period or until the health plan issuer can demonstrate to the applicable certifying authority (as defined in section 142(d)) that the health plan issuer has adequate capacity, whichever is later.

(2) FIRST-COME-FIRST-SERVED.—A health plan issuer offering a group health plan is only eligible to exercise the limitations provided for in paragraph (1) if the health plan issuer offers coverage to group purchasers under such plan on a first-come-first-served basis or other basis established by a State to ensure a fair opportunity to enroll in the plan and avoid risk selection.

(e) CONSTRUCTION.—

(1) MARKETING OF GROUP HEALTH PLANS.—Nothing in this section shall be construed to prevent a State from requiring health plan issuers offering group health plans to actively market such plans.

(2) INVOLUNTARY OFFERING OF GROUP HEALTH PLANS.—Nothing is this section shall be construed to require a health plan issuer to involuntarily offer group health plans in a particular market. For the purposes of this paragraph, the term ''market'' means either the large employer market or the small employer market (as defined under applicable State law, or if not so defined, an employer with not more than 50 employees).

SEC. 102. GUARANTEED RENEWABILITY OF HEALTH COVERAGE.

(A) IN GENERAL.—

(1) GROUP PURCHASER.—Subject to subsections (b) and (c), a group health plan shall be renewed or continued in force by a health plan issuer at the option of the group purchaser, except that the requirement of this subparagraph shall not apply in the case of—

(A) the nonpayment of premiums or contributions by the group purchaser in accordance with the terms of the group health plan or where the health plan issuer has not received timely premium payments;

(B) fraud or misrepresentation of material fact on the part of the group purchaser;

(C) the termination of the group health plan in accordance with subsection (b); or

(D) the failure of the group purchaser to meet contribution or participation requirements in accordance with paragraph (3).

(2) PARICIPANT.—Subject to subsections (b) and (c), coverage under an employee health benefit plan or group health plan shall be renewed or continued in force, if the group purchaser elects to continue to provide coverage under such plan, at the option of the participant (or beneficiary where such right exists under the terms of the plan or under applicable law), except that the requirement of this paragraph shall not apply in the case of—

(A) the nonpayment of premiums or contributions by the participant or beneficiary in accordance with the terms of the employee health benefit plan or group health plan or where such plan has not received timely premium payments.

(B) fraud or misrepresentation of material fact on the part of the participant or beneficiary relating to an application for coverage or claim for benefits;

(C) the termination of the employee health benefit plan or group health plan;

(D) loss of eligibility for continuation coverage as described in part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.); or

(E) failure of a participant or beneficiary to meet requirements for eligibility for coverage under an employee health benefit plan or group health plan that are not prohibited by this title.

(3) RULES OF CONSTRUCTION.—Nothing in this subsection, nor in section 101(a), shall be construed to—

(A) preclude a health plan issuer from establishing employer contribution rules or group participation rules for group health plans as allowed under applicable State law;

(B) preclude a plan defined in section 3(37) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1102(37)) from establishing employer contribution rules or group participation rules; or

(C) permit individuals to decline coverage under an employee health benefit plan if such right is not otherwise available under such plan.

(b) TERMINATION OF GROUP HEALTH PLANS.—

(1) PARTICULAR TYPE OF GROUP HEALTH PLAN NOT OFFERED.—In any case in which a health plan issuer decides to discontinue offering a particular type of group health plan. A group health plan of such type may be discontinued by the health plan issuer only if—

(A) the health plan issuer provides notice to each group purchaser covered under a group health plan of this type (and participants and beneficiaries covered under such group health plan) of such discontinuation at least 90 days prior to the date of the discontinuation of such plan;

(B) the health plan issuer offers to each group purchaser covered under a group health plan of this type, the option to purchase any other group health plan currently being offered by the health plan issuer; and

(C) in exercising the option to discontinue a group health plan of this type and in offering one or more replacement plans, the health plan issuer acts uniformly without regard to the health status of participants or beneficiaries covered under the group health plan, or new participants or beneficiaries who may become eligible for coverage under the group health plan.

(2) DISCONTINUANCE OF ALL GROUP HEALTH PLANS.—

(A) IN GENERAL.—In any case in which a health plan issuer elects to discontinue offering all group health plans in a State, a group health plan may be discontinued by the health plan issuer only if—

(i) the health plan issuer provides notice to the applicable certifying authority (as defined in section 142(d)) and to each group purchaser (and participants and beneficiaries covered under such group health plan) of such discontinuation at least 180 days prior to the date of the expiration of such plan, and

(ii) all group health plans issued or delivered for issuance in the State or discontinued and coverage under such plans is not renewed.

(B) APPLICATION OF PROVISIONS.—The provisions of this paragraph and paragraph (3) may be applied separately by a health plan issuer—

(i) to all group health plans offered to small employers (as defined under applicable State law, or if not so defined, an employer with not more than 50 employees); or

(ii) to all other group health plans offered by the health plan issuer in the State.

(3) PROHIBITION ON MARKET REENTRY.—In the case of a discontinuation under paragraph (2), the health plan issuer may not provide for the issuance of any group health plan in the market sector (as described in paragraph (2)(B)) in which issuance of such group health plan was discontinued in the State involved during the 5-year period beginning on the date of the discontinuation of the last group health plan not so renewed.

TREATMENT OF NETWORK PLANS.—

(1) GEOGRAPHIC LIMITATIONS.—A network plan (as defined in paragraph (2)) may deny continued participation under such plan to participants or beneficiaries who neither live, reside, nor work in an area in which such network plan is offered, but only if such denial is applied uniformly, without regard to health status of particular participants or beneficiaries.

(2) NETWORK PLAN.—As used in paragraph (1), the term ''network plan'' means an employee health benefit plan or a group health plan that arranges for the financing and delivery of health care services to participants or beneficiaries covered under such plan, in whole or in part, through arrangements with providers.

(d) COBRA COVERAGE.—Nothing in subsection (a)(2)(E) or subsection (c) shall be construed to affect any right to COBRA continuation coverage as described in part 6 of subtitle B of title I of the employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.).

SEC. 103. PORTABILITY OF HEALTH COVERAGE AND LIMITATION ON PREEXISTING CONDITION EXCLUSIONS.

(a) IN GENERAL.—An employee health benefit plan or a health plan issuer offering a group health plan may impose a limitation or exclusion of benefits relating to treatment of a preexisting condition based on the fact that the condition existed prior to the coverage of the participant or beneficiary under the plan only if—

(1) the limitation or exclusion extends for a period of not more than 12 months after the date of enrollment in the plan;

(2) the limitation or exclusion does not apply to an individual who, within 30 days of the date of birth or placement for adoption (as determined under section 609(c)(3)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1169(c)(3)(B)), was covered under the plan; and

(3) the limitation or exclusion does not apply to a pregnancy.

(b) CREDITING OF PREVIOUS QUALIFYING COVERAGE.—

(1) IN GENERAL.—Subject to paragraph (4), an employee health benefit plan or a health plan issuer offering a group health plan shall provide that if a participant or beneficiary is in a period of previous qualifying coverage as of the date of enrollment under such plan, any period of exclusion or limitation of coverage with respect to a preexisting condition shall be reduced by 1 month for each month in which the participant or beneficiary was in the period of previous qualifying coverage. With respect to an individual described in subsection (a)(2) who maintains continuous coverage, no limitation or exclusion of benefits relating to treatment of a preexisting condition may be applied to a child within the child's first 12 months of life or within 12 months after the placement of a child for adoption.

(2) DISCHARGE OF DUTY.—An employee health benefit plan shall provide documentation of coverage to participants and beneficiaries who coverage is terminated under the plan. Pursuant to regulations promulgated by the Secretary, the duty of an employee health benefit plan to verify previous qualifying coverage with respect to a participant or beneficiary is effectively discharged when such employee health benefit plan provides documentation to a participant or beneficiary that includes the following information:

(A) the dates that the participant or beneficiary was covered under the plan; and

(B) the benefits and cost-sharing arrangement available to the participant or beneficiary under such plan.

An employee health benefit plan shall retain the documentation provided to a participant or beneficiary under subparagraphs (A) and (B) for at least the 12-month period following the date on which the participant or beneficiary ceases to be covered under the plan. Upon request, an employee health benefit plan shall provide a second copy of such documentation or such participant or beneficiary within the 12-month period following the date of such ineligibility.

(3) DEFINITIONS.—As used in this section:

(A) PREVIOUS QUALIFYING COVERAGE.—The term ''previous qualifying coverage'' means the period beginning on the date—

(i) a participant or beneficiary is enrolled under an employee health benefit plan or a group health plan, and ending on the date the participant or beneficiary is not so enrolled; or

(ii) an individual is enrolled under an individual health plan (as defined in section 113) or under a public or private health plan established under Federal or State law, and ending on the date the individual is not so enrolled;

for a continuous period of more than 30 days (without regard to any waiting period).

(B) LIMITATION OR EXCLUSION OF BENEFITS RELATING TO TREATMENT OF A PREEXISTING CONDITION.—The term ''limitation or exclusion of benefits relating to treatment of a preexisting condition'' means a limitation or exclusion of benefits imposed on an individual based on a preexisting condition of such individual.

(4) EFFECT OF PREVIOUS COVERAGE.—An employee health benefit plan or a health plan issuer offering a group health plan may impose a limitation or exclusion of benefits relating to the treatment of a preexisting condition, subject to the limits in subsection (a)(1), only to the extent that such service or benefit was not previously covered under the group health plan, employee health benefit plan, or individual health plan in which the participant or beneficiary was enrolled immediately prior to enrollment in the plan involved.

(c) LATE ENROLLEES.—Except as provided in section 104, with respect to a participant or beneficiary enrolling in an employee health benefit plan or group health plan during a time that is other than the first opportunity to enroll during an enrollment period of at least 30 days, coverage with respect to benefits or services relating to the treatment of a preexisting condition in accordance with subsection (a) and (b) may be excluded except the period of such exclusion may not exceed 18 months beginning on the date of coverage under the plan.

(d) AFFILIATION PERIODS.—With respect to a participant or beneficiary who would otherwise be eligible to receive benefits under an employee health benefit plan or a group health plan but for the operation of a preexisting condition limitation or exclusion, if such plan does not utilize a limitation or exclusion of benefits relating to the treatment of a preexisting condition, such plan may impose an affiliation period on such participant or beneficiary not to exceed 60 days (or in the case of a late participant or beneficiary described in subsection (c), 90 days) from the date on which the participant or beneficiary would otherwise be eligible to receive benefits under the plan. An employee health benefit plan or a health plan issuer offering a group health plan may also use alternative methods to address adverse section as approved by the applicable certifying authority (as defined in section 142(d)). During such an affiliation period, the plan may not be required to provide health care services or benefits and no premium shall be charged to the participant or beneficiary.

(e) PREEXISTING CONDITIONS.—For purposes of this section, the term ''preexisting condition'' means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the day before the effective date of the coverage (without regard to any waiting period).

(f) STATE FLEXIBILITY.—Nothing in this section shall be construed to preempt State laws that—

(1) require health plan issuers to impose a limitation or exclusion of benefits relating to the treatment of a preexisting condition for periods that are shorter than those provided for under this section; or

(2) allow individuals, participants, and beneficiaries to be considered to be in a period of previous qualifying coverage if such individual, participant, or beneficiary experiences a lapse in coverage that is greater than the 30-day period provided for under subsection (b)(3);

unless such laws are preempted by section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144).

SEC. 104. SPECIAL ENROLLMENT PERIODS.

In the case of a participant, beneficiary or family member who—

(1) through marriage, separation, divorce, death, birth or placement of a child for adoption, experiences a change in family composition affecting eligibility under a group health plan, individual health plan, or employee health benefit plan;

(2) experiences a change in employment status, as described in section 603(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1163(2)), that causes the loss of eligibility for coverage, other than COBRA continuation coverage under a group health plan, individual health plan, or employee health benefit plan; or

(3) experiences a loss of eligibility under a group health plan, individual health plan, or employee health benefit plan because of a change in the employment status of a family member;

each employee health benefit plan and each group health plan shall provide for a special enrollment period extending for a reasonable time after such event that would permit the participant to change the individual or family basis of coverage or to enroll in the plan if coverage would have been available to such individual, participant, or beneficiary but for failure to enroll during a previous enrollment period. Such a special enrollment period shall ensure that a child born or placed for adoption shall be deemed to be covered under the plan as of the date of such birth or placement for adoption if such child is enrolled within 30 days of the date of such birth or placement for adoption.

SEC. 105. DISCLOSURE OF INFORMATION.

(a) DISCLOSURE OF INFORMATION BY HEALTH PLAN ISSUER.—

(1) IN GENERAL.—In connection with the offering of any group health plan to a small employer (as defined under applicable State law, or if not so defined, an employer with not more than 50 employees), a health plan issuer shall make a reasonable disclosure to such employer, as part of its solicitation and sales materials, of—

(A) the provisions of such group health plan concerning the health plan issuer's right to change premium rates and the factors that may affect changes in premium rates.

(B) the provisions of such group health plan relating to renewability of coverage;

(C) the provisions of such group health plan relating to any preexisting condition provision; and

(D) descriptive information about the benefits and premiums available under all group health plans for which the employer is qualified.

Information shall be provided to small employers under this paragraph in a manner determined to be understandable by the average small employer, and shall be sufficiently accurate and comprehensive to reasonably inform small employers, participants and beneficiaries of their rights and obligations under the group health plan.

(2) EXCEPTION.—With respect to the requirement of paragraph (1), any information that is proprietary and trade secret information under applicable law shall not be subject to the disclosure requirements of such paragraph.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed to preempt State reporting and disclosure requirements to the extent that such requirements are not preempted under section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144).

(b) DISCLOSURE OF INFORMATION TO PARTICIPANTS AND BENEFICIARIES.—

(1) IN GENERAL.—Section 104(b)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1024(b)(1)) is amended in the matter following subparagraph (B)—

(A) by striking ''102(a)(1),'' and inserting ''102(a)(1) that is not a material reduction in covered services or benefits provided,''; and

(B) by adding at the end thereof the following new sentences: ''If there is a modification or change described in section 102(a)(1)

that is a material reduction in covered services or benefits provided, a summary description of such modification or change shall be furnished to participants not later than 60 days after the date of the adoption of the modification or change. In the alternative, the plan sponsors may provide such description at regular intervals of not more than 90 days. The Secretary shall issue regulations within 180 days after the date of enactment of the Health Insurance Reform Act of 1996, providing alternative mechanisms to delivery by mail through which employee health benefit plans may notify participants of material reductions in covered services or benefits.''.

(2) PLAN DESCRIPTION AND SUMMARY.—Section 102(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1022(b)) is amended—

(A) by inserting ''including the office or title of the individual who is responsible for approving or denying claims for coverage of benefits'' after ''type of administration of the plan'';

(B) by inserting ''including the name of the organization responsible for financing claims'' after ''source of financing of the plan''; and

(C) by inserting ''including the office, contact, or title of the individual at the Department of Labor through which participants may seek assistance or information regarding their rights under this Act and title I of the Health Insurance Reform Act of 1996 with respect to health benefits that are not offered through a group health plan.'' after ''benefits under the plan''.

Subtitle B—Individual Market Rules

SEC. 110. INDIVIDUAL HEALTH PLAN PORTABILITY.

(a) LIMITATION ON REQUIREMENTS.—

(1) IN GENERAL.—Except as provided in subsections (b) and (c), a health plan issuer described in paragraph (3) may not, with respect to an eligible individual (as defined in subsection (b)) desiring to enroll in an individual health plan—

(A) decline to offer coverage to such individual, or deny enrollment to such individual based on the health status of the individual; or

(B) impose a limitation or exclusion of benefits otherwise covered under the plan for the individual based on a preexisting condition unless such limitation or exclusion could have been imposed if the individual remained covered under a group health plan or employee health benefit plan (including providing credit for previous coverage in the manner provided under subtitle A).

(2) HEALTH PROMOTION AND DISEASE PREVENTION.—Nothing in this subsection shall be construed to prevent a health plan issuer offering an individual health plan from establishing premium discounts or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion or disease prevention.

(3) HEALTH PLAN ISSUER.—A health plan issuer described in this paragraph in a health plan issuer that issues or renews individual health plans.

(4) PREMIUMS.—Nothing in this subsection shall be construed to affect the determination of a health plan issuer as to the amount of the premium payable under an individual health plan under applicable State law.

(b) DEFINITION OF ELIGIBLE INDIVIDUAL.—As used in subsection (a)(1), the term ''eligible individual'' means an individual who—

(1) was a participant or beneficiary enrolled under one or more group health plans, employee health benefit plans, or public plans established under Federal or State law, for not less than 18 months (without a lapse in coverage of more than 30 consecutive days) immediately prior to the date on which the individual desired to enroll in the individual health plan.

(2) is not eligible for coverage under a group health plan or an employee health benefit plan;

(3) has not had coverage terminated under a group health plan or employee health benefit plan for failure to make required premium payments or contributions, or for fraud or misrepresentation of material fact; and

(4) has, if applicable, accepted and exhausted the maximum required period of continuous coverage as described in section 602(2)(A) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1162(2)(A)) or under an equivalent State program.

(c) APPLICABLE OF CAPACITY LIMIT.—

(1) IN GENERAL.—Subject to paragraph (2), a health plan issuer offering coverage to individuals under an individual health plan may cease enrolling individuals under the plan if—

(A) the health plan issuer ceases to enroll any new individuals; and

(B) the health plan issuer can demonstrate to the applicable certifying authority (as defined in section 142(d)), if required, that its financial or provider capacity to serve previously covered individuals will be impaired if the health plan issuer is required to enroll additional individuals.

Such a health plan issuer shall be prohibited from offering coverage after a cessation in offering coverage under this paragraph for a 6-month period or until the health plan issuer can demonstrate to the applicable certifying authority (as defined in section 142(d)) that the health plan issuer has adequate capacity, whichever is later.

(2) FIRST-COME-FIRST-SERVED.—A health plan issuer offering coverage to individuals under an individual health plan is only eligible to exercise the limitations provided for in paragraph (1) if the health plan issuer provides for enrollment of individuals under such plan on a first-come-first-served basis or other basis established by a State to ensure a fair opportunity to enroll in the plan and avoid risk selection.

(d) MARKET REQUIREMENT.—

(1) IN GENERAL.—The provisions of subsection (a) shall not be construed to require that a health plan issuer offering group health plans to group purchasers offer individual health plans to individuals.

(2) CONVERSION POLICIES.—A health plan issuer offering group health plans to group purchasers under this title shall not be deemed to be a health plan issuer offering an individual health plan solely because such health plan issuer offers a conversion policy.

(3) MARKETING OF PLANS.—Nothing in this section shall be construed to prevent a State from requiring health plan issuers offering coverage to individuals under an individual health plan to actively market such plan.

SEC. 111. GUARANTEED RENEWABILITY OF INDIVIDUAL HEALTH COVERAGE.

(a) IN GENERAL.—Subject to subsections (b) and (c), coverage for individuals under an individual health plan shall be renewed or continued in force by a health plan issuer at the option of the individual, except that the requirement of this subsection shall not apply in the case of—

(1) the nonpayment of premiums or contributions by the individual in accordance with the terms of the individual health plan or where the health plan issuer has not received timely premium payments;

(2) fraud or misrepresentation of material fact on the part of the individual; or

(3) the termination of the individual health plan in accordance with subsection (b).

(b) TERMINATION OF INDIVIDUAL HEALTH PLANS.—

(1) PARTICULAR TYPE OF INDIVIDUAL HEALTH PLAN NOT OFFERED.—In any case in which a health plan issuer decides to discontinue offering a particular type of individual health plan to individuals, an individual health plan may be discontinued by the health plan issuer only if—

(A) the health plan issuer provides notice to each individual covered under the plan of such discontinuation at least 90 days prior to the date of the expiration of the plan.

(B) the health plan issuer offers to each individual covered under the plan the option to purchase any other individual health plan currently being offered by the health plan issuer to individuals; and

(C) in exercising the option to discontinue the individual health plan and in offering one or more replacement plans, the health plan issuer acts uniformly without regard to the health status of particular individuals.

(21) DISCONTINUANCE OF ALL INDIVIDUAL HEALTH PLANS.—In any case in which a health plan issuer elects to discontinue all individual health plans in a State, an individual health plan may be discontinued by the health plan issuer only if—

(A) the health plan issuer provides notice to the applicable certifying authority (as defined in section 142(d)) and to each individual covered under the plan of such discontinuation at least 180 days prior to the date of the discontinuation of the plan; and

(B) all individual health plans issued or delivered for issuance in the State are discontinued and coverage under such plans is not renewed.

(3) PROHIBITION ON MARKET REENTRY.—In the case of a discontinuation under paragraph (2), the health plan issuer may not provide for the issuance of any individual health plan in the State involved during the 5-year period beginning on the date of the discontinuation of the last plan not so renewed.

(c) TREATMENT OF NETWORK PLANS.—

(1) GEOGRAPHIC LIMITATIONS.—A health plan issuer which offers a network plan (as defined in paragraph (2)) may deny continued participation under the plan to individuals who neither live, reside, nor work in an area in which the individual health plan is offered, but only if such denial is applied uniformly, without regard to health status of particular individuals.

(2) NETWORK PLAY.—As used in paragraph (1), the term ''network plan'' means an individual health plan that arranges for the financing and delivery of health care services to individuals covered under such health plan, in whole or in part, through arrangements with providers.

SEC. 112. STATE FLEXIBILITY IN INDIVIDUAL MARKET REFORMS.

(a) IN GENERAL.—With respect to any State law with respect to which the Governor of the State notifies the Secretary of Health and Human Services that such State law will achieve the goals of sections 110 and 111, and that is in effect on, or enacted after, the date of enactment of this Act (such as laws providing for guaranteed issue, open enrollment by one or more health plan issuers, high-risk pools, or mandatory conversion policies), such State law shall apply in lieu of the standards described in sections 110 and 111 unless the Secretary of Health and Human Services determines, after considering the criteria described in subsection (b)(1), in consultation with the Governor and Insurance Commissioner or chief insurance regulatory official of the State, that such State law does not achieve the goals of providing access to affordable health care coverage for those individuals described in sections 110 and 111.

(b) DETERMINATION.—

(1) IN GENERAL.—In making a determination under subsection (a), the Secretary of Health and Human Services shall only—

(A) evaluate whether the State law or program provides guaranteed access to affordable coverage to individuals described in sections 110 and 111;

(B) evaluate whether the State law or program provides coverage for preexisting conditions (as defined in section 103(e)) that were covered under the individuals' previous group health plan or employee health benefit plan for individuals described in sections 110 and 111.

(C) evaluate whether the State law or program provides individuals described in sections 110 and 111 with a choice of health plans or a health plan providing comprehensive coverage, and

(D) evaluate whether the application of the standards described in sections 110 and 111 will have an adverse impact on the number of individuals in such State having access to affordable coverage.

(2) NOTICE OF INTENT.—If, within 6 months after the date of enactment of this Act, the Governor of a State notifies the Secretary of Health and Human Services that the State intends to enact a law, or modify an existing law, described in subsection (a), the Secretary of Health and Human Services may not make a determination under such subsection until the expiration of the 12-month period beginning on the date on which such notification is made, or until January 1, 1998, whichever is later. With respect to a State that provides notice under this paragraph and that has a legislature that does not meet within the 12-month period beginning on the date of enactment of this Act, the Secretary shall not make a determination under subsection (a) prior to January 1, 1998.

(3) NOTICE TO STATE.—If the Secretary of Health and Human Services determines that a State law or program does not achieve the goals described in subsection (a), the Secretary of Health and Human Services shall provide the State with adequate notice and reasonable opportunity to modify such law or program to achieve such goals prior to making a final determination under subsection (a).

(c) ADOPTION OF NAIC MODEL.—If, not later than 9 months after the date of enactment of this Act—

(1) the National Association of Insurance Commissioners (hereafter referred to as the ''NAIC''), through a process which the Secretary of Health and Human Services determines has included consultation with representatives of the insurance industry and consumer groups, adopts a model standard or standards for reform of the individual health insurance market, and

(2) the Secretary of Health and Human Services determines, within 30 days of the adoption of such NAIC standard or standards, that such standards comply with the goals of sections 110 and 111:

a State that elects to adopt such model standards or substantially adopt such model standards shall be deemed to have met the requirements of sections 110 and 111 and shall be subject to a determination under subsection (a).

SEC. 113. DEFINITION.

(a) IN GENERAL.—As used this title, the term ''individual health plan'' means any contract, policy, certificate or other arrangement offered to individuals by a health plan issuer that provides or pays for health benefits (such as provider and hospital benefits) and that is not a group health plan under section 2(6).

(b) ARRANGEMENTS NOT INCLUDED.—Such term does not include the following, or any combination thereof:

(1) Coverage only for accident, or disability income insurance, or any combination thereof.

(2) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act).

(3) Coverage issued as a supplement to liability insurance.

(4) Liability insurance, including general liability insurance and automobile liability insurance.

(5) Workers' compensation or similar insurance.

(6) Automobile medical payment insurance.

(7) Coverage for a specified disease or illness.

(8) Hospital of fixed indemnity insurance.

(9) Short-term limited duration insurance.

(10) Credit-only, dental-only, or vision-only insurance.

(11) A health insurance policy providing benefits only for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

Subtitle C—COBRA Clarifications

SEC. 121. COBRA CLARIFICATIONS.

(a) PUBLIC HEALTH SERVICE ACT.—

(1) PERIOD OF COVERAGE.—Section 2202(2) of the Public Health Service Act (42 U.S.C. 300bb–2(2)) is amended—

(A) in subparagraph (A)—

(i) by transferring the sentence immediately preceding clause (iv) so as to appear immediately following such clause (iv); and

(ii) in the last sentence (as so transferred)—

(I) by inserting '', or a beneficiary-family member of the individual,'' after ''an individual''; and

(II) by striking ''at the time of a qualifying event described in section 2203(2)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this title'';

(B) in subparagraph (D)(i), by inserting before '', or'' the following: '', except that the exclusion or limitation contained in this clause shall not be considered to apply to a plan under which a preexisting condition or exclusion does not apply to an individual otherwise eligible for continuation coverage under this section because of the provision of the Health Insurance Reform Act of 1996'', and

(C) in subparagraph (E), by striking ''at the time of a qualifying event described in section 2203(2)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this title'',

(2) ELECTION.—Section 2205(1)(C) of the Public Health Service Act (42 U.S.C. 300bb–5(1)(C)) is amended—

(A) in clause (i), by striking ''or'' at the end thereof.

(B) in clause (ii), by striking the period and inserting '', or'', and

(C) by adding at the end thereof the following new clause:

''(iii) in the case of an individual described in the last sentence of section 2202(2)(A), or a beneficiary-family member of the individual, the date such individual is determined to have been disabled.''.

(3) NOTICES.—Section 2206(3) of the Public Health Service Act (42 U.S.C. 300bb–6(3)) is amended by striking ''at the time of a qualifying event described in section 2203(2)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this title''.

(4) BIRTH OR ADOPTION OF A CHILD.—Section 2208(3)(A) of the Public Health Service Act (42 U.S.C. 300bb–8(3)(A)) is amended by adding at the end thereof the following new flush sentence:

''Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continued coverage under this title.''.

(b) EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(1) PERIOD OF COVERAGE.—Section 602(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1162(2)) is amended—

(A) in the last sentence of subparagraph (A)—

(i) by inserting '', or a beneficiary-family member of the individual.'' after ''an individual''; and

(ii) by striking ''at the time of a qualifying event described in section 603(2)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this part'',

(B) in subparagraph (D)(i), by inserting before '', or'' the following '', except that the exclusion or limitation contained in this clause shall not be considered to apply to a plan under which a preexisting condition or exclusion does not apply to an individual otherwise eligible for continuation coverage under this section because of the provision of the Health Insurance Reform Act of 1996''; and

(C) in subparagraph (E), by striking ''at the time of a qualifying event described in section 603(2)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this part''.

(2) ELECTION.—Section 605(1)(C) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1165(1)(C)) is amended—

(A) in clause (i), by striking ''or'' at the end thereof;

(B) in clause (ii), by striking the period and inserting '', or''; and

(C) by adding at the end thereof the following new clause:

''(iii) in the case of an individual described in the last sentence of section 602(2)(A), or a beneficiary-family member of the individual, the date such individual is determined to have been disabled.''.

(3) NOTICES.—Section 606(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1166(3)) is amended by striking ''at the time of a qualifying event described in section 603(2)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this part''.

(4) BIRTH OR ADOPTION OF A CHILD.—Section 607(3)(A) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1167(3)) is amended by adding at the end thereof the following new flush sentence:

''Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continued coverage under this part.''.

(c) INTERNAL REVENUE CODE OF 1986.—

(1) PERIOD OF COVERAGE.—Section 4980B(f)(2)(B) of the Internal Revenue Code of 1986 is amended—

(A) in the last sentence of clause (i) by striking ''at the time of a qualifying event described in paragraph (3)(B)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this section''.

(B) in clause (iv)(I), by inserting before '', or'' the following: '', except that the exclusion or limitation contained in this subclause shall not be considered to apply to a plan under which a preexisting condition or exclusion does not apply to an individual otherwise eligible for continuation coverage under this subsection because of the provision of the Health Insurance Reform Act of 1996''; and

(C) in clause (v), by striking ''at the time of a qualifying event described in paragraph (3)(B)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this section''.

(2) ELECTION.—Section 4980B(f)(5)(A)(ii) of the Internal Revenue Code of 1986 is amended—

(A) in subclause (I), by striking ''or'' at the end thereof;

(B) in subclause (II), by striking the period and inserting '', or'', and

(C) by adding at the end thereof the following new subclause:

''(III) in the case of an qualified beneficiary described in the last sentence of paragraph (2)(B)(i), the date such individual is determined to have been disabled.''.

(3) NOTICES.—Section 4980B(f)(6)(C) of the Internal Revenue Code of 1986 is amended by striking ''at the time of a qualifying event described in paragraph (3)(B)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this section''.

(4) BIRTH OR ADOPTION OF A CHILD.—Section 4980B(g)(1)(A) of the Internal Revenue Code of 1986 is amended by adding at the end thereof the following new flush sentence:

''Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continued coverage under this section.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to qualifying events occurring on or after the date of enactment of this Act for plan years beginning after December 31, 1997.

(e) NOTIFICATION OF CHANGES.—Not later than 60 days prior to the date on which this section becomes effective, each group health plan (covered under title XXII of the Public Health Service Act, part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, and section 4980B(f) of the Internal Revenue Code of 1986) shall notify each qualified beneficiary who has elected continuation coverage under such title, part or section of the amendments made by this section.

Subtitle D—Private Health Plan Purchasing Cooperatives

SEC. 131. PRIVATE HEALTH PLAN PURCHASING COOPERATIVES.

(a) DEFINITION.—As used in this title, the term ''health plan purchasing cooperative'' means a group of individuals or employers that, on a voluntary basis and in accordance with this section, form a cooperative for the purpose of purchasing individual health plans or group health plans offered by health plan issuers. A health plan issuer, agent, broker or any other individual or entity engaged in the sale of insurance may not underwrite a cooperative.

(b) CERTIFICATION.—

(1) IN GENERAL.—If a group described in subsection (a) desires to form a health plan purchasing cooperative in accordance with this section and such group appropriately notifies the State and the Secretary of such desire, the State, upon a determination that such group meets the requirements of this section, shall certify the group as a health plan purchasing cooperative. The State shall make a determination of whether such group meets the requirements of this section in a timely fashion. Each such cooperative shall also be registered with the Secretary.

(2) STATE REFUSAL TO CERTIFY.—If a State fails to implement a program for certifying health plan purchasing cooperatives in accordance with the standards under this title, the Secretary shall certify and oversee the operations of such cooperative in such State.

(3) INTERSTATE COOPERATIVES.—For purposes of this section a health plan purchasing cooperative operating in more than one State shall be certified by the State in which the cooperative is domiciled. States may enter into cooperative agreements for the purpose of certifying and overseeing the operation of such cooperatives. For purposes of this subsection, a cooperative shall be considered to be domiciled in the State in which most of the members of the cooperative reside.

(c) BOARD OF DIRECTORS.—

(1) IN GENERAL.—Each health plan purchasing cooperative shall be governed by a Board of Directors that shall be responsible for ensuring the performance of the duties of the cooperative under this section. The Board shall be composed of a board cross-section of representatives of employers, employees, and individuals participating in the cooperative. A health plan issuer, agent, broker or any other individual or entity engaged in the sale of individual health plans or group health plans may not hold or control any right to vote with respect to a cooperative.

(2) LIMITATION ON COMPENSATION.—A health plan purchasing cooperative may not provide compensation to members of the Board of Directors. The cooperative may provide reimbursements to such members for the reasonable and necessary expenses incurred by the members in the performance of their duties as members of the Board.

(3) CONFLICT OF INTEREST.—No member of the Board of Directors (or family members of such members) nor any management personnel of the cooperative may be employed by, be a consultant of, be a member of the board of directors or, be affiliated with an agent of, or otherwise be a representative of any health plan issuer, health care provider, or agent or broker. Nothing in the preceding sentence shall limit a member of the Board from purchasing coverage offered through the cooperative.

(d) MEMBERSHIP AND MARKETING AREA.—

(1) MEMBERSHIP.—A health plan purchasing cooperative may establish limits on the maximum size of employers who may become members of the cooperative, and may determine whether to permit individuals to become members. Upon the establishment of such membership requirements, the cooperative shall, except as provided in subparagraph (B), accept all employers (or individuals) residing within the area served by the cooperative who meet such requirements as members on a first-come, first-served basis, or on another basis established by the State to ensure equitable access to the cooperative.

(2) MARKETING AREA.—A State may establish rules regarding the geographic area that must be served by a health plan purchasing cooperative. With respect to a State that has not established such rules, a health plan purchasing cooperative operating in the State shall define the boundaries of the area to be served by the cooperative, except that such boundaries may not be established on the basis of health status of the populations that reside in the area.

(e) DUTIES AND RESPONSIBILITIES.—

(1) IN GENERAL.—A health plan purchasing cooperative shall—

(A) enter into agreements with multiple, unaffiliated health plan issuers, except that the requirement of this subparagraph shall not apply in regions (such as remote or frontier areas) in which compliance with such requirement is not possible.

(B) enter into agreements with employers and individuals who become members of the cooperative;

(C) participate in any program of risk-adjustment or reinsurance, or any similar program, that is established by the State.

(D) prepare and disseminate comparative health plan materials (including information about cost, quality, benefits, and other information concerning group health plans and individual health plans offered through the cooperative);

(E) actively market to all eligible employers and individuals residing within the service area; and

(F) act as an ombudsman for group health plan or individual health plan enrollees.

(2) PERMISSIBLE ACTIVITIES.—A health plan purchasing cooperative may perform such other functions as necessary to further the purposes of this title, including—

(A) collecting and distributing premiums and performing other administrative functions;

(B) collecting and analyzing surveys of enrollee satisfaction;

(C) charging membership fee to enrollees (such fees may not be based on health status) and charging participation fees to health plan issuers;

(D) cooperating with (or accepting as members) employers who provide health benefits directly to participants and beneficiaries only for the purpose of negotiating with providers, and

(E) negotiating with health care providers and health plan issuers.

(f) LIMITATIONS ON COOPERATIVE ACTIVITIES.—A health plan purchasing cooperative shall not—

(1) perform any activity relating to the licensing of health plan issuers.

(2) assume financial risk directly or indirectly on behalf of members of a health plan purchasing cooperative relating to any group health plan or individual health plan;

(3) establish eligibility, continuation of eligibility, enrollment, or premium contribution requirements for participants, beneficiaries, or individuals based on health status;

(4) operate on a for-profit or other basis where the legal structure of the cooperative permits profits to be made and not returned to the members of the cooperative, except that a for-profit health plan purchasing cooperative may be formed by a nonprofit organization—

(A) in which membership in such organization is not based on health status; and

(B) that accepts as members all employers or individuals on a first-come, first-served basis, subject to any established limit on the maximum size of and employer that may become a member; or

(5) perform any other activities that conflict or are inconsistent with the performance of its duties under this title.

(g) LIMITED PREEMPTIONS OF CERTAIN STATE LAWS.—

(1) IN GENERAL.—With respect to a health plan purchasing cooperative that meets the requirements of this section, State fictitious group laws shall be preempted.

(2) HEALTH PLAN ISSUERS.—

(A) RATING.—With respect to a health plan issuer offering a group health plan or individual health plan through a health plan purchasing cooperative that meets the requirements of this section. State premium rating requirement laws, except to the extent provided under subparagraph (B), shall be preempted unless such laws permit premium rates negotiated by the cooperative to be less than rates that would otherwise be permitted under State law, if such rating differential is not based on differences in health status or demographic factors.

(B) EXCEPTION.—State laws referred to in subparagraph (A) shall not be preempted if such laws—

(i) prohibit the variance of premium rates among employers, plan sponsors, or individuals that are members of health plan purchasing cooperative in excess of the amount of such variations that would be permitted under such State rating laws among employers, plan sponsors, and individuals that are not members of the cooperative; and

(ii) prohibit a percentage increase in premium rates for a new rating period that is in excess of that which would be permitted under State rating laws.

(C) BENEFITS.—Except as provided in subparagraph (D), a health plan issuer offering a

group health plan or individual health plan through a health plan purchasing cooperative shall comply with all State mandated benefit laws that require the offering of any services, category or care, or services of any class or type of provider.

(D) EXCEPTION.—In those states that have enacted laws authorizing the issuance of alternative benefit plans to small employers, health plan issuers may offer such alternative benefit plans through a health plan purchasing cooperative that meets the requirements of this section.

(h) RULES OF CONSTRUCTION.—Nothing in this section shall be construed to—

(1) require that a State organize, operate, or otherwise create health plan purchasing cooperatives;

(2) otherwise require the establishment of health plan purchasing cooperatives.

(3) require individuals, plan sponsors, or employers to purchase group health plans or individual health plans through a health plan purchasing cooperative;

(4) require that a health plan purchasing cooperative be the only type of purchasing arrangement permitted to operate in a State.

(5) confer authority upon a State that the State would not otherwise have to regulate health plan issuers or employee health benefits plans, or

(6) confer authority up a State (or the Federal Government) that the State (or Federal Government) would not otherwise have to regulate group purchasing arrangements, coalitions, or other similar entities that do not desire to become a health plan purchasing cooperative in accordance with this section.

(i) APPLICATION OF ERISA.—For purposes of enforcement only, the requirements of parts 4 and 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1101) shall apply to a health pan purchasing cooperative as if such plan were an employee welfare benefit plan.

Subtitle E—Application and Enforcement of Standards

SEC. 141. APPLICABILITY.

(A) CONSTRUCTION.—

(1) ENFORCEMENT.—

(A) IN GENERAL.—A requirement or standard imposed under this title on a group health plan or individual health plan offered by a health plan issuer shall be deemed to be a requirement or standard imposed on the health plan issuer. Such requirements or standards shall be enforced by the State insurance commissioner for the State involved or the official or officials designated by the State to enforce the requirements of this title. In the case of a group health plan offered by a health plan issuer in connection with an employee health benefit plan, the requirements of standards imposed under the title shall be enforced with respect to the health plan issuer by the State insurance commissioner for the State involved or the official of officials designated by the State to enforce the requirements of this title.

(B) LIMITATION.—Except as provided in subsection (c), the Secretary shall not enforce the requirements or standards of this title as they relate to health plan issuers, group health plans, or individual health plans. In no case shall a Sate enforce the requirements or standards of this title as they relate to employee health benefit plans.

(2) PREEMPTION OF STATE LAW.—Nothing in this title shall be construed to prevent a State from establishing, implementing, or continuing in effect standards and requirements—

(A) not prescribed in this title; or

(B) related to the issuance, renewal, or portability of health insurance or the establishment or operation of group purchasing arrangements, that are consistent with, and are not in direct conflict with, this title and provide greater protection or benefit to participants, beneficiaries or individuals.

(b) RULE OF CONSTRUCTION.—Nothing in this title shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144).

(c) CONTINUATION.—Nothing in this title shall be construed as requiring a group health plan or an employee health benefit plan to provide benefits to a particular participant or beneficiary in excess of those provided under the terms of such plan.

SEC. 202. ENFORCEMENT OF STANDARDS.

(a) HEALTH PLAN ISSUERS.—Each State shall require that each group health plan and individual health plan issued, sold, renewed, offered for sale or operated in such State by a health plan issuer meet the standards established under this title pursuant to an enforcement plan filed by the State with the Secretary. A State shall submit such information as required by the Secretary demonstrating effective implementation of the State enforcement law.

(b) EMPLOYEE HEALTH BENEFIT PLANS.—With respect to employee health benefit plans, the Secretary shall enforce the reform standards established under this title in the same manner as provided for under sections 502, 504, 506, and 510 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132, 1134, 1136, and 1140). The civil penalties contained in paragraphs (1) and (2) of section 502(c) of such Act (29 U.S.C. 1132(c) (1) and (2)) shall apply to any information required by the Secretary to be disclosed and reported under this section.

(c) FAILURE TO IMPLEMENT PLAN.—In the case of the failure of a State to substantially enforce the standards and requirements set forth in this title with respect to group health plans and individual health plans as provided for under the State enforcement plan filed under subsection (a), the Secretary, in consultation with the Secretary of Health and Human Services, shall implement an enforcement plan meeting the standards of this title in such State. In the case of a State that fails to substantially enforce the standards and requirements set forth in this title, each health plan issuer operating in such State shall be subject to civil enforcement as provided for under sections 502, 504, 506, and 510 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132, 1134, 1136, and 1140). The civil penalties contained in paragraphs (1) and (2) of section 502(c) of such Act (29 U.S.C. 1132(c) (1) and (2)) shall apply to any information required by the Secretary to be disclosed and reported under this section.

(d) APPLICABLE CERTIFYING AUTHORITY.—As used in this title, the term ''applicable certifying authority''means, with respect to—

(1) health plan issuers, the State insurance commissioner or official or officials designated by the State to enforce the requirements of this title for the State involved; and

(2) an employee health benefit, plan, the Secretary.

(e) REGULATIONS.—The Secretary may promulgate such regulations as may be necessary or appropriate to carry out this title.

(f) TECHNICAL AMENDMENT.—Section 508 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1138) is amended by inserting ''and under the Health Insurance Reform Act of 1996'' before the period.

Subtitle F—Miscellaneous Provisions

SEC. 191. HEALTH COVERAGE AVAILABILITY STUDY.

(a) IN GENERAL.—The Secretary of Health and Human Services, in consultation with the Secretary, representatives of State officials, consumers, and other representatives of individuals and entities that have expertise in health insurance and employee benefits, shall conclude a two-part study, and prepare and submit reports, in accordance with this section.

(b) EVALUATION OF AVAILABILITY.—Not later than January 1, 1998, the Secretary of Health and Human Services shall prepare and submit to the appropriate committees of Congress a report, concerning—

(1) an evaluation, based on the experience of States, expert opinions, and such additional data as may be available, of the various mechanisms used to ensure the availability of reasonably priced health coverage to employers purchasing group coverage and to individuals purchasing coverage on a nongroup basis; and

(2) whether standards that limit the variation in premiums will further the purposes of this Act.

(c) EVALUATION OF EFFECTIVENESS.—Not later than January 1, 1999, the Secretary of Health and Human Services shall prepare and submit to the appropriate committees of Congress a report, concerning the effectiveness of the provisions of this Act and the various State laws, in ensuring the availability of reasonably priced health coverage to employers purchasing group coverage and individuals purchasing coverage on a nongroup basis.

SEC. 192. EFFECTIVE DATE.

Except as otherwise provided for in this title, the provisions of this title shall apply as follows:

(1) With respect to group health plans and individual health plans, such provisions shall apply to plans offered, sold, issued, renewed, in effect, or operated on or after January 1, 1997, and

(2) With respect to employee health benefit plans, on the first day of the first plan year beginning on or after January 1, 1997.

SEC. 193. SEVERABILITY.

If any provision of this title or the application of such provision to any person or circumstance is held to be unconstitutional, the remainder of this title and the application of the provisions of such to any person or circumstance shall not be affected thereby.

TITLE II—INCREASE IN DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS

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SEC. 200. AMENDMENT OF 1986 CODE.

Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

Subtitle A—Increase in Deduction For Health Insurance Costs of Self-Employed Individuals

SEC. 201. INCREASE IN DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

(a) IN GENERAL.—Paragraph (1) of section 162(l) is amended to read as follows:

''(1) ALLOWANCE OF DEDUCTION.—

''(A) IN GENERAL.—In the case of an individual who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an amount equal to the applicable percentage of the amount paid during the taxable year for insurance which constitutes medical care for the taxpayer, his spouse, and dependents.

''(B) APPLICABLE PERCENTAGE.—For purposes of subparagraph (A), the applicable percentage shall be determined under the following table:

''For taxable years beginning in calendar year—	The applicable percentage is—
After 1996 and before 2002	50 percent.
2002 or thereafter	80 percent.''

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 1996.

Subtitle B—Revenue Offsets

CHAPTER 1—TREATMENT OF INDIVIDUALS WHO EXPATRIATE

SEC. 211. REVISION OF TAX RULES ON EXPATRIATION.

(a) IN GENERAL.—Subpart A of part II of subchapter N of chapter 1 is amended by inserting after section 877 the following new section:

''SEC. 877A. TAX RESPONSIBILITIES OF EXPATRIATION.

''(a) GENERAL RULES.—For purposes of this subtitle—

''(1) MARK TO MARKET.—Except as provided in subsection (f), all property of a covered expatriate to which this section applies shall be treated as sold on the expatriation date for its fair market value.

''(2) RECOGNITION OF GAIN OR LOSS.—In the case of any sale under paragraph (1)—

''(A) notwithstanding any other provision of this title, any gain arising from such sale shall be taken into account for the taxable year of the sale unless such gain is excluded from gross income under part III of subchapter B, and

''(B) any loss arising from such sale shall be taken into account for the taxable year of the sale to the extent otherwise provided by this title, except that section 1091 shall not apply (and section 1092 shall apply) to any such loss.

''(3) EXCLUSION FOR CERTAIN GAIN.—The amount which would (but for this paragraph) be includible in the gross income of any individual by reason of this section shall be reduced (but not below zero) by $600,000. For purposes of this paragraph, allocable expatriation gain taken into account under subsection (f)(2) shall be treated in the same manner as an amount required to be includible in gross income.

''(4) ELECTION TO CONTINUE TO BE TAXED AS UNITED STATES CITIZEN.—

''(A) IN GENERAL.—If an expatriate elects the application of this paragraph—

''(i) this section (other than this paragraph) shall not apply to the expatriate, but

''(ii) the expatriate shall be subject to tax under this title, with respect to property to which this section would apply but for such election, in the same manner as if the individual were a United States citizen.

''(B) LIMITATION ON AMOUNT OF ESTATE, GIFT, AND GENERATION-SKIPPING TRANSFER TAXES.—The aggregate amount of taxes imposed under subtitle B with respect to any transfer of property by reason of an election under subparagraph (A) shall not exceed the amount of income tax which would be due if the property were sold for its fair market value immediately before the time of the transfer or death (taking into account the rules of paragraph (2)).

''(c) REQUIREMENTS.—Subparagraph (A) shall not apply to an individual unless the individual—

''(i) provides security for payment of tax in such form and manner, and in such amount, as the Secretary may require,

''(ii) consents to the waiver of any right of the individual under any treaty of the United States which would preclude assessment or collection of any tax which may be imposed by reason of this paragraph, and

''(iii) complies with such other requirements as the Secretary may prescribe.

''(D) ELECTION.—An election under subparagraph (A) shall apply to all property to which this section would apply but for the election and, once made, shall be irrevocable. Such election shall also apply to property the basis of which is determined in whole or in part by reference to the property with respect to which the election was made.

''(b) ELECTION TO DEFER TAX.—

''(1) IN GENERAL.—If the taxpayer elects the application of this subsection with respect to any property—

''(A) no amount shall be required to be included in gross income under subsection (a)(1) with respect to the gain for such property for the taxable year of the sale, but

''(B) the taxpayer's tax for the taxable year in which such property is disposed of shall be increased by the deferred tax amount with respect to the property.

Except to the extent provided in regulations, subparagraph (B) shall apply to a disposition whether or not gain or loss is recognized in whole or in part on the disposition.

''(2) DEFERRED TAX AMOUNT.—

''(A) IN GENERAL.—For purposes of paragraph (1), the term 'deferred tax amount' means, with respect to any property, an amount equal to the sum of—

''(i) the difference between the amount of tax paid for the taxable year described in paragraph (1)(A) and the amount which would have been paid for such taxable year if the election under paragraph (1) had not applied to such property, plus

''(ii) an amount of interest on the amount described in clause (i) determined for the period—

''(I) beginning on the 91st day after the expatriation date, and

''(II) ending on the due date for the taxable year described in paragraph (1)(B),

by using the rates and method applicable under section 6621 for underpayments of tax for such period.

For purposes of clause (ii), the due date is the date prescribed by law (determined without regard to extension) for filing the return of the tax imposed by this chapter for the taxable year.

''(B) ALLOCATION OF LOSSES.—For purposes of subparagraph (A), any losses described in subsection (a)(2)(B) shall be allocated ratably among the gains described in subsection (a)(2)(A).

''(3) SECURITY.—

''(A) IN GENERAL.—No election may be made under paragraph (1) with respect to any property unless adequate security is provided with respect to such property.

''(B) ADEQUATE SECURITY.—For purposes of subparagraph (A), security with respect to any property shall be treated as adequate security if—

''(i) it is a bond in an amount equal to the deferred tax amount under paragraph (2)(A) for the property, or

''(ii) the taxpayer otherwise establishes to the satisfaction of the Secretary that the security is adequate.

''(4) WAIVER OF CERTAIN RIGHTS.—No election may be made under paragraph (1) unless the taxpayer consents to the waiver of any right under any treaty of the United States which would preclude assessment or collection of any tax imposed by reason of this section.

''(5) DISPOSITIONS.—For purposes of this subsection, a taxpayer making an election under this subsection with respect to any property shall be treated as having disposed of such property—

''(A) immediately before death if such property is held at such time, and

''(B) at any time the security provided with respect to the property fails to meet the requirements of paragraph (3) and the taxpayer does not correct such failure within the time specified by the Secretary.

''(6) ELECTIONS.—An election under paragraph (1) shall only apply to property described in the election and, once made, is irrevocable. An election may be under paragraph (1) with respect to an interest in a trust with respect to which gain is required to be recognized under subsection (f)(1).

''(c) COVERED EXPATRIATE.—For purposes of this section—

''(1) IN GENERAL.—The term 'covered expatriate' means an expatriate—

''(A) whose average annual net income tax (as defined in section 38(c)(1)) for the period of 5 taxable years ending before the expatriation date is greater than $100,000, or

''(B) whose net worth as of such date is $500,000 or more.

If the expatriation date is after 1996, such $100,000 and $500,000 amounts shall be increased by an amount equal to such dollar amount multiplied by the cost-of-living adjustment determined under section 1(f)(3) for such calendar year by substituting '1995' for '1992' in subparagraph (B) thereof. Any increase under the preceding sentence shall be rounded to the nearest multiple of $1,000.

''(2) EXCEPTIONS.—An individual shall not be treated as a covered expatriate if—

''(A) the individual—

''(i) became at birth a citizen of the United States and a citizen of another country and, as of the expatriation date, continues to be a citizen of, and is taxed as a resident of, such other country, and

''(ii) has been a resident of the United Stats (as defined in section 7701(b)(1)(A)(ii)) for not more than 8 taxable years during the 15-taxable year period ending with the taxable year during which the expatriation date occurs, or

''(B)(i) the individual's relinquishment of United States citizenship occurs before such individual attains age 18½, and

''(ii) the individual has been a resident of the United States (as so defined) for not more than 5 taxable years before the date of relinquishment.

''(d) PROPERTY TO WHICH SECTION APPLIES.—For purposes of this section—

''(1) IN GENERAL.—Except as otherwise provided by the Secretary, this section shall apply to—

''(A) any interest in property held by a covered expatriate on the expatriation date the gain from which would be included in the gross income of the expatriate if such interest had been sold for its fair market value on such data in a transaction in which gain is recognized in whole or in part, and

''(B) any other interest in a trust to which subsection (f) applies.

''(2) EXCEPTIONS.—This section shall not apply to the following property:

''(A) UNITED STATES REAL PROPERTY INTERESTS.—Any United States real property interest (as defined in section 897(c)(1)), other than stock of a United States real property holding corporation which does not, on the expatriation date, meet the requirements of section 897(c)(2).

''(B) INTEREST IN CERTAIN RETIREMENT PLANS.—

''(i) IN GENERAL.—Any interest in a qualified retirement plan (as defined in section 4974(c)), other than any interest attributable to contributions which are in excess of any limitation or which violate any condition for tax-favored treatment.

''(ii) FOREIGN PENSION PLANS.—

''(I) IN GENERAL.—Under regulations prescribed by the Secretary, interests in foreign pension plans or similar retirement arrangements or programs.

''(II) LIMITATION.—The value of property which is treated as not sold by reason of this subparagraph shall not exceed $500,000.

''(e) DEFINITIONS.—For purposes of this section—

''(1) EXPATRIATE.—The term 'expatriate' means—

''(A) any United States citizen who relinquishes his citizenship, or

''(B) any long-term resident of the United States who—

''(i) ceases to be a lawful permanent resident of the United States (within the meaning of section 7701(b)(6)), or

''(ii) commences to be treated as a resident of a foreign country under the provisions of a tax treaty between the United States and the foreign country and who does not waive the benefits of such treaty applicable to residents of the foreign country.

''(2) EXPATRIATION DATE.—The term 'expatriation date' means—

''(A) the date an individual relinquishes United States citizenship, or

''(B) in the case of a long-term resident of the United States, the date of the event described in clause (i) or (ii) of paragraph (1)(B).

''(3) RELINQUISHMENT OF CITIZENSHIP.—A citizen shall be treated as relinquishing his United States citizenship on the earliest of—

''(A) the date the individual renounces his United States nationality before a diplomatic or consular officer of the United States pursuant to paragraph (5) of section 349(a) of the Immigration and Nationality Act (8 U.S.C. 1481(a)(5)).

''(B) the date the individual furnishes to the United States Department of State a signed statement of voluntary relinquishment of United States nationality confirming the performance of an act of expatriation specified in paragraph (1), (2), (3), or (4) of section 349(a) of the Immigration and Nationality Act (8 U.S.C. 1481(a)(1)–(4)).

''(C) the date the United States Department of State issues to the individual a certificate of loss of nationality, or

''(D) the date a court of the United States cancels a naturalized citizen's certificate of naturalization.

Subparagraph (A) or (B) shall not apply to any individual unless the renunciation or voluntary relinquishment is subsequently approved by the issuance to the individual of a certificate of loss of nationality by the United States Department of State.

''(4) LONG-TERM RESIDENT.—

''(A) IN GENERAL.—The term 'long-term resident' means any individual (other than a citizen of the United States) who is a lawful permanent resident of the United States in at least 8 taxable years during the period of 15 taxable years ending with the taxable year during which the expatriation date occurs. For purposes of the preceding sentence, an individual shall not be treated as a lawful permanent resident for any taxable year if such individual is treated as a resident of a foreign country for the taxable year under the provisions of a tax treaty between the United States and the foreign country and does not waive the benefits of such treaty applicable to residents of the foreign country.

''(B) SPECIAL RULE.—For purposes of subparagraph (A), there shall not be taken into account—

''(i) any taxable year during which any prior sale is treated under subsection (a)(1) as occurring, or

''(ii) any taxable year prior to the taxable year referred to in clause (i).

''(f) SPECIAL RULES APPLICABLE TO BENEFICIARIES' INTERESTS IN TRUST.—

''(1) IN GENERAL.—Except as provided in paragraph (2), if an individual is determined under paragraph (3) to hold an interest in a trust—

''(A) the individual shall not be treated as having sold such interest,

''(B) such interest shall be treated as a separate share in the trust, and

''(C)(i) such separate share shall be treated as a separate trust consisting of the assets allocable to such share,

''(ii) the separate trust shall be treated as having sold its assets immediately before the expatriation date for their fair market value and as having distributed all of its assets to the individual as of such time, and

''(iii) the individual shall be treated as having recontributed the assets to the separate trust.

Subsection (a)(2) shall apply to any income, gain, or loss of the individual arising from a distribution described in subparagraph (C)(ii).

''(2) SPECIAL RULES FOR INTERESTS IN QUALIFIED TRUSTS.—

''(A) IN GENERAL.—If the trust interest described in paragraph (1) is an interest in a qualified trust—

''(i) paragraph (1) and subsection (a) shall not apply, and

''(ii) in addition to any other tax imposed by this title, there is hereby imposed on each distribution with respect to such interest a tax in the amount determined under subparagraph (B).

''(B) AMOUNT OF TAX.—The amount of tax under subparagraph (A)(ii) shall be equal to the lesser of—

''(i) the highest rate of tax imposed by section 1(e) for the taxable year in which the expatriation date occurs, multiplied by the amount of the distribution, or

''(ii) the balance in the deferred tax account immediately before the distribution determined without regard to any increases under subparagraph (C)(ii) after the 30th day preceding the distribution.

''(C) DEFERRED TAX ACCOUNT.—For purposes of subparagraph (B)(ii)—

''(i) OPENING BALANCE.—The opening balance in a deferred tax account with respect to any trust interest in an amount equal to the tax which would have been imposed on the allocable expatriation gain with respect to the trust interest if such gain had been included in gross income under subsection (a).

''(ii) INCREASE FOR INTEREST.—The balance in the deferred tax account shall be increased by the amount of interest determined (on the balance in the account at the time the interest accrues), for periods after the 90th day after the expatriation date, by using the rates and method applicable under section 6621 for underpayments of tax for such periods.

''(iii) DECREASE FOR TAXES PREVIOUSLY PAID.—The balance in the tax deferred account shall be reduced—

''(I) by the amount of taxes imposed by subparagraph (A) on any distribution to the person holding the trust interest, and

''(II) in the case of a person holding a nonvested interest, to the extent provided in regulations, by the amount of taxes imposed by subparagraph (A) on distributions from the trust with respect to nonvested interests not held by such person.

''(D) ALLOCABLE EXPATRIATION GAIN.—For purposes of this paragraph, the allocable expatriation gain with respect to any beneficiary's interest in a trust in the amount of gain which would be allocable to such beneficiary's vested and nonvested interests in the trust if the beneficiary held directly all assets allocable to such interests.

''(E) TAX DEDUCTED AND WITHHELD.—

''(i) IN GENERAL.—The tax imposed by subparagraph (A)(ii) shall be deducted and withheld by the trustees from the distribution to which it relates.

''(ii) EXCEPTION WHERE FAILURE TO WAIVE TREATY RIGHTS.—If an amount may not be deducted and withheld under clause (i) by reason of the distributee failing to waive any treaty right with respect to such distribution—

''(I) the tax imposed by subparagraph (A)(ii) shall be imposed on the trust and each trustee shall be personally liable for the amount of such tax, and

''(II) any other beneficiary of the trust shall be entitled to recover from the distributee the amount of such tax imposed on the other beneficiary.

''(F) DISPOSITION.—If a trust ceases to be a qualified trust at any time, a covered expatriate disposes of an interest in a qualified trust, or a covered expatriate holding an interest in a qualified trust dies, then, in lieu of the tax imposed by subparagraph (A)(ii), there is hereby imposed a tax equal to the lesser of—

''(i) the tax determined under paragraph (1) as if the expatriation date were the date of such cessation, disposition, or death, whichever is applicable, or

''(ii) the balance in the tax deferred account immediately before such date.

Such tax shall be imposed on the trust and each trustee shall be personally liable for the amount of such tax and any other beneficiary of the trust shall be entitled to recover from the covered expatriate or the estate the amount of such tax imposed on the other beneficiary.

''(G) DEFINITIONS AND SPECIAL RULE.—For purposes of this paragraph—

''(i) QUALIFIED TRUST.—The term 'qualified trust' means a trust—

''(I) which is organized under, and governed by, the laws of the United States or a State, and

''(II) with respect to which the trust instrument requires that at least 1 trustee of the trust be an individual citizen of the United States or a domestic corporation.

''(ii) VESTED INTEREST.—The term 'vested interest' means any interest which, as of the expatriation date, is vested in the beneficiary.

''(iii) NONVESTED INTEREST.—The term 'nonvested interest' means, with respect to any beneficiary, any interest in a trust

which is not a vested interest. Such interest shall be determined by assuming the maximum exercise of discretion in favor of the beneficiary and the occurrence of all contingencies in favor of the beneficiary.

''(iv) ADJUSTMENTS.—The Secretary may provide for such adjustments to the bases of assets in a trust or a deferred tax account, and the timing of such adjustments, in order to ensure that gain is taxed only once.

''(3) DETERMINATION OF BENEFICIARIES' INTEREST IN TRUST.—

''(A) DETERMINATIONS UNDER PARAGRAPH (1)—For purposes of paragraph (1), a beneficiary's interest in a trust shall be based upon all relevant facts and circumstances, including the terms of the trust instrument and any letter of wishes or similar document, historical patterns of trust distributions, and the existence of and functions performed by a trust protector or any similar advisor.

''(B) OTHER DETERMINATIONS.—For purposes of this section—

''(i) CONSTRUCTIVE OWNERSHIP.—If a beneficiary of a trust is a corporation, partnership, trust, or estate, the shareholders, partners, or beneficiaries shall be deemed to be the trust beneficiaries for purposes of this section.

''(ii) TAXPAYER RETURN POSITION.—A taxpayer shall clearly indicate on its income tax return—

''(I) the methodology used to determine that taxpayer's trust interest under this section, and

''(II) if the taxpayer knows (or has reason to know) that any other beneficiary of such trust is using a different methodology to determine such beneficiary's trust interest under this section.

''(g) TERMINATION OF DEFERRALS, ETC.—On the date any property held by an individual is treated as sold under subsection (a), notwithstanding any other provision of this title—

''(1) any period during which recognition of income or gain is deferred shall terminate, and

''(2) any extension of time for payment of tax shall cease to apply and the unpaid portion of such tax shall be due and payable at the time and in the manner prescribed by the Secretary.

''(h) IMPOSITION OF TENTATIVE TAX.—

''(1) IN GENERAL.—If an individual is required to include any amount in gross income under subsection (a) for any taxable year, there is hereby imposed, immediately before the expatriation date, a tax in an amount equal to the amount of tax which would be imposed if the taxable year were a short taxable year ending on the expatriation date.

''(2) DUE DATE.—The due date for any tax imposed by paragraph (1) shall be the 90th day after the expatriation date.

''(3) TREATMENT OF TAX.—Any tax paid under paragraph (1) shall be treated as a payment of the tax imposed by this chapter for the taxable year to which subsection (a) applies.

''(4) DEFERRAL OF TAX.—The provisions of subsection (b) shall apply to the tax imposed by this subsection to the extent attributable to gain includible in gross income by reason of this section.

''(i) COORDINATION WITH ESTATE AND GIFT TAXES.—If subsection (a) applies to property held by an individual for any taxable year and—

''(1) such property is includible in the gross estate of such individual solely by reason of section 2107, or

''(2) section 2501 applies to a transfer of such property by such individual solely by reason of section 2501(a)(3).

then there shall be allowed as a credit against the additional tax imposed by section 2101 or 2501, whichever is applicable, solely by reason of section 2107 or 2501(a)(3) an amount equal to the increase in the tax imposed by this chapter for such taxable year by reason of this section.

''(j) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary or appropriate to carry out the purposes of this section, including regulations—

''(1) to prevent double taxation by ensuring that—

''(A) appropriate adjustments are made to basis to reflect gain recognized by reason of subsection (a) and the exclusion provided by subsection (a)(3), and

''(B) any gain by reason of a deemed sale under subsection (a) of an interest in a corporation, partnership, trust, or estate is reduced to reflect that portion of such gain which is attributable to an interest in a trust which a shareholder, partner, or beneficiary is treated as holding directly under subsection (f)(3)(B)(i), and

''(2) which provide for the proper allocation of the exclusion under subsection (a)(3) to property to which this section applies.

''(k) CROSS REFERENCE.—

''For income tax treatment of individuals who terminate United States citizenship, see section 7701(a)(47).''.

(b) INCLUSION IN INCOME OF GIFTS AND INHERITANCES FROM COVERED EXPATRIATES.—Section 102 (relating to gifts, etc. not included in gross income) is amended by adding at the end the following new subsection:

''(d) GIFTS AND INHERITANCES FROM COVERED EXPATRIATES.—Subsection (a) shall not exclude from gross income the value of any property acquired by gift, bequest, devise, or inheritance from a covered expatriate after the expatristion date. For purposes of this subsection, any term used in this subsection which is also used in section 877A shall have the same meaning as when used in section 877A.''.

(c) DEFINITION OF TERMINATION OF UNITED STATES CITIZENSHIP.—Section 7701(a) is amended by adding at the end the following new paragraph:

''(47) TERMINATION OF UNITED STATES CITIZENSHIP.—An individual shall not cease to be treated as a United States citizen before the date on which the individual's citizenship is treated as relinquished under section 877A(e)(3).''.

(d) CONFORMING AMENDMENTS.—

(1) Section 877 is amended by adding at the end the following new subsection:

''(f) APPLICATION.—This section shall not apply to any individual who relinquishes (within the meaning of section 877A(e)(3)) United States citizenship on or after February 6, 1995.''.

(2) Section 2107(c) is amended by adding at the end the following new paragraph:

''(3) CROSS REFERENCE.—For credit against the tax imposed by subsection (a) for expatriation tax, see section 877A(i).''.

(3) Section 2501(a)(3) is amended by adding at the end the following new flush sentence: ''For credit against the tax imposed under this section by reason of this paragraph, see section 877A(i).''.

(4) Paragraph (10) of section 7701(b) is amended by adding at the end the following new sentence: ''This paragraph shall not apply to any long-term resident of the United States who is an expatriate (as defined in section 877A(e)(1)).''.

(e) CLERICAL AMENDMENT.—The table of sections for subpart A of part II of subchapter N of chapter 1 is amended by inserting after the item relating to section 877 the following new item:

''Sec. 877A. Tax responsibilities of expatriation.''.

(f) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in this subsection, the amendments made by this section shall apply to expatriates (within the meaning of section 877A(e) of the Internal Revenue Code of 1986, as added by this section) whose expatriation date (as so defined) occurs on or after February 6, 1995.

(2) GIFTS AND BEQUESTS.—Section 102(d) of the Internal Revenue Code of 1986 (as added by subsection (b)) shall apply to amounts received from expatriates (as so defined) whose expatriation date (as so defined) occurs on and after February 6, 1995.

(3) SPECIAL RULES RELATING TO CERTAIN ACTS OCCURRING BEFORE FEBRUARY 6, 1995.—In the case of an individual who took an act of expatriation specified in paragraph (1), (2), (3), or (4) of section 349(a) of the Immigration and Nationality Act (8 U.S.C. 1481(a) (1)–(4)) before February 6, 1995, but whose expatriation date (as so defined) occurs after February 6, 1995—

(A) the amendment made by subsection (c) shall not apply,

(B) the amendment made by subsection (d)(1) shall not apply for any period prior to the expatriation date, and

(C) the other amendments made by this section shall apply as of the expatriation date.

(4) DUE DATE FOR TENTATIVE TAX.—The due date under section 877A(h)(2) of such Code shall in no event occur before the 90th day after the date of the enactment of this Act.

SEC. 212. INFORMATION ON INDIVIDUALS EXPATRIATING.

(a) IN GENERAL.—Subpart A of part III of subchapter A of chapter 61 is amended by inserting after section 6039E the following new section:

''SEC. 6039F. INFORMATION ON INDIVIDUALS EXPATRIATING.

''(a) REQUIREMENT.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, any expatriate (within the meaning of section 877A(e)(1)) shall provide a statement which includes the information described in subsection (b).

''(2) TIMING.—

''(A) CITIZENS.—In the case of an expatriate described in section 877(e)(1)(A), such statement shall be—

''(i) provided not later than the expatriation date (within the meaning of section 877A(e)(2)), and

''(ii) provided to the person or court referred to in section 877A(e)(3).

''(B) NONCITIZENS.—In the case of an expatriate described in section 877A(e)(1)(B), such statement shall be provided to the Secretary with the return of tax imposed by chapter 1 for the taxable year during which the event described in such section occurs.

''(b) INFORMATION TO BE PROVIDED.—Information required under subsection (a) shall include—

''(1) the taxpayer's TIN,

''(2) the mailing address of such individual's principal foreign residence,

''(3) the foreign country in which such individual is residing,

''(4) the foreign country of which such individual is a citizen,

''(5) in the case of an individual having a net worth of at lease the dollar amount applicable under section 877A(c)(1)(B), information detailing the assets and liabilities of such individual, and

''(6) such other information as the Secretary may prescribe.

''(c) PENALTY.—Any individual failing to provide a statement required under subsection (a) shall be subject to a penalty for each year during any portion of which such failure continues in an amount equal to the greater of—

''(1) 5 percent of the additional tax required to be paid under section 877A for such year, or

''(2) $1,000, unless it is shown that such failure is due to reasonable cause and not to willful neglect.

''(d) INFORMATION TO BE PROVIDED TO SECRETARY.—Notwithstanding any other provision of law—

''(1) any Federal agency or court which collects (or is required to collect) the statement under subsection (a) shall provide to the Secretary—

''(A) a copy of any such statement, and

''(B) the name (and any other identifying information) of any individual refusing to comply with the provisions of subsection (a),

''(2) the Secretary of State shall provide to the Secretary a copy of each certificate as to the loss of American nationality under section 358 of the Immigration and Nationality Act which is approved by the Secretary of State, and

''(3) the Federal agency primarily responsible for administering the immigration laws shall provide to the Secretary the name of each lawful permanent resident of the United States (within the meaning of section 7701(b)(6)) whose status as such has been revoked or has been administratively or judicially determined to have been abandoned.

Notwithstanding any other provision of law, not later than 30 days after the close of each calendar quarter, the Secretary shall publish in the Federal Register the name of each individual relinquishing United States citizenship (within the meaning of section 877A(e)(3)) with respect to whom the Secretary receives information under the preceding sentence during such quarter.

''(e) EXEMPTION.—The Secretary may by regulations exempt any class of individuals from the requirements of this section if the Secretary determines that applying this section to such individuals is not necessary to carry out the purposes of this section.''.

(b) CLERICAL AMENDMENT.—The table of sections for such subpart A is amended by inserting after the item relating to section 6039E the following new item:

''Sec. 6039F. Information on individuals expatriating.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to individuals to whom section 877A of the Internal Revenue Code of 1986 applies and whose expatriation date (as defined in section 877A(e)(2)) occurs on or after February 6, 1995, except that no statement shall be required by such amendments before the 90th day after the date of the enactment of this Act.

CHAPTER 2—FOREIGN TRUST TAX COMPLIANCE

SEC. 221. IMPROVED INFORMATION REPORTING ON FOREIGN TRUSTS.

(a) IN GENERAL.—Section 6048 (relating to returns as to certain foreign trusts) is amended to read as follows:

''SEC. 6048. INFORMATION WITH RESPECT TO CERTAIN FOREIGN TRUSTS.

''(a) NOTICE OF CERTAIN EVENTS.—

''(1) GENERAL RULE.—On or before the 90th day (or such later day as the Secretary may prescribe) after any reportable event, the responsible party shall provide written notice of such event to the Secretary in accordance with paragraph (2).

''(2) CONTENTS OF NOTICE.—The notice required by paragraph (1) shall contain such information as the Secretary may prescribe, including—

''(A) the amount of money or other property (if any) transferred to the trust in connection with the reportable event, and

''(B) the identify of the trust and of each trustee and beneficiary or class of beneficiaries) of the trust.

''(3) REPORTABLE EVENT.—For purposes of this subsection—

''(A) IN GENERAL.—The term 'reportable event' means—

''(i) the creation of any foreign trust by a United States person,

''(ii) the transfer of any money or property (directly or indirectly) to a foreign trust by a United States person, including a transfer by reason of death, and

''(iii) the death of a citizen or resident of the United States if—

''(I) the decedent was treated as the owner of any portion of a foreign trust under the rules of subpart E of part I of subchapter J of chapter 1, or

''(II) any portion of a foreign trust was included in the gross estate of the decedent.

''(B) EXCEPTIONS.—

''(i) FAIR MARKET VALUE SALES.—Subparagraph (A)(ii) shall not apply to any transfer of property to a trust in exchange for consideration of at least the fair market value of the transferred property. For purposes of the preceding sentence, consideration other than cash shall be taken into account at its fair market value and the rules of section 679(a)(3) shall apply.

''(ii) DEFERRED COMPENSATION AND CHARITABLE TRUSTS.—Subparagraph (A) shall not apply with respect to a trust which is—

''(I) described in section 402(b), 404(a)(4), or 404A, or

''(II) determined by the Secretary to be described in section 501(c)(3).

''(4) RESPONSIBLE PARTY.—For purposes of this subsection, the term 'responsible party' means—

''(A) the grantor in the case of the creation of an inter vivos trust.

''(B) the transferor in the case of a reportable event described in paragraph (3)(A)(ii) other than a transfer by reason of death, and

''(C) the executor of the decedent's estate in any other case.

''(b) UNITED STATES GRANTOR OF FOREIGN TRUST.—

''(1) IN GENERAL.—If, at any time during any taxable year of a United States person, such person is treated as the owner of any portion of a foreign trust under the rules of subpart E of part I of subchapter J of chapter 1, such person shall be responsible to ensure that

''(A) such trust makes a return for such year which sets forth a full and complete accounting of all trust activities and operations for the year, the name of the United States agent for such trust, and such other information as the Secretary may prescribe, and

''(B) such trust furnishes such information as the Secretary may prescribe to each United States person (i) who is treated as the owner of any portion of such trust or (ii) who receives (directly or indirectly) any distribution from the trust.

''(2) TRUSTS NOT HAVING UNITED STATES AGENT.—

''(A) IN GENERAL.—If the rules of this paragraph apply to any foreign trust, the determination of amounts required to be taken into account with respect to such trust by a United States person under the rules of subpart E of part I of subchapter J of chapter 1 shall be determined by the Secretary.

''(B) UNITED STATES AGENT REQUIRED.—The rules of this paragraph shall apply to any foreign trust to which paragraph (1) applies unless such trust agrees (in such manner, subject to such conditions, and at such time as the Secretary shall prescribe) to authorize a United States person to act as such trust's limited agent solely for purposes of applying sections 7602, 7603, and 7604 with respect to—

''(i) any request by the Secretary to examine records or produce testimony related to the proper treatment of amounts required to be taken into account under the rules referred to in subparagraph (A), or

''(ii) any summons by the Secretary for such records or testimony.

The appearance of persons or production of records by reason of a United States person being such an agent shall not subject such persons or records to legal process for any purpose other than determining the correct treatment under this title of the amounts required to be taken into account under the rules referred to in subparagraph (A). A foreign trust which appoints an agent described in this subparagraph shall not be considered to have an office or a permanent establishment in the United States, or to be engaged in a trade or business in the United States, solely because of the activities of such agent pursuant to this subsection.

''(C) OTHER RULES TO APPLY.—Rules similar to the rules of paragraphs (2) and (4) of section 6038A(e) shall apply for purposes of this paragraph.

''(c) REPORTING BY UNITED STATES BENEFICIARIES OF FOREIGN TRUSTS.—

''(1) IN GENERAL.—If any United States person receives (directly or indirectly) during any taxable year of such person any distribution from a foreign trust, such person shall make a return with respect to such trust for such year which includes—

''(A) the name of such trust,

''(B) the aggregate amount of the distributions so received from such trust during such taxable year, and

''(C) such other information as the Secretary may prescribe.

''(2) INCLUSION IN INCOME IF RECORDS NOT PROVIDED.—

''(A) IN GENERAL.—If applicable records are not provided to the Secretary to determine the proper treatment of any distribution from a foreign trust, such distribution shall be treated as an accumulation distribution includable in the gross income of the distributee under chapter 1. To the extent provided in regulations, the preceeding sentence shall not apply if the foreign trust elects to be subject to rules similar to the rules of subsection (b)(2)(B).

''(B) APPLICATION OF ACCUMULATION DISTRIBUTION RULES.—For purposes of applying section 668 in a case to which subparagraph (A) applies, the applicable number of years for purposes of section 668(a) shall be ½ of the number of years the trust has been in existence.

''(d) SPECIAL RULES.—

''(1) DETERMINATION OF WHETHER UNITED STATES PERSON RECEIVES DISTRIBUTION.—For purposes of this section, in determining whether a United States person receives a distribution from a foreign trust, the fact that a portion of such trust is treated as owned by another person under the rules of subpart E of part I of subchapter J of chapter 1 shall be disregarded.

''(2) DOMESTIC TRUSTS WITH FOREIGN ACTIVITIES.—To the extent provided in regulations, a trust which is a United States person shall be treated as a foreign trust for purposes of this section and section 6677 if such trust has substantial activities, or holds substantial property, outside the United States.

''(3) TIME AND MANNER OF FILING INFORMATION.—Any notice or return required under this section shall be made at such time and in such manner as the Secretary shall prescribe.

''(4) MODIFICATION OF RETURN REQUIREMENTS.—The Secretary is authorized to suspend or modify any requirement of this section if the Secretary determines that the United States has no significant tax interest in obtaining the required information.''.

(b) INCREASED PENALTIES.—Section 6677 (relating to failure to file information returns with respect to certain foreign trusts) is amended to read as follows:

"SEC. 6677. FAILURE TO FILE INFORMATION WITH RESPECT TO CERTAIN FOREIGN TRUSTS.

''(a) CIVIL PENALTY.—In addition to any criminal penalty provided by law, if any notice or return required to be filed by section 6048—

''(1) is not filed on or before the time provided in such section, or

''(2) does not include all the information required pursuant to such section or includes incorrect information.

the person required to file such notice or return shall pay a penalty equal to 35 percent of the gross reportable amount. If any failure described in the preceding sentence continues for more than 90 days after the day on which the Secretary mails notice of such failure to the person required to pay such penalty, such person shall pay a penalty (in addition to the amount determined under the preceding sentence) of $10,000 for each 30-day period (or fraction thereof) during which such failure continues after the expiration of such 90-day period. In no event shall the penalty under this subsection with respect to any failure exceed the gross reportable amount.

''(b) SPECIAL RULES FOR RETURNS UNDER SECTION 6048(b).—In the case of a return required under section 6048(b)—

''(1) the United States person referred to in such section shall be liable for the penalty imposed by subsection (a), and

''(2) subsection (a) shall be applied by substituting '5 percent' for '35 percent'.

''(c) GROSS REPORTABLE AMOUNT.—For purposes of subsection (a), the term 'gross reportable amount' means—

''(1) the gross value of the property involved in the event (determined as of the date of the event) in the case of a failure relating to section 6048(a),

''(2) the gross value of the portion of the trust's assets at the close of the year treated as owned by the United States person in the case of a failure relating to section 6048(b)(1), and

''(3) the gross amount of the distributions in the case of a failure relating to section 6048(c).

''(d) REASONABLE CAUSE EXCEPTION.—No penalty shall be imposed by this section on any failure which is shown to be due to reasonable cause and not due to willful neglect. The fact that a foreign jurisdiction would impose a civil or criminal penalty on the taxpayer (or any other person) for disclosing the required information is not reasonable cause.

''(e) DEFICIENCY PROCEDURES NOT TO APPLY.—Subchapter B of chapter 63 (relating to deficiency procedures for income, estate, gift, and certain excise taxes) shall not apply in respect of the assessment or collection of any penalty imposed by subsection (a).''.

(c) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 6724(d), as amended by sections 11004 and 11045, is amended by striking ''or'' at the end of subparagraph (U), by striking the period at the end of subparagraph (V) and inserting ',or'', and by inserting after subparagraph (V) the following new subparagraph:

''(W) section 6048(b)(1)(B) (relating to foreign trust reporting requirements).''.

(2) The table of sections for subpart B of part III of subchapter A of chapter 61 is amended by striking the item relating to section 6048 and inserting the following new item:

''Sec. 604 Information with respect to certain foreign trusts.''.

(3) The table of sections for part I of subchapter B of chapter 68 is amended by striking the item relating to section 6677 and inserting the following new item:

''Sec. 6677. Failure to file information with respect to certain foreign trusts''

(d) EFFECTIVE DATES.—

(1) REPORTABLE EVENTS.—To the extent related to subsection (a) of section 6048 of the Internal Revenue Code of 1986, as amended by this section, the amendments made by this section shall apply to reportable events (as defined in such section 6048) occurring after the date of the enactment of this Act.

(2) GRANTOR TRUST REPORTING.—To the extent related to subsection (b) of such section 6048, the amendments made by this section shall apply to taxable years of United States persons beginning after the date of the enactment of this Act.

(3) REPORTING BY UNITED STATES BENEFICIARIES.—To the extent related to subsection (c) of such section 6048, the amendments made by this section shall apply to distributions received after the date of the enactment of this Act.

SEC. 222. MODIFICATIONS OF RULES RELATING TO FOREIGN TRUSTS HAVING ONE OR MORE UNITED STATES BENEFICIARIES.

(a) TREATMENT OF TRUST OBLIGATIONS, ETC.—

(1) Paragraph (2) of section 679(a) is amended by striking subparagraph (B) and inserting the following:

''(B) TRANSFERS AT FAIR MARKET VALUE.—To any transfer of property to a trust in exchange for consideration of at least the fair market value of the transferred property. For purposes of the preceding sentence, consideration other than cash shall be taken into account at its fair market value.''.

(2) Subsection (a) of section 679 (relating to foreign trusts having one or more United States beneficiaries) is amended by adding at the end the following new paragraph:

''(3) CERTAIN OBLIGATIONS NOT TAKEN INTO ACCOUNT UNDER FAIR MARKET VALUE EXCEPTIONS.—

''(A) IN GENERAL.—In determining whether paragraph (2)(B) applies to any transfer by a person described in clause (ii) or (iii) of subparagraph (C), there shall not be taken into account—

''(i) except as provided in regulations, any obligation of a person described in subparagraph (C), and

''(ii) to the extent provided in regulations, any obligation which is guaranteed by a person described in subparagraph (C).

''(B) TREATMENT OF PRINCIPAL PAYMENTS ON OBLIGATION.—Principal payments by the trust on any obligation referred to in subparagraph (A) shall be taken into account on and after the date of the payment in determining the portion of the trust attributable to the property transferred.

''(C) PERSONS DESCRIBED.—The persons described in this subparagraph are—

''(i) the trust,

''(ii) any grantor or beneficiary of the trust, and

''(iii) any person who is related (within the meaning of section 643(i)(2)(B)) to any grantor or beneficiary of the trust.''.

(b) EXEMPTION OF TRANSFERS TO CHARITABLE TRUSTS.—Subsection (a) of section 679 is amended by striking ''section 404(a)(4) or 404A'' and inserting ''section 6048(a)*(3)(B)(ii)''.

(c) OTHER MODIFICATIONS.—Subsection (a) of section 679 is amended by adding at the end the following new paragraphs:

''(4) SPECIAL RULES APPLICABLE TO FOREIGN GRANTOR WHO LATER BECOMES A UNITED STATES PERSON.—

''(A) IN GENERAL.—If a nonresident alien individual has a residency starting date within 5 years after directly or indirectly transferring property to a foreign trust, this section and section 6048 shall be applied as if such individual transferred to such trust on the residency starting date an amount equal to the portion of such trust attributable to the property transferred by such individual to such trust in such transfer.

''(B) TREATMENT OF UNDISTRIBUTED INCOME.—For purposes of this section, undistributed net income for periods before such individual's residency starting date shall be taken into account in determining the portion of the trust which is attributable to property transferred by such individual to such trust but shall not otherwise be taken into account.

''(C) RESIDENCY STARTING DATE.—For purposes of this paragraph, an individual's residency starting date is the residency starting date determined under section 7701(b)(2)(A).

''(5) OUTBOUND TRUST MIGRATIONS.—If—

''(A) an individual who is a citizen or resident of the United States transferred property to a trust which was not a foreign trust, and

''(B) such trust becomes a foreign trust while such individual is alive,

then this section and section 6048 shall be applied as if such individual transferred to such trust on the date such trust becomes a foreign trust an amount equal to the portion of such trust attributable to the property previously transferred by such individual to such trust. A rule similar to the rule of paragraph (4)(B) shall apply for purposes of this paragraph.''.

(d) MODIFICATION RELATING TO WHETHER TRUST HAS UNITED STATES BENEFICIARIES.—Subsection (c) of section 679 is amended by adding at the end the following new paragraph:

''(3) CERTAIN UNITED STATES BENEFICIARIES DISREGARDED.—A beneficiary shall not be treated as a United States person in applying this section with respect to any transfer of property to foreign trust if such beneficiary first became a United States person more than 5 years after the date of such transfer.''.

(e) TECHNICAL AMENDMENT.—Subparagraph (A) of section 679(c)(2) is amended to read as follows:

''(A) in the case of a foreign corporation, such corporation is a controlled foreign corporation (as defined in section 957(a)),''.

(f) REGULATIONS.—Section 679 is amended by adding at the end the following new subsection:

''(d) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary or appropriate to carry out the purposes of this section.''.

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to transfers of property after February 6, 1995.

SEC. 233. FOREIGN PERSONS NOT TO BE TREATED AS OWNERS UNDER GRANTOR TRUST RULES.

(a) GENERAL RULE.—

(1) Subsection (f) of section 672 (relating to special rule where grantor is foreign person) is amended to read as follows:

''(f) SUBPART NOT TO RESULT IN FOREIGN OWNERSHIP.—

''(1) IN GENERAL.—Notwithstanding any other provision of this subpart, this subpart shall apply only to the extent such application results in an amount being currently taken into account (directly or through 1 or more entities) under this chapter in computing the income of a citizen or resident of the United States or a domestic corporation.

''(2) EXCEPTIONS.—

''(A) CERTAIN REVOCABLE AND IRREVOCABLE TRUSTS.—Paragraph (1) shall not apply to any trust if—

''(i) the power to revest absolutely in the grantor title to the trust property is exercisable solely by the grantor without the approval or consent of any other person or with

the consent of a related or subordinate party who is subservient to the grantor, or

''(ii) the only amounts distributable from such trust (whether income or corpus) during the lifetime of the grantor are amounts distributable to the grantor or the spouse of the grantor.

''(B) COMPENSATORY TRUSTS.—Except as provided in regulations, paragraph (1) shall not apply to any portion of a trust distributions from which are taxable as compensation for services rendered.

''(3) SPECIAL RULES.—Except as otherwise provided in regulations prescribed by the Secretary—

''(A) a controlled foreign corporation (as defined in section 957) shall be treated as a domestic corporation for purposes of paragraph (1), and

''(B) paragraph (1) shall not apply for purposes of applying section 1296.

''(4) RECHARACTERIZATION OF PURPORTED GIFTS.—In the case of any transfer directly or indirectly from a partnership or foreign corporation which the transferee treats as a gift or bequest, the Secretary may recharacterize such transfer in such circumstances as the Secretary determines to be appropriate to prevent the avoidance of the purposes of this subsection.

''(5) SPECIAL RULE WHERE GRANTOR IS FOREIGN PERSON.—If—

''(A) but for this subsection, a foreign person would be treated as the owner of any portion of a trust, and

''(B) such trust has a beneficiary who is a United States person,

such beneficiary shall be treated as the grantor of such portion to the extent such beneficiary has made transfers of property by gift (directly or indirectly) to such foreign person. For purposes of the preceding sentence, any gift shall not be taken into account to the extent such gift would be excluded from taxable gifts under section 2503(b).

''(6) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary or appropriate to carry out the purposes of this subsection, including regulations providing that paragraph (1) shall not apply in appropriate cases.''.

(2) The last sentence of subsection (c) of section 672 of such Code is amended by inserting ''subsection (f) and'' before ''sections 674''.

(b) CREDIT FOR CERTAIN TAXES.—Paragraph (2) of section 665(d) is amended by adding at the end the following new sentence: ''Under rules or regulations prescribed by the Secretary, in the case of any foreign trust of which the settlor or another person would be treated as owner of any portion of the trust under subpart E but for section 672(f), the term 'taxes imposed on the trust' includes the allocable amount of any income, war profits, and excess profits taxes imposed by any foreign country or possession of the United States on the settlor or such other person in respect of trust gross income.''.

(c) DISTRIBUTION BY CERTAIN FOREIGN TRUSTS THROUGH NOMINEES.—

(1) Section 643 is amended by adding at the end the following new subsection:

''(h) DISTRIBUTION BY CERTAIN FOREIGN TRUSTS THROUGH NOMINEES.—For purposes of this part, any amount paid to a United States person which is derived directly or indirectly from a foreign trust of which the payor is not the grantor shall be deemed in the year of payment to have been directly paid by the foreign trust to such United States person.''.

(2) Section 665 is amended by striking subsection (c).

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided by paragraph (2), the amendments made by this section shall take effort on the date of the enactment of this Act.

(2) EXCEPTION FOR CERTAIN TRUSTS.—The amendments made by this section shall not apply to any trust—

(A) which is treated as owned by the grantor or another person under section 676 or 677 (other than subsection (a)(3) thereof) of the Internal Revenue Code of 1986, and

(B) which is in existence on September 19, 1995.

The preceding sentence shall not apply to the portion of any such trust attributable to any transfer to such trust after September 19, 1995.

(e) TRANSITIONAL RULE.—If—

(1) by reason of the amendments made by this section, any person other than a United States person ceases to be treated as the owner of a portion of a domestic trust, and

(2) before January 1, 1997, such trust becomes a foreign trust, or the assets of such trust are transferred to a foreign trust,

no tax shall be imposed by section 1491 of the Internal Revenue Code of 1986 by reason of such trust becoming a foreign trust or the assets of such trust being transferred to a foreign trust.

SEC. 224. INFORMATION REPORTING REGARDING FOREIGN GIFTS.

(a) IN GENERAL.—Subpart A of part III of subchapter A of chapter 61 is amended by inserting after section 6039F the following new section:

''SEC. 6039G. NOTICE OF GIFTS RECEIVED FROM FOREIGN PERSONS.

''(a) IN GENERAL.—If the value of the aggregate foreign gifts received by a United States person (other than an organization described in section 501(c) and exempt from tax under section 501(a)) during any taxable year exceeds $10,000, such United States person shall furnish (at such time and in such manner as the Secretary shall prescribe) such information as the Secretary may prescribe regarding each foreign gift received during such year.

''(b) FOREIGN GIFT.—For purposes of this section, the term 'foreign gift' means any amount received from a person other than a United States person which the recipient treats as a gift or bequest. Such term shall not include any qualified transfer (within the meaning of section 2503(e)(2)).

''(c) PENALTY FOR FAILURE TO FILE INFORMATION.—

''(1) IN GENERAL.—If a United States person fails to furnish the information required by subsection (a) with respect to any foreign gift within the time prescribed therefor (including extensions)—

''(A) the tax consequences of the receipt of such gift shall be determined by the Secretary in the Secretary's sole discretion from the Secretary's own knowledge or from such information as the Secretary may obtain through testimony or otherwise, and

''(B) such United States person shall pay (upon notice and demand by the Secretary and in the same manner as tax) an amount equal to 5 percent of the amount of such foreign gift for each month for which the failure continues (not to exceed 25 percent of such amount in the aggregate).

''(2) REASONABLE CAUSE EXCEPTION.—Paragraph (1) shall not apply to any failure to report a foreign gift if the United States person shows that the failure is due to reasonable cause and not due to willful neglect.

''(d) COST-OF-LIVING ADJUSTMENT.—In the case of any taxable year beginning after December 31, 1996, the $10,000 amount under subsection (a) shall be increased by an amount equal to the product of such amount and the cost-of-living adjustment for such taxable year under section 1(f)(3), except that subparagraph (B) thereof shall be applied by substituting '1995' for '1992'.

''(e) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary or appropriate to carry out the purposes of this section.''.

''(b) CLERICAL AMENDMENT.—The table of sections for such subpart is amended by inserting after the item relating to section 6039F the following new item:

''Sec. 6039G. Notice of large gifts received from foreign persons.''.

''(c) EFFECTIVE DATE.—The amendments made by this section shall apply to amounts received after the date of the enactment of this Act in taxable years ending after such date.

SEC. 225. MODIFICATION OF RULES RELATING TO FOREIGN TRUSTS WHICH ARE NOT GRANTOR TRUSTS.

''(a) MODIFICATION OF INTEREST CHARGE ON ACCUMULATION DISTRIBUTIONS.—Subsection (a) of section 668 (relating to interest charge on accumulation distributions from foreign trusts) is amended to read as follows:

''(a) GENERAL RULE.—For purposes of the tax determined under section 667(a)—

''(1) INTEREST DETERMINED USING UNDERPAYMENT RATES.—The interest charge determined under this section with respect to any distribution is the amount of interest which would be determined on the partial tax computed under section 667(b) for the period described in paragraph (2) using the rates and the method under section 6621 applicable to underpayments of tax.

''(2) PERIOD.—For purposes of paragraph (1), the period described in this paragraph is the period which begins on the date which is the applicable number of years before the date of the distribution and which ends on the date of the distribution.

''(3) APPLICABLE NUMBER OF YEARS.—For purposes of paragraph (2)—

''(A) IN GENERAL.—The applicable number of years with respect to a distribution is the number determined by dividing—

''(i) the sum of the products described in subparagraph (B) with respect to each undistributed income year, by

''(ii) the aggregate undistributed net income.

The quotient determined under the preceding sentence shall be rounded under procedures prescribed by the Secretary.

''(B) PRODUCT DESCRIBED.—For purposes of subparagraph (A), the product described in this subparagraph with respect to any undistributed income year is the product of—

''(i) the undistributed net income for such year, and

''(ii) the sum of the number of taxable years between such year and the taxable year of the distribution (counting in each case the undistributed income year but not counting the taxable year of the distribution).

''(4) UNDISTRIBUTED INCOME YEAR.—For purposes of this subsection, the term 'undistributed income year' means any prior taxable year of the trust for which there is undistributed net income, other than a taxable year during all of which the beneficiary receiving the distribution was not a citizen or resident of the United States.

''(5) DETERMINATION OF UNDISTRIBUTED NET INCOME.—Notwithstanding section 666, for purposes of this subsection, an accumulation distribution from the trust shall be treated as reducing proportionately the undistributed net income for undistributed income years.

''(6) PERIODS BEFORE 1996.—Interest for the portion of the period described in paragraph (2) which occurs before January 1, 1996, shall be determined—

''(A) by using an interest rate of 6 percent, and

''(B) without compounding until January 1, 1996.''.

(b) ABUSIVE TRANSACTIONS.—Section 643(a) is amended by inserting after paragraph (6) the following new paragraph:

''(7) ABUSIVE TRANSACTIONS.—The Secretary shall prescribe such regulations as may be necessary or appropriate to carry out the purposes of this part, including regulations to prevent avoidance of such purposes.''.

(c) TREATMENT OF LOANS FROM TRUSTS.—

(1) IN GENERAL.—Section 643 (relating to definitions applicable to subparts A, B, C, and D) is amended by adding at the end the following new subsection:

''(i) LOANS FROM FOREIGN TRUSTS.—For purposes of subparts B, C, and D—

''(1) GENERAL RULE.—Except as provided in regulations, if a foreign trust makes a loan of cash or marketable securities directly or indirectly to—

''(A) any grantor or beneficiary of such trust who is a United States person, or

''(B) any United States person not described in subparagraph (A) who is related to such grantor or beneficiary,

the amount of such loan shall be treated as a distribution by such trust to such grantor or beneficiary (as the case may be).

''(2) DEFINITIONS AND SPECIAL RULES.—For purposes of this subsection—

''(A) CASH.—The term 'cash' includes foreign currencies and cash equivalents.

''(B) RELATED PERSON.—

''(i) IN GENERAL.—A person is related to another person if the relationship between such persons would result in a disallowance of losses under section 267 or 707(b). In applying section 267 for purposes of the preceding sentence, section 267(c)(4) shall be applied as if the family of an individual includes the spouses of the members of the family.

''(ii) ALLOCATION.—If any person described in paragraph (1)(B) is related to more than one person, the grantor or beneficiary to whom the treatment under this subsection applies shall be determined under regulations prescribed by the Secretary.

''(C) EXCLUSION OF TAX-EXEMPTS.—The term 'United States person' does not include any entity exempt from tax under this chapter.

''(D) TRUST NOT TREATED AS SIMPLE TRUST.—Any trust which is treated under this subsection as making a distribution shall be treated as not described in section 651.

''(3) SUBSEQUENT TRANSACTIONS REGARDING LOAN PRINCIPAL.—If any loan is taken into account under paragraph (1), any subsequent transaction between the trust and the original borrower regarding the principal of the loan (by way of complete or partial repayment, satisfaction, cancellation, discharge, or otherwise) shall be disregarded for purposes of this title.''

(2) TECHNICAL AMENDMENT.—Paragraph (8) of section 7872(f) is amended by inserting '', 643(i).'' before ''or 1274'' each place it appears.

(d) EFFECTIVE DATES.—

(1) INTEREST CHARGE.—The amendment made by subsection (a) shall apply to distributions after the date of the enactment of this Act.

(2) ABUSIVE TRANSACTIONS.—The amendment made by subsection (b) shall take effect on the date of the enactment of this Act.

(3) LOANS FROM TRUSTS.—The amendment made by subsection (c) shall apply to loans of cash or marketable securities after September 19, 1995.

SEC. 226. RESIDENCE OF ESTATES AND TRUSTS, ETC.

(a) TREATMENT AS UNITED STATES PERSON.—

(1) IN GENERAL.—Paragraph (30) of section 7701(a) is amended by striking subparagraph (D) and by inserting after subparagraph (C) the following:

''(D) any estate or trust if—

''(i) a court within the United States is able to exercise primary supervision over the administration of the estate or trust, and

''(ii) in the case of a trust, one or more United States fiduciaries have the authority to control all substantial decisions of the trust.''.

(2) CONFORMING AMENDMENT.—Paragraph (31) of section 7701(a) is amended to read as follows:

''(31) FOREIGN ESTATE OR TRUST.—The term 'foreign estate' or 'foreign trust' means any estate or trust other than an estate or trust described in section 7701(a)(30)(D).''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply—

(A) to taxable years beginning after December 31, 1996, or

(B) at the election of the trustee of a trust, to taxable years ending after the date of the enactment of this Act.

Such an election, once made, shall be irrevocable.

(b) DOMETIC TRUSTS WHICH BECOME FOREIGN TRUSTS.—

(1) IN GENERAL.—Section 1491 (relating to imposition of tax on transfers to avoid income tax) is amended by adding at the end the following new flush sentence:

''If a trust which is not a foreign trust becomes a foreign trust, such trust shall be treated for purposes of this section as having transferred, immediately before becoming a foreign trust, all of its assets to a foreign trust.''.

(2) PENALTY.—Section 1494 is amended by adding at the end the following new subsection:

''(c) PENALTY.—In the case of any failure to file a return required by the Secretary with respect to any transfer described in section 1491 with respect to a trust, the person required to file such return shall be liable for the penalties provided in section 6677 in the same manner as if such failure were a failure to file a return under section 6048(a).''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date of the enactment of this Act.

CHAPTER 3—REPEAL OF BAD DEBT RESERVE METHOD FOR THRIFT SAVINGS ASSOCIATIONS

SEC. 231. REPEAL OF BAD DEBT RESERVE METHOD FOR THRIFT SAVINGS ASSOCIATIONS.

(a) IN GENERAL.—Section 593 (relating to reserves for losses on loans) is amended by adding at the end the following new subsections:

''(f) TERMINATION OF RESERVE METHOD.—Subsections (a), (b), (c), and (d) shall not apply to any taxable year beginning after December 31, 1995.

''(g) 6-YEAR SPREAD OF ADJUSTMENTS.—

''(1) IN GENERAL.—In the case of any taxpayer who is required by reason of subsection (f) to change its method of computing reserves for bad debts—

''(A) such change shall be treated as a change in a method of accounting,

''(B) such change shall be treated as initiated by the taxpayer and as having been made with the consent of the Secretary, and

''(C) the net amount of the adjustments required to be taken into account by the taxpayer under section 481(a)—

''(i) shall be determined by taking into account only applicable excess reserves, and

''(ii) as so determined, shall be taken into account ratably over the 6-taxable year period beginning with the first taxable year beginning after December 31, 1995.

''(2) APPLICABLE EXCESS RESERVES.—

''(A) IN GENERAL.—For purposes of paragraph (1), the term 'applicable excess reserves' means the excess (if any) of—

''(i) the balance of the reserves described in subsection (c)(1) (other than the supplemental reserve) as of the close of the taxpayer's last taxable year beginning before December 31, 1995, over

''(ii) the lesser of—

''(I) the balance of such reserves as of the close of the taxpayer's last taxable year beginning before January 1, 1988, or

''(II) the balance of the reserves described in subclause (I), reduced in the same manner as under section 585(b)(2)(B)(ii) on the basis of the taxable years described in clause (i) and this clause.

''(B) SPECIAL RULE FOR THRIFTS WHICH BECOME SMALL BANKS.—In the case of a bank (as defined in section 581) which was not a large bank (as defined in section 585(c)(2)) for its first taxable year beginning after December 31, 1995—

''(i) the balance taken into account under subparagraph (A)(ii) shall not be less than the amount which would be the balance of such reserves as of the close of its last taxable year beginning before such date if the additions to such reserves for all taxable years had been determined under section 585(b)(2)(A), and

''(ii) the opening balance of the reserve for bad debts as of the beginning of such first taxable year shall be the balance taken into account under subparagraph (A)(ii) (determined after the application of clause (i) of this subparagraph).

The preceding sentence shall not apply for purposes of paragraphs (5) and (6) or subsection (e)(1).

''(3) RECAPTURE OF PRE–1988 RESERVES WHERE TAXPAYER CEASES TO BE BANK.—If, during any taxable year beginning after December 31, 1995, a taxpayer to which paragraph (1) applied is not a bank (as defined in section 581), paragraph (1) shall apply to the reserves described in paragraph (2)(A)(ii) and the supplemental reserve: except that such reserves shall be taken into account ratably over the 6-taxable year period beginning with such taxable year.

''(4) SUSPENSION OF RECAPTURE IF RESIDENTIAL LOAN REQUIREMENT MET.—

''(A) IN GENERAL.— In the case of a bank which meets the residential loan requirement of subparagraph (B) for the first taxable year beginning after December 31, 1995, or for the following taxable year—

''(i) no adjustment shall be taken into account under paragraph (1) for such taxable year, and

''(ii) such taxable year shall be disregarded in determining—

''(I) whether any other taxable year is a taxable year for which an adjustment is required to be taken into account under paragraph (1), and

''(II) the amount of such adjustment.

''(B) RESIDENTIAL LOAN REQUIREMENT.—A taxpayer meets the residential loan requirement of this subparagraph for any taxable year if the principal amount of the residential loans made by the taxpayer during such year is not less than the base amount for such year.

''(C) RESIDENTIAL LOAN.—For purposes of this paragraph, the term 'residential loan' means any loan described in clause (v) of section 7701(a)(19)(C) but only if such loan is incurred in acquiring, constructing, or improving the property described in such clause.

''(D) BASE AMOUNT.—For purposes of subparagraph (B), the base amount is the average of the principal amounts of the residential loans made by the taxpayer during the 6 most recent taxable years beginning on or before December 31, 1995. At the election of the taxpayer who made such loans during each of such 6 taxable years, the preceding sentence shall be applied without regard to

the taxable year in which such principal amount was the highest and the taxable year in such principal amount was the lowest. Such an election may be made only for the first taxable year beginning after such date, and, if made for such taxable year, shall apply to the succeeding taxable year unless revoked with the consent of the Secretary.

''(E) CONTROLLED GROUPS.—In the case of a taxpayer which is a member of any controlled group of corporations described in section 1563(a)(1), subparagraph (B) shall be applied with respect to such group.

''(5) CONTINUED APPLICATION OF FRESH START UNDER SECTION 585 TRANSITIONAL RULES.—In the case of a taxpayer to which paragraph (1) applied and which was not a large bank (as defined in section 585(c)(2)) for its first taxable year beginning after December 31, 1995.

''(A) IN GENERAL.—For purposes of determining the net amount of adjustments referred to in section 585(c)(3)(A)(iii), there shall be taken into account only the excess (if any) of the reserve for bad debts as of the close of the last taxable year before the disqualification year over the balance taken into account by such taxpayer under paragraph (2)(A)(ii) of this subsection.

''(B) TREATMENT UNDER ELECTIVE CUTOFF METHOD.—For purposes of applying section 585(c)(4)—

''(i) the balance of the reserve taken into account under subparagraph (B) thereof shall be reduced by the balance taken into account by such taxpayer under paragraph (2)(A)(ii) of this subsection, and

''(ii) no amount shall be includable in gross income by reason of such reduction.

''(6) SUSPENDED RESERVE INCLUDED AS SECTION 381(C) ITEMS.—The balance taken into account by a taxpayer under paragraph (2)(A)(ii) of this subsection and the supplemental reserve shall be treated as items described in section 381(c).

''(7) CONVERSIONS TO CREDIT UNIONS.—In the case of a taxpayer to which paragraph (1) applied which becomes a credit union described in section 501(c) and exempt from taxation under section 501(a)—

''(A) any amount required to be included in the gross income of the credit union by reason of this subsection shall be treated as derived from an unrelated trade or business (as defined in section 513), and

''(B) for purposes of paragraph (3), the credit union shall not be treated as if it were a bank.

''(8) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out this subsection and subsection (e), including regulations providing for the application of such subsections in the case of acquisitions, mergers, spinoffs, and other reorganizations.''

(b) CONFORMING AMENDMENTS.—

(1) Subsection (d) of section 50 is amended by adding at the end the following new sentence:

''Paragraphs (1)(A), (2)(A), and (4) of the section 46(e) referred to in paragraph (1) of this subsection shall not apply to any taxable year beginning after December 31, 1995.''

(2) Subsection (e) of section 52 is amended by striking paragraph (1) and by redesignating paragraph (2) and (3) as paragraphs (1) and (2), respectively.

(3) Subsection (a) of section 57 is amended by striking paragraph (4).

(4) Section 246 is amended by striking subsection (f).

(5) Clause (i) of section 291(e)(1)(B) is amended by striking ''or to which section 593 applies''.

(6) Subparagraph (A) of section 585(a)(2) is amended by striking ''other than an organization to which section 593 applies''.

(7)(A) The material preceding subparagraph (A) of section 593(e)(1) is amended by striking ''by a domestic building and loan association or an institution that is treated as a mutual savings bank under section 591(b)'' and inserting ''by a taxpayer having a balance described in subsection (g)(2)(A)(ii)''.

(B) Subparagraph (B) of section 593(e)(1) is amended to read as follows:

(B) then out of the balance taken into account under subsection (g)(2)(A)(ii) (properly adjusted for amounts charged against such reserves for taxable years beginning after December 31, 1987).''.

(C) Paragraph (1) of section 593(e) is amended by adding at the end the following new sentence: ''This paragraph shall not apply to any distribution of all of the stock of a bank (as defined in section 581 to another corporation if, immediately after the distribution, such bank and such other corporation are members of the same affiliated group (as defined in section 1504) and the provisions of section 5(e) of the Federal Deposit Insurance Act (as in effect on December 31, 1995) or similar provisions are in effect.''.

(8) Section 595 is hereby repealed.

(9) Section 596 is hereby repealed.

(10) Subsection (a) of section 860E is amended—

(A) by striking ''Except as provided in paragraph (2), the'' in paragraph (1) and inserting ''The''.

(B) by striking paragraphs (2) and (4) and redesignating paragraphs (3) and (5) as paragraphs (2) and (3), respectively, and

(C) by striking in paragraph (2) (as so redesignated) all that follows ''subsection'' and inserting a period.

(11) Paragraph (3) of section 992(d) is amended by striking ''or 593''.

(12) Section 1038 is amended by striking subsection (f).

(13) Clause (ii) of section 1042(c)(4)(B) is amended by striking ''or 593''.

(14) Subsection (c) of section 1277 is amended by striking ''or to which section 593 applies''.

(15) Subparagraph (B) of section 1361(b)(2) is amended by striking ''or to which section 593 applies''.

(16) The table of sections for part II of subchapter H of chapter 1 is amended by striking the items relating to sections 595 and 596.

(c) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall apply to taxable years beginning after December 31, 1995.

(2) SUBSECTION (b)(7).—The amendments made by subsection (b)(7) shall not apply to any distribution with respect to preferred stock if—

(A) such stock is outstanding at all times after October 31, 1995, and before the distribution, and

(B) such distribution is made before the date which is 1 year after the date of the enactment of this Act (or, in the case of stock which may be redeemed, if later, the date which is 30 days after the earliest date that such stock may be redeemed).

(3) SUBSECTION (b)(8).—The amendment made by subsection (b)(8) shall apply to property acquired in taxable years beginning after December 31, 1995.

(4) SUBSECTION (b)(10).—The amendments made by subsection (b)(10) shall not apply to any residual interest held by a taxpayer if such interest has been held by such taxpayer at all times after October 31, 1995.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Michigan [Mr. DINGELL] and a Member opposed will each control 30 minutes.

The Chair recognizes the gentleman from Michigan [Mr. DINGELL].

PARLIAMENTARY INQUIRY

Mr. DINGELL. Mr. Speaker, I have a parliamentary inquiry.

The SPEAKER pro tempore. The gentleman will state it.

Mr. DINGELL. Mr. Speaker, I believe I will have the right to close under this as the author of the amendment?

The SPEAKER pro tempore. Who seeks control in opposition?

Mr. THOMAS. Mr. Speaker, I seek to control the time in opposition.

The SPEAKER pro tempore. The Chair would state that because the gentleman from California [Mr. THOMAS] is a member of the Committee on Ways and Means, the gentleman from California would have the right to close.

Mr. DINGELL. Mr. Speaker, further parliamentary inquiry. Is it not the rule that the author of the amendment has the right to close?

The SPEAKER pro tempore. The manager of the bill has the right to close, and the Committee on Ways and Means is the reporting committee on the pending bill.

Mr. DINGELL. That is a rather extraordinary ruling.

PARLIAMENTARY INQUIRY

Mr. THOMAS. Mr. Speaker, I have a parliamentary inquiry.

The SPEAKER pro tempore. The gentleman will state it.

Mr. THOMAS. Mr. Speaker, is it rather unusual for the committee that offers the bill on which a Member offers a substitute to the committee bill not to close? Is that a rather unusual ruling, or is that the ordinary rule around this place and has been for years?

The SPEAKER pro tempore. The Chair indicated that the representative of the managing committee would have the right to close.

The Chair recognizes the gentleman from Michigan [Mr. DINGELL].

Mr. DINGELL. Mr. Speaker, I yield 4 minutes to the distinguished gentleman from Texas [Mr. BENTSEN], a coauthor of the amendment.

(Mr. BENTSEN asked and was given permission to revise and extend his remarks.)

Mr. BENTSEN. Mr. Speaker, I thank the gentleman from Michigan for yielding me time.

Mr. Speaker, I am pleased to join with my distinguished colleagues, Mr. DINGELL and Mr. SPRATT, in offering this substitute.

Mr. Speaker, earlier today, my wife called to tell me that our 2-year-old daughter Meredith had gotten hold of her sister's cough medicine. The doctor ordered her to the hospital and my wife rushed her to the emergency room. As I drove to meet her, I was concerned about my daughter, but I didn't worry about the bill. We in Congress have health insurance. Fortunately, Meredith is OK, and we need not worry about how we pay.

That's not the case for the young woman I recently met in my district who could not purchase health insurance because here daughter had a heart

condition. Her husband earns too much to be on Medicaid, nor does she want to receive such assistance. She only wants the right to buy health insurance, but her daughter's preexisting heart condition precludes that. The Bentsen-Spratt-Dingell substitute would prohibit discrimination based on such preexisting conditions and ensure that this family could finally provide health care for their child without falling into poverty.

Today, this House has the opportunity to pass simple, straightforward steps that will help millions of Americans like this Channelview, TX, family. If we focus on reforms that have broad, bipartisan support, and put aside for now those proposals that divide us, as this substitute does, we can begin to address the health care fears that weigh ever heavier on the minds of families across this country.

I urge my colleagues to keep in mind the people we are trying to help. Let us remember the 40 million Americans who are without health insurance today, including 4.6 million people in my home State of Texas. That is 1 million more Americans without insurance than when Congress last debated health care 2 years ago. Millions more face becoming uninsured if they lose or change jobs, and others are locked in jobs they do not want because they or a family member have a preexisting condition.

These are the people we must remember as we debate this issue today. That young mother in Channelview needs our help now. She and millions of other Americans do not have the luxury of waiting as we spend months, even years, debating the controversial, untested provisions, such as Medical Savings Accounts, that are in the bill before us. These provisions may even have merit. But they should not be allowed to hold up or kill the commonsense, bipartisan, noncontroversial reforms in our substitute. The American people deserve what we in Congress have, and our substitute provides that.

This substitute tracks the bipartisan Health Insurance Reform Act of 1996 as introduced in the other body by Senators NANCY KASSEBAUM and EDWARD KENNEDY and as filed in the House by our Republican colleague, MARGE ROUKEMA. I want to congratulate my colleague from New Jersey for her leadership on this issue and urge her and others on her side of the aisle to join us in supporting this substitute.

This substitute ends insurance discrimination against people with preexisting health conditions. It guarantees people access to group or individual coverage if they change jobs, lose jobs, or get sick. It helps small businesses to join together and purchase more affordable coverage.

Our substitute makes one major addition to the Roukema bill. It phases in an increase from 30 to 80 percent the amount that self-employed individuals can deduct from their taxes for the cost of health insurance, affording the same treatment to the self-employed as we do to corporations.

Altogether, these reforms will help 28 million Americans to buy and keep health insurance.

Mr. Speaker, I want to underscore the broad consensus for these reforms. Most of us in this body from both sides of the aisle support them. The President supports them. More than 135 organizations representing business, workers, and health care providers support them. These include the American Medical Association, the American Hospital Association, the AFL–CIO, the Independent Insurance Agents, and the National Association of Manufacturers.

We need to remember the lessons learned from Congresses past regarding health care reform. A comprehensive, complicated reform bill is too controversial and cannot be enacted in whole. Instead we should pass this consensus bill of incremental reforms that will bring immediate help to millions of Americans.

But the addition of controversial provisions isn't the only reason we should pass this substitute. The Republican bill also has weaker portability provisions than the substitute and weakens important consumer protections.

The Republican bill weakens the portability provision by limiting group to individual transfer to a single plan. This will ensure that high risk individuals are pooled together and forced to pay exorbitant premiums.

The Republican plan also would limit the number of businesses that could benefit from this plan. The Republican plan only guarantees first-time issuance of insurance for businesses employing between 2 and 50 people. All businesses with more than 51 employees would not be protected.

This bill also would create a new class of insurance with lower capital and solvency requirements, thus increasing risk to the small businesses that purchase from these new plans. It would contradict the McCarran-Ferguson Act, creating federally regulated insurance using lower standards. And it provides a huge loophole for New York and New Jersey, but not the other 48 States.

Finally, the Republican plan would weaken consumer protection laws by eliminating regulations that prohibit the sale of duplicative health insurance policies to senior citizens. Under the bill, insurance companies would be permitted to sell policies that duplicate Medicare benefits and then collect premiums from seniors who already are covered under Medicare. They would pay twice. These plans are currently prohibited and I am concerned that many seniors will not be aware of the risks associated with purchasing such plans.

Mr. Speaker, this is a fairly easy vote. We can vote to increase the economic security of hundreds of millions of Americans who are currently covered by private insurance by passing this amendment and end once and for all insurance discrimination against: people with a preexisting medical condition; people who lose their job but still need health insurance; and small businesses of any size that want to buy safe, sound, and affordable health insurance for their employees.

It is a market-based plan that the American people support, that addresses their real concerns, and that can become a reality tomorrow. The Republican bill fails this test and will take years to even come close to becoming law. My colleagues, tonight let's forget we are Democrats and Republicans for one shining moment of compromise. Let us put victory for the American people and their health security ahead of political victory. Let's do right by the American people and pass the Bentsen-Spratt-Dingell substitute.

Mr. THOMAS. Mr. Speaker, I yield 15 minutes to the gentleman from Virginia [Mr. BLILEY], the chairman of the Committee on Commerce, and ask unanimous consent that he be allowed to allocate said time.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

There was no objection.

Mr. THOMAS. Mr. Speaker, I yield myself 4 minutes.

Mr. Speaker, the special rule for coordination of long-term care policies has been misinterpreted by some in the administration. I want to clarify that this rule applies to policies that provide health care benefits only for long-term care and similar benefits, such as community-based care, and would not apply to a policy that covers other health care benefits.

Mr. Speaker, we have been hearing for some time that all the Democrats want is Kassebaum. The gentleman from New York said ''Let's have 'pure' Kassebaum.''

Let me tell you, what you have in front of you is not pure Kassebaum. As you might expect, the Democrats have changed the bill. They have told you they have only added things to it. They said, ''We just wanted to help the self-employed more than the Republicans.''

You left the self-employed stranded for a whole year in 1994 when you were in the majority. Nice to have you come around and have you helping the self-employed.

If this is supposed to be pure Kassebaum, why don't you include the items on page 105? Title III, miscellaneous provisions. ''HMO's allowed to offer plans with deductibles to individuals with medical savings accounts.''

Kassebaum includes medical savings accounts and the ability to apply to an HMO to receive benefits while you have a medical savings account. You conveniently left that out. If you want pure Kassebaum, you would have MSA's in the bill.

On page 106, Sense of the Senate. ''It is the sense of the Senate that the Congress should take measures to further the purposes of this act, including any necessary changes to the Internal Revenue Code of 1986 to encourage groups and individuals to obtain health coverage and to promote access, equity, portability, affordability, and security of health benefits.'' That is exactly what the Committee on Ways and Means has done.

The Senate committee cried out in the Kassebaum bill, ''We don't have jurisdiction over the Tax Code, but if we

did, these are the kinds of things that we would do.'' And what they asked for, we have included in our bill.

Only one committee has looked at the Kassebaum bill in the Senate. It is not on the floor of the Senate. They did not have jurisdiction over the revenue code. Four committees in the House looked at our bill, and given our distinct and unique jurisdictions, we contributed to and improved to this bill. We did exactly what Senator KASSEBAUM asked us to do. We added items that provided and promoted access, equity, portability, affordability and security of health benefits.

Guess what you left in the bill? Notwithstanding all of the protestations on the floor about the Democrats in terms of States rights, and, after all, the Republicans are going to usurp the States rights, and, after all, the Republicans are going to usurp the States rights, take a look at page 91 in the Kassebaum bill.

It says under subtitle D(b), certification, number 2, State refusal to certify. It says, ''If a state fails to implement a program for a certifying health plan purchasing cooperative in accordance with the standards under this act, the secretary shall certify and oversee operations of such cooperative's Federal preemption.''

Notwithstanding all of your crocodile tears, about ''pure'' Kassebaum, the Feds have a role in play in your substitution.

I would tell my Republican colleagues, beware: This is not Kansas. This bill is not from Dorothy. It isn't even from Toto. It has been written and comes from the Land of Oz.

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Mr. BLILEY. Mr. Speaker, I reserve the balance of my time.

Mr. DINGELL. Mr. Speaker, I yield 3 minutes to the gentlewoman from New Jersey [Mrs. ROUKEMA].

(Mrs. ROUKEMA asked and was given permission to revise and extend her remarks.)

Mrs. ROUKEMA. Mr. Speaker, I thank the gentleman from Michigan [Mr. DINGELL] for yielding me time to express my strong support for his substitute to H.R. 3103, an omnibus package of health reform proposals.

The Dingell amendment is comprised, essentially, of two items: the so-called Kassebaum-Kennedy-Roukema health insurance reform package and a proposal to allow self-employed individuals to deduct 80 percent of their health insurance premiums, rather than the 30 percent current law allows for.

The difference between this package and H.R. 3103 is this simple: If the House approves the Dingell plan it can be quickly passed by the Senate and signed into law by President Clinton immediately. This will immediately deliver insurance portability; eliminate job lock and give guaranteed insurance to 30 million Americans who presently do not qualify.

H.R. 3103, as brought to the House floor today, cannot.

The Republican leadership's package, which contains several very controversial elements, faces a guaranteed Senate filibuster, or, if it were to ever get that far, a certain veto at the White House.

If you want to vote in support of health insurance reform legislation that will make a real difference in the daily lives of millions of Americans this year, support the Dingell alternative.

Anything else won't survive the legislative process, and is simply a political exercise rather than an attempt to enact commonsense, bipartisan health reforms.

I am very proud to be the House author of the companion bill to the Kassebaum-Kennedy measure, H.R. 2893—which currently has 193 cosponsors—17 Republicans and 176 Democrats—which encompasses precisely the kind of incremental health reforms that the Republicans so strongly advocated in 1993–94 when the 103d Congress was debating President Clinton's massive health care reform plan.

This modest package of insurance reforms would simply make health insurance plans portable for workers leaving one job for another; restrict the ability of insurance carriers to impose pre-existing condition limitations in their policies; and allow small employers to pool together to purchase health benefits for their workers.

A very strong and broad coalition has endorsed the Kassebaum-Roukema legislation including: The National Governors Association; the American Medical Association; the American Hospital Association; the National Association of Manufacturers; the Business Roundtable, and the AFL-CIO—on the Senate side, the U.S. Chamber of Commerce has endorsed the Kassebaum-Kennedy package, too; the Healthcare Leadership Council, and the Independent Insurance Agents Association; and the ERISA Industry Committee [ERIC], and the American Association of Retired Persons [AARP] are just a few of the more prominent supporters of the Kassebaum-Kennedy-Roukema legislation.

I might add that, during his State of the Union speech 2 months ago, President Clinton endorsed this bill, and has repeatedly stated that he is prepared to sign this legislation if we can just move it through the Congress this year.

Some of the reforms in H.R. 3103—such as medical malpractice reforms—I have supported in the past, and will continue to support in the future as freestanding measures.

However, we must acknowledge that these issues raise significant policy questions.

Reforms such as medical malpractice and medical savings accounts should be debated by the Congress on an individual, case-by-case basis, particularly given the level of controversy that these proposals raise in both parties of the House and Senate.

In addition, it is highly unlikely that, given the limited number of legislative days in our session this year, that the Senate would ever be able to pass such a controversial and omnibus package of health reforms.

In fact, prominent Republican Senators have repeatedly and publicly stated their opposition to such an omnibus bill, as recently as a day or 2 ago.

It's time for the Congress to stop playing these games—the American people are sick and tired of bickering and political gamesmanship.

We must immediately enact common-sense, incremental health insurance reforms.

The General Accounting Office [GAO] has estimated that up to 30 million American citizens would benefit from the health insurance reforms incorporated in the Kassebaum-Roukema plan.

Let's not permit such a golden opportunity to help so many people slip through our collective fingers because of partisan politics.

In closing, Mr. Speaker, I urge my colleagues to join me in support of the Dingell substitute to H.R. 3103, because it's the right thing to do for the American people now.

Mr. BLILEY. Mr. Speaker, I yield myself such time as I may consume.

(Mr. BLILEY asked and was given permission to revise and extend his remarks.)

Mr. BLILEY. Mr. Speaker, first of all, with all due respect to my good friend and colleague from new Jersey [Mrs. ROUKEMA], we had a bipartisan plan in the last Congress authored by my good friend from Florida, the chairman now of our Subcommittee on Health and Environment of the Committee on Commerce, and the gentleman from Georgia who is no longer with us, Dr. Roy Rowland. I sat right over there on this night 2 years ago with then the chairman of my committee, and I said, you cannot move this massive socialized medicine bill of the President's. We have a good bipartisan bill and we ought to take it up. It was not enough for him.

Mr. Speaker, but now all of a sudden, this bill, which is more modest than the Bilirakis-Rowland bill, is too much. I find that rather ironic.

Mr. Speaker, I rise in strong opposition to the substitute. While it is a well-intentioned proposal, it simply falls short of the mark of ensuring that health insurance is both available and affordable.

Our bill is focused on the real problems people encounter in obtaining health insurance in the small business market. Small employers who are trying to provide their employees and their families with adequate coverage will not be helped by this substitute. They will not be able to purchase affordable health insurance coverage.

In addition, a recent letter from the National Association of Independent

Businesses points out that big business is in the position of purchasing health insurance under a different set of rules than small business. Their letter points out that the Health Coverage Availability and Affordability Act would stop the unfairness by allowing small firms to band together across State lines to purchase health insurance with nearly the same exemption from State law that big business has. Achieving this is NFIB's highest health reform priority. And I quote from their letter: ''Any substitute amendment that does not directly address this inequity between big and small business is unacceptable to the more than 600,000 members of NFIB.''

Mr. Speaker, the Democratic substitute does not address this inequity. It is all form and no substance. Its pooling provisions simply allow the formation of purchasing cooperatives, which can be formed under current law. Thus, it falls short of the mark in addressing the key concerns of small business in reforming the small employer health insurance market.

Mr. Speaker, I would also like to point out to my colleagues that National Right to Life has raised a serious concern about the nondiscrimination language in the substitute. The nondiscrimination language could be read to apply to the content of a benefits package. Thus, the language could be used to require the inclusion of elective abortions in all health insurance plans. This problem has not been addressed in the substitute and remains an issue for pro-life Members.

In addition, the Democrat substitute fails to allow for medical savings accounts, an option that provides true portability for individuals, including the self-employed. It does not encourage the purchasing of long-term health insurance coverage, because it does not allow expenses for long-term care and long-term care insurance premiums to be tax deductible.

Mr. Speaker, it also fails to address the question of affordability because it does nothing to address the increased costs our current malpractice laws bring to the health care system.

Perhaps the substitute's most glaring omission is its failure to address the issue of fraud and abuse, which has also contributed to the high cost of health insurance coverage. According to the General Accounting Office, each year as much as 10 percent of total health care costs are lost to fraud and abuse. Given that annual health care costs in the United States are now approaching $1 trillion, fraud and abuse are costing taxpayers and policyholders large sums of money. Despite the enormity of the problem, GAO has concluded that only a small fraction of this fraud and abuse is detected. The failure of a health reform bill to address this issue is unfortunate.

The HHS Inspector General in a letter to the ranking member of the Committee on Commerce points out that the provisions in the Republican bill will help to reduce fraud and abuse. It states:

> Generally speaking, these provisions are excellent . . . The bill contains many improvements to the laws intended to address health care fraud. In our judgment, enactment of the provisions . . . would be very effective in reducing the amount of fraud and abuse in the health care system . . .

Finally, I feel I must address the constant refrain we have heard that somehow Senators KASSEBAUM and KENNEDY's bill, is the gold standard and cannot be amended. It is absolutely absurd for us to say that a bill cannot be improved. It is also rather naive for us to say that a bill that come out of Committee in the Senate will not be amended on the floor of that body where there are no germaneness rules and anything can be attached to anything.

Mr. Speaker, do not expect a clean Kassebaum-Kennedy bill to come out of the Senate. I assure my colleagues that whatever we do tonight, we will be in conference.

Mr. Speaker, I reserve the balance of my time.

Mr. DINGELL. Mr. Speaker, I yield 3 minutes to the gentleman from South Carolina [Mr. SPRATT].

(Mr. SPRATT asked and was given permission to revise and extend his remarks.)

Mr. SPRATT. Mr. Speaker, I thank the gentleman for yielding me the time.

Mr. Speaker, I rise in strong support of Bentsen-Spratt-Dingell. There is a lot on our agenda about which the American people are undecided or divided, but clearly they want us to change the way that health insurance in this country is written. They want the law to say that if they lose their jobs or leave it, they can take their health insurance with them; if they have an illness or an injury, they can keep their insurance and not be ostracized by carriers as having preexisting conditions.

Mr. Speaker, there is something else the American people want. They want an end to partisan bickering. Our substitute goes to both goals. It is not just a chance to change health insurance. It is a chance to do something bipartisan. We make health insurance portable. We take care of people with preexisting conditions, and we do it in a bipartisan bill, a clean bill that is unencumbered by pet provisions.

Mr. Speaker, the differences between the base bill, H.R. 3103, and our substitute, which is essentially Kennedy-Kassebaum-Roukema, are seemingly small but the differences are potentially insidious.

First of all, let me just cover a couple. The base bill in our substitute says that if you lose your job, you can convert from group to individual coverage once your extension under COBRA has expired. But in the substitute, we say that when you convert, you have the right to pick among the policies that an insurance company offers.

In the base bill, people lose this flexibility. They have got a Hobson's choice. That is because the base bill has been amended to let the States restrict individuals to a single policy, and that one policy is bound to become the high-risk pool for all the rejects and bad risks. That will make the premium cost excessive, probably beyond the reach of most people who need it, and we are not giving health insurance availability unless we give health insurance affordability.

There is another provision very deep in this base bill which differs from the substitute. Both of us permit small employers to band together to purchase insurance, and, banded together, they can broaden their risk pool and get better rates. So far, so good. But the base bill goes on to exempt multiemployer health plans from State regulations that govern other multiemployer health plans and places these under the Department of Labor. You got it. The Republicans want to give the Federal Government the power to regulate these insurance, self-insurance plans, and take it away from the State government.

Here, do not take it from me, listen to what Mr. Gradison, a very respected member of this body from the other side of the aisle, now head of the Health Insurance Association of America, says about that particular provision of the main bill before us. He says,

> We strongly oppose the provision contained in the House leadership bill which we believe will undermine the progress States have made in reforming their small employer insurance markets and leave an unstable health care market in its wake.

Mr. Speaker, we have a chance to pass a bipartisan bill, to keep this bill on track and I urge support for the bill.

Mr. Speaker, there is much of our agenda about which the people are undecided or divided. But clearly they want us to change the way health insurance is written. They want the law to say that if they lose their job or leave it, they don't have to lose their health insurance—they can take it with them. And if they have an illness or injury, they can keep their insurance, and not be ostracized by carriers for a ''preexisting condition.''

There's something else people want: They want an end to partisan bickering.

Our substitute goes to both goals. It is not just a chance to change health insurance, it's a chance to do something bipartisan. We make health insurance portable; we take care of people with preexisting conditions; and we do it in a bipartisan bill, a clean bill, unencumbered by pet provisions and special concessions.

The differences between the base bill, H.R. 3103, and our substitute, which is the Kennedy-Kassebaum-Roukema bill, are seemingly small but potentially insidious.

First of all, both the base bill and our substitute say that if you lose your job, you can convert from group to individual coverage once your 18-month extension under COBRA has expired. But in the substitute, we say that when you convert, you can pick among the policies a company offers. In the base bill, you lose this flexibility. That's because the base

bill was amended to let the States restrict individuals to a single policy; and that one policy is bound to become the high-risk pool for all the rejects and bad risks. This will make the premium cost excessive, probably beyond the reach of most who need it. Our substitute guarantees individual coverage, but it does not limit that guarantee to one insurance policy. The person who converts may still have his premium rated, adjusted upward for a preexisting condition; but he can also buy into an insurance pool with lots of other people who are ordinary, unrated risks. And while this bill gives that no one protection against higher premiums, our substitute leaves the States the power to regulate premiums, as many already have. And if you are in an insurance pool with ordinary risks, the States can limit the rated premium you have to pay for your policy, say, to 50 percent of the standard premium. But if you end up in a risk pool with all bad risks, there is no way to spread the cost and mitigate the premiums.

Next, the base bill, as well as our substitute, permits small employers to band together to purchase insurance. In banding together, they can broaden their risk pool and get better rates. But the base bill exempts multiemployer health plans from the State regulations that govern other multiemployer plans, and places these under the Department of Labor. In bypassing State laws, particularly on what constitutes an adequately capitalized plan, the base bill, in the words of the Health Insurance Association of America, sets up ''a very flimsy safety net for employees with self-insured, federally regulated coverage.'' It puts the insured in peril of being in an unsound plan and not having coverage when it is needed. Our bill respects the competency of the States in this field, and leaves multiemployer insurance plans subject to State law.

Next, the base bill includes Medicare fraud and abuse provisions, and claims savings back into Medicare to boost the solvency of the Part A trust fund. Instead these Medicare funds are used to offset the tax revenues lost by allowing MSA's. This comes from the group that for the past year has told seniors that deep cuts in Medicare were needed to keep the trust fund solvent.

Next, the base bill raises the tax deduction allowed the self-employed to 50 percent of the premiums they pay, but reaches that level only in year 2003. On this subject, our substitute departs from Kennedy-Kassebaum-Roukema; it too increases the tax deduction for the self-employed, but we go to 80 percent by the year 2002. I am not altogether opposed to MSA's, but I would much rather use the tax offsets to cover the revenue losses to pay for a higher rate of deductibility. More small business people, more self-employed Americans, will benefit from being able to deduct 80 percent of their health insurance premiums than will benefit from medical savings accounts.

Finally, the base bill repeals current laws that we put in place to regulate the sale of policies that duplicate Medicare coverage. These protections were enacted to protect unsuspecting seniors from purchasing coverage that they already have under Medicare. The base bill opens a loophole that would allow insurers to sell Medicare beneficiaries a policy that is not identical to Medicare coverage, say offering additional homecare visits, but include a rider in the policy that denies payment for any service covered by Medicare.

Mrs. ROUKEMA tonight, and Senator KASSEBAUM several days ago, have all warned against overloading this bill with extraneous stuff, like medical savings accounts and malpractice reform. I am not opposed to all those add-ons; I've voted for malpractice reform; but what I favor most is moving this bill. It is a shame to bog it down with controversial provisions, and a shame to blow this opportunity to do something bipartisan for a change.

Let's keep this bill on track; let's keep it clean and make it bipartisan. Vote for the Bentsen-Spratt-Dingell substitute.

Mr. THOMAS of California. Mr. Speaker, I yield 3 minutes to the gentlewoman from Connecticut [Mrs. JOHNSON], an extremely important member of the Committee on Ways and Means and the chairman of the Subcommittee on Oversight.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I thank the chairman.

Mr. Speaker, I rise in strong opposition to the substitute, not because it is not an admirable bill. In fact, Senators KASSEBAUM and KENNEDY deserve enormous credit for bringing this issue of insurance reform to the top of the agenda of both Houses, but our bill is literally better. My amendment conformed this bill in many of its details to the Kassebaum-Kennedy bill, working with my chairman. Our bill actually adds protection, not in the Kassebaum-Kennedy bill, to assure that genetic information about an individual cannot be used to exclude that person from health coverage. Our bill is far better on portability. It is far more generous in its determination of what is continuous coverage and what is a break in service because it counts, that is gives credit for coverage, time on Medicare, Medicaid, DOD's Tricare, the Indian Health Service, the Federal Employees Health Benefits programs and State risk pools. Furthermore, our bill gives protection that the Kennedy-Kassebaum bill does not give to people covered under individual policies to assure that they can get into a new policy without discrimination if they move outside the service area or if the insurer goes out of business.

In many of its details, our bill is simply an improved version, a stronger bill than the Kennedy-Kassebaum bill. In its breadth it is also superior. This Chamber has had before it for 5 years, proposals to allow people to deduct the premiums of long-term-care insurance so that we can get employers providing long-term-care insurance and we can encourage seniors to buy long-term-care insurance so that in the future, seniors will not have to spend down to poverty, spend every cent they worked for and were able to save, to cover the costs of nursing home care.

□ 2115

That kind of public-private partnership is imperative to providing security and dignity to our seniors in their retirement years. This is the only bill that has ever brought those long-term-care provisions to the floor of the House in a form in which the President would sign the bill.

Furthermore, this bill will allow deduction of long-term home care costs. Think for how many seniors that is terribly important. For many, it will probably wipe out their entire tax liability.

So this bill is a thoughtful broadening, an inclusion of a number of terribly important health policy solutions that this House at other times has supported, that are not that controversial, that the President will clearly sign, and ought to be part of a health care reform—and part of this Congress' accomplishments.

So do not yield to the siren song of all we can pass is Kennedy-Kassebaum. It is simply far too little. It is too narrow a vision. It does not answer the needs of the American people.

Mr. BLILEY. Mr. Speaker, I reserve the balance of my time.

Mr. BENTSEN. Mr. Speaker, I yield 3 minutes to the gentleman from California [Mr. WAXMAN].

(Mr. WAXMAN asked and was given permission to revise and extend his remarks.)

Mr. WAXMAN. Mr. Speaker, today employees who have insurance coverage where they work fear that if they lose their job or change jobs they will not be able to get insurance. If they have a medical problem, they worry they will be excluded from coverage permanently or that they will have a long waiting period before they can be covered. They face the so-called ''job lock'' where they cannot move on to other or better jobs because they cannot risk the loss of their health insurance coverage, and if they lose their job, their situation is made worse by facing the loss of that insurance.

The substitute before us would change that. It would guarantee them access to health insurance coverage. It would assure them that an existing health problem would not be a reason to exclude them from coverage.

Now this base bill that we are seeking to amend has provisions that are similar to Kennedy-Kassebaum, the Dingell bill, the Roukema bill. There really is not a lot of difference between all these provisions. There are some differences, but they are minor, and they are differences that can be worked out if people sat down and talked them through. In fact, I voted for the Kennedy-Kassebaum-Roukema version of this legislation when it was in the Committee on Commerce. Everybody did. It was a unanimous vote.

But the Republican proposal before us adds some things that I think will make this legislation fail ultimately to become law. They take medical savings accounts, which may or may not be a good idea; the small employer pooling, which may or may not work. A lot of people fear that it will lead to cherry-picking of the least risky people by insurance companies. They make medical malpractice changes, which are very controversial because some people fear that this will deprive injured parties of their full redress. They take

savings from the Medicare Program because of an antifraud provision, and they use those savings to fund the tax breaks for medical savings accounts.

Those are controversial issues. They should not be in a bill that can be passed on a bipartisan basis and turned into law.

There are things I would like us to do, because let us realize what we are not addressing is the problem of the 40 million uninsured in this country. I do not care what version of the bills we pass today, they are not going to be covered after all is said and done.

I think there are important changes we need in our health care system, but if we do not have a consensus to accomplish them, let us do what we can and pass the bill that would prevent this job lock and assure that people will get insurance if they leave their jobs and take another job or want to buy a private insurance policy.

I would urge support for the substitute. I will not go through the denigration of what the other people have to say. What I do say is let us pass what we can into law. Let us not lose this chance.

Mr. BLILEY. Mr. Speaker, I yield 2 minutes to the gentleman from Florida [Mr. BILIRAKIS], the chairman of the Health and Environment Subcommittee, a pioneer in health care reform, the man who led the bipartisan effort in the 103d Congress.

Mr. BILIRAKIS. I thank the gentleman for yielding the time to me.

Mr. Speaker, I rise in opposition to this substitute, and yet without question I certainly support the goals of the substitute. Both bills address insurance portability, eliminate preexisting condition prohibitions, end job lock, and both bills address medical savings accounts.

The Kassebaum bill amends the HMO act to allow the offering of high deductible MSA's, and it also provides a sense of committee resolution to encourage MSA's. But that is where the common elements end. The substitute simply falls far short of the mark on true practical health care reform.

Our bill offers more options to the American people. My constituents are always asking me, I am sure my colleagues' are, what Congress is doing to address fraud and abuse. What is Congress doing to eliminate unnecessary paperwork? When will our medical malpractice laws be changed? Our bill addresses these important areas.

In addition, it also extends the medical expenses deduction to long-term care services which is important to our seniors. A Band-Aid solution like the substitute proposes would not address more systematic problems which drive up costs and limit access to our health care system.

On health care reform, the American people deserve more than a Band-Aid. They deserve our best efforts to fix what we can in a system which everyone agrees is broken.

Mr. BENTSEN. Mr. Speaker, I yield 1½ minutes to the gentleman from Pennsylvania [Mr. KLINK].

(Mr. KLINK asked and was given permission to revise and extend his remarks.)

Mr. KLINK. Mr. Speaker, I just wanted to talk a little bit about the matter that is before us. One of the previous speakers talked about a bipartisan effort called Roland-Bilirakis. Mr. Speaker, While I respect both of the people greatly who came out with that effort, it did not pass this House, it did not have the necessary support, and so we are here today trying to figure out what steps we can take to make an improvement upon the trillion dollar industry that is health care in this Nation.

Mr. Speaker, I would suggest that Roukema-Kassebaum-Kennedy is that modest step. It is that first step that is going to help tens of millions of Americans keep their health insurance when they switch their jobs, regardless of preexisting health conditions.

The Republicans, though, in this House are proposing a health insurance reform that is not as strong as Roukema-Kassebaum-Kennedy. They are adding on what I believe to be special interest amendments and paybacks that are going to sabotage the first real attempt we had to be able to do a bipartisan step in the right direction for the working people of this country.

Now, we are talking about two editions, that in one instance the CBO is saying that the bill's profraud loopholes are going to cost $400 million. Less revenue coming in, and enforcement of fraud is going to suffer. Why should we want to do this?

The MSA proposal is not going to fly in the Senate, it is not going to fly with the President. Why would the Republicans want to doom this package by adding these two things to it?

Mr. THOMAS. Mr. Speaker, I yield 2 minutes to the gentleman from Florida [Mr. SHAW].

Mr. SHAW. Mr. Speaker, I thank the gentleman for yielding this time to me.

Mr. Speaker, tonight I rise to deliver to my congressional colleagues a message from the 180,000 Medicare beneficiaries who reside in my south Florida district, and that message is simply:

Stop the fraudulent and abusive practices against the Medicare Program, and do it now.

This substitute ignores the issue of fraud and abuse.

Mr. Speaker, this body has already voted for the Medicare fraud and abuse provisions that are included in this bill when it passed the Medicare Preservation Act, and, as we all remember, the Medicare Preservation Act was vetoed by President Clinton. Now we have another chance to move a step closer to saving the Medicare Program from bankruptcy.

This bill is the toughest and most serious attempt that this Congress has made to stop fraud and abuse in the Medicare Program and health care generally with the new strong criminal penalties for offenses against the American people. I am proud to have contributed to this effort, and I know that when my constituents learn of their new rights under the Medicare Program, they will be proud of this Congress, too.

Let us pass this bill and save Medicare millions of dollars and save all the American taxpayers billions of dollars in reducing fraud and abuse.

Mr. BENTSEN. Mr. Speaker, I yield 1 minute to the gentlewoman from California [Ms. ROYBAL-ALLARD].

Ms. ROYBAL-ALLARD. Mr. Speaker, I rise in support of the Democratic substitute. By correcting the most obvious deficiencies in the health insurance market, this legislation is a much-needed, albeit small step toward reforming our health care system, because it frees the American worker from job lock which prevents millions from taking better jobs for fear of losing their health care coverage.

It protects people with preexisting conditions by limiting the exclusion period and prohibiting employers and insurers from denying coverage to these individuals. It expands availability and access by prohibiting insurers from denying coverage to specific employee groups, and it increases the deduction for the self-employed to 80 percent in support of America's small business.

The Democratic substitute brings a measure of fairness and justice to our health insurance system without the special interest provisions in the House Republican bill. I urge all Members to vote in favor of the Democratic substitute.

Mr. BLILEY. Mr. Speaker, I yield 2 minutes to the gentleman from Connecticut [Mr. SHAYS], a distinguished member of the Committee on the Budget.

Mr. SHAYS. Mr. Speaker, I thank the gentleman for yielding me the time.

Mr. Speaker, a number of years ago the President came in with major reform of health care. It was wide reaching, it was well beyond what anyone in this House wanted to do, and now we have a bill that in my judgment is very sensible. It is very logical. The Roland-Bilirakis bill never passed 2 years ago because it never had a vote. It never had a vote because unfortunately the other party was jealously guarding the jurisdictions of each committee.

This bill here has the input of the Committee on the Judiciary, the Committee on Commerce, the Committee on Ways and Means, and the Committee on Economic and Educational Opportunities, and in it there is a very significant portion of this bill dealing with fraud, title II, preventing health care fraud and abuse; it goes for about 70 pages. I have a hard time understanding what is meant by a clean bill.

□ 2130

What is a clean bill that does not deal with waste, fraud, and abuse? We have been having hearings for decades about the waste, fraud, and abuse. That

so-called clean substitute ignores it completely. This bill here deals with waste, fraud, and abuse, and for the first time makes health care fraud a Federal offense, an all-payer system, not just for Medicare and Medicaid and Champus, but for all health care fraud. We are determined that this House is going to do something responsible.

I will just conclude by saying I am totally convinced that this House is going to pass a health care bill. It may not be exactly like this one when we deal with our conference with the Senate, but it will be a meaningful bill, and it will be far better than the substitute bill presented. I urge my colleagues to take part in what we are doing. We are going after waste, fraud, and abuse for the first time in a serious way. It is happening under our watch. Be proud of it.

Mr. BENTSEN. Mr. Speaker, I yield 1 minute to the gentlewoman from California [Ms. WOOLSEY].

(Ms. WOOLSEY asked and was given permission to revise and extend her remarks.)

Ms. WOOLSEY. Once again, Mr. Speaker, the Gingrich Republicans are standing in the way of meaningful health care reform and it's American families who are going to wind up paying the price. While Speaker GINGRICH says his plan may make health insurance more available, it does nothing whatsoever to make it affordable.

Thankfully, for the American people, we have another choice before us today. We have the Democratic substitute. The one bill that will extend coverage to 25 million Americans. The one bill that has bipartisan support in the Senate. And the one bill that will be signed into law by the President.

To my colleagues on the other side of the aisle: Don't use your vote to scuttle significant health care reform this year. Instead, stand up for working families, and support the Democratic substitute.

Mr. BENTSEN. Mr. Speaker, I yield 1½ minutes to the gentleman from Illinois [Mr. DURBIN].

Mr. DURBIN. Mr. Speaker, several years ago I introduced legislation which allowed a full 100 percent deductibility of health insurance premiums for self-employed people. I represent a rural district. I represent a lot of farm families. It is very difficult for them to buy health insurance, and when they do, it is expensive, and they find that they can only deduct now 30 percent of the cost of the premiums.

The real unfairness is the fact that corporations can deduct 100 percent of the cost of health insurance premiums. Self-employed people cannot. What we do with the Democratic substitute is to address this in an honest way. I hope some of my Republican colleagues will consider breaking ranks tonight and joining in this bipartisan approach to health care reform.

Let me tell the Members what we know now. The fastest growing sector in the American economy are self-employed people, people who are starting their own businesses. If you ask them their No. 1 headache, you are going to find, to your surprise, it is health insurance; how to pay for it, how to cover your family and a few employees.

What we do in the Democratic substitute is to allow up to 80 percent deductibility over a period of several years. If Members take a look at the alternative on the Republican side, they will find they only reach 50 percent. This is a big difference for a small business.

I hope that some of my colleagues will think twice and join us. I think it is far better for us to come together, Democrats and Republicans, pass real health care reform, instead of trying to score some political victory for the Golden Rule Life Insurance Company. Let us do something for the real self-employed people who need a helping hand.

Mr. THOMAS. Mr. Speaker, it is my pleasure to yield 1 minute to the gentleman from Illinois [Mr. WELLER], who knows full well that in the calendar year 1994 it was the Democrats who left the self-employed with no deductibility whatsoever.

(Mr. WELLER asked and was given permission to revise and extend his remarks.)

Mr. WELLER. Mr. Speaker, I rise to oppose the substitute and support H.R. 3103, which deserves the votes of Democrats as well as Republicans. Mr. Speaker, H.R. 3103 addresses a real problem faced by almost 40 million Americans, 85 percent of whom are small business people, the self-employed, farmers, and their families and workers.

I have listened over the last several years to many families unable to afford health insurance. They say the prices of health insurance are too high if they are self-employed or work for small business. H.R. 3103 helps the little guy, the self-employed, and small business; frankly, people like my mother and father, fifth generation family farmers who, because their rates are based on two, face very high rates.

Mr. Speaker, H.R. 3103 helps make health insurance more affordable, the risk pools allowing small employers, perhaps through the Farm Bureau or the local Chamber of Commerce, to purchase in a cooperative fashion a bigger group policy, getting more affordable rates, also giving 100 percent tax deduction for long-term care, and raising the 50 percent self-employed taxes.

Mr. BENTSEN. Mr. Speaker, I yield 2 minutes to the gentleman from North Dakota [Mr. POMEROY].

Mr. POMEROY. Mr. Speaker, for 8 years I had the privilege of representing North Dakota as its State insurance commissioner. During that time I evaluated the health insurance crises experienced by families all across the State. While undoubtedly there were many facets to the problems I encountered, far and away the largest problem was affordability.

I am astounded that the previous speaker could talk about affordability as a health issue addressed by the majority plan and deride the substitute, when in fact, deductibility of health insurance premium geared specifically at enhancing the affordability of coverage is the feature best exemplified in the substitute, as opposed to the majority plan. Look at the facts: Fifty percent deductibility immediately under the substitute, and only 30 percent under the majority plan, phasing up to 80 percent deductibility under the substitute plan, and only 50 percent in the majority plan.

The difference between 80 percent and 50 percent deductibility is the difference between affordability and unaffordability of health insurance for farm families, for self-employed families in North Dakota and all across the country. The No. 1 problem for so many families with health insurance tonight, Mr. Speaker, is affordability. Let us make it more affordable by increasing the deductibility. Only the substitute, in my opinion, goes the limits it needs to increasing the deductibility for purposes of making this coverage more affordable.

Mr. BLILEY. Mr. Speaker, I yield 3 minutes to the deputy whip, the gentleman from Illinois [Mr. HASTERT], a gentleman who has put more work into this bill than anyone on the Committee on Commerce.

Mr. HASTERT. Mr. Speaker, I thank the gentleman for yielding time to me.

I guess we just need to straighten out some things. To my friend who just talked over here about the deductibility, I guess plagiarism is one of the best compliments there is. To my friend, the gentleman from Illinois, who talked about the deductibility issue, it is interesting, it is the same folks who for years just let the deductibility for small businesses go to zero and left it there until we moved it to 30 percent. We are going to move it to 50 percent. They are talking about something in 2002. It is a promise, folks. I would not count on that promise.

Mr. Speaker, also I would say to my good friend from New Jersey, who says that the Senate leadership wants this Kassebaum bill, it is interesting, she did not read her papers, because the Senate leadership endorses our bill. They are going to move an add-on to the Senate to exactly what we have passed in this House tonight, so she might be apprised of that.

Mr. Speaker, we have heard a lot of outrageous claims on the other side of the aisle. I think now is the time of reckoning. This substitute is just a whisper in the dark. It does not do anything to help health care. We cover group-to-group, we cover group-to-individual, and we also make health care affordable for the American people.

If Members want real change in health care, if we really want to help Americans from the shoestore and the barber shop and the truck drivers and the real people that work out there in

America, defeat this substitute, the farce out here that they are putting out as the substitute, and support the Republican bill.

Mr. BENTSEN. Mr. Speaker, I yield 1 minute to the gentleman from Maryland [Mr. CARDIN].

Mr. CARDIN. Mr. Speaker, I thank the gentleman for yielding time to me.

Mr. Speaker, I urge my colleagues to support this substitute, this alternative. It does two things, and it does them better than the original bill. First, it provides for portability. It does it better than the underlying bill, because if you lose your job and you lose your insurance and you try to find an individual plan, the substitute allows you to have some options and lets you be able to buy an affordable individual plan.

The second thing this bill does is deal with the self-employed by allowing them to be able to deduct 80 percent of their premium, whereas the underlying bill is at 50 percent. It makes it better for the self-employed. Both of these issues enjoy strong bipartisan support. This bill, the alternate, if it is passed, will be signed quickly by the President, will be approved by the Senate. It can be a reality. It is stronger than the underlying bill, and it can be passed and enacted into law.

Mr. Speaker, I urge my colleagues to support the substitute.

Mr. THOMAS. Mr. Speaker, it is my privilege to yield 1 minute to the gentleman from Oregon [Mr. BUNN], who came here to make a difference, and he does.

Mr. BUNN of Oregon. Mr. Speaker, I am pleased tonight to say that the substitute is a good bill, but the Republican version is a better bill. We have a win-win tonight. I think we ought to be pleased with that.

Mr. Speaker, I am also delighted that we had the opportunity to address some concerns in the Committee on Rules, and the Committee on Rules was willing to make the necessary changes to assure that this bill is a floor, not a ceiling, so that reforms like Oregon passed just last year will be maintained. I think we are on track to assuring that Americans will have good, affordable health care, and State reforms which will stay on track.

Again, we have a win-win. Theirs is good, ours is great. I support maintaining the Republican version, which means saying no to a good substitute.

Mr. Speaker, let me start by saying that I am glad that we were able to protect State health insurance reform efforts within this bill. As many people brought to my attention, including my State insurance commissioner, State insurance reform efforts may have been jeopardized by specific language not exempting them within this bill. I am proud to say that the language currently in this bill is very similar to that of the Democratic substitute, and while I support many of the reform efforts contained in that bill, I believe the Republican bill goes even further and ensures even broader coverage than that alternative. I am supporting the base bill and opposing the substitute. I look forward to reforming our national health insurance laws as soon as possible.

Mr. BENTSEN. Mr. Speaker, I yield 1½ minutes to the gentlewoman from California [Ms. WATERS].

(Ms. WATERS asked and was given permission to revise and extend her remarks.)

Ms. WATERS. Mr. Speaker, I am pleased to join with my colleagues in supporting the substitute. It is time to stop just talk about health care reform, and accomplish some real health care reform. This substitute represents a sensible approach to health care reform, and it may be the only chance we have to enact affordable health care for the American people. This bill would prohibit many of the current unfair insurance practices which deny and exclude individuals and families with significant health problems. Insurers often deny health coverage for preexisting conditions, the very illnesses most likely to require quality medical care.

Approximately 81 million Americans have medical conditions which could result in the denial of coverage. We know from recent studies that African-American women are dying at a faster rate from heart disease and stroke. Minority children are dying and experiencing more complications from asthma and other preventable respiratory diseases. We are seeing an increase in the infection rate for HIV and AIDS among young African-American males.

We know that low-income persons are dying because they simply cannot purchase the ability to live. Many of those who are fortunate enough to have insurance give up opportunities for new jobs because they are afraid of losing what little coverage they have. We must have portability. This substitute, while it does not address all health care concerns, does move in the right direction.

Mr. BLILEY. Mr. Speaker, it gives me great pleasure to yield 2 minutes to the distinguished gentleman from Louisiana [Mr. MCCRERY], a member of the Committee on Ways and Means.

(Mr. MCCRERY asked and was given permission to revise and extend his remarks.)

Mr. MCCRERY. Mr. Speaker, I thank the gentleman for yielding time to me.

Mr. Speaker, I want to congratulate the gentlewoman from New Jersey, the gentleman from Michigan, the gentleman from South Carolina, the gentleman from Texas, for I think putting forth a well-intentioned effort to improve the lot of people in this country vis-a-vis the health insurance system. It is a good effort. However, in the face of what we should be doing in health care reform in this country, it is weak. It is watered down. It is half-hearted.

Mr. Speaker, we should not be so timid in this House to bend to the threats of the President of the United States, who is up for reelection this year. We should do what we think is right for the American people in our health care system. If you go to a town meeting and listen to the people, what do they talk about? They talk about portability. That is a problem. We solved that in our bill. But what is the main thing they talk about? Cost. ''Mr. Congressman, do something about the escalating cost in our health care system.''

The substitute, regrettably, does nothing for cost containment. Our bill, on the other hand, has medical malpractice reform, which goes to the heart of the escalation of costs in the health care system. We attack fraud and abuse, waste in the system, which goes to the heart of cost escalation. We introduce a new concept, make it tax-advantaged, medical savings accounts, which will allow a lot of little people in this country to get health care coverage for the first time.

□ 2145

These are all things that we should be doing if we were not so timid. We need to vote against the substitute and vote for the underlying bill.

Mr. BENTSEN. Mr. Speaker, I yield 2 minutes to the gentleman from Florida [Mr. GIBBONS], the ranking member of the Committee on Ways and Means.

Mr. GIBBONS. Mr. Speaker, I want to take just a couple of minutes to explain why the medical savings account is not popular on our side of the aisle, and why it probably is pretty popular with our colleagues over here, our Republicans friends.

If we look at the average family in America, it has an average family income of $34,000 a year, $34,000 a year. That is what half of the taxpayers have as family income. Now, if we look very closely at that family, they are paying about an 18- or 20-percent tax level, but only 3 or 4 percent of that tax is income tax. All the rest of it is FICA tax. They are only getting a medical savings account deduction out of income tax, not out of FICA tax.

So half of the people in the United States that we claim as constituents and part of our party get absolutely nothing out of these medical savings accounts. But what do we do for our very well-off friends?

Mr. Speaker, first of all, they can afford it. They get a large deduction percentage-wise in all of this as opposed to 2 or 3 percent for our folks. Second, do not even make them pay FICA tax on that cash that they get as income. So that is another tax reduction they get, and we have not even talked about it here.

Third, and this is the insult of all, this allows them to exclude it from their estate tax. Now, how many of our constituents over here even have to worry about an estate tax? Obviously, many of my colleagues' do. My colleagues exempt them from the estate tax.

Now, what do we have to have in the estate tax? Well, between husband and wife, they can have millions of dollars and not pay any estate tax. But when the last of the family dies, they have

an estate tax. They have to have $600,000 before they pay a penny's worth of estate tax. This thing is just designed for very wealthy people.

Mr. BLILEY. Mr. Speaker, I yield 1 minute to the gentleman from Ohio [Mr. HOBSON].

Mr. HOBSON. Mr. Speaker, I rise in opposition to the substitute. I think the substitute is a laudable effort, but there are a lot of other things that we can do that are important to this issue. There is a bipartisan bill, it is called Hobson-Sawyer, and it is called Bond-Lieberman in the Senate, and it is in our bill, it is not in this bill. It is the administrative simplification bill.

It gets rid of a lot of forms that have to be transferred around, a multiplicity of forms. It makes it simple. Everyone agrees that that is good. It also gets at fraud. Everyone agrees we ought to do that, but it is not in my colleagues' bill, and it should be in their bill. Everybody agrees that it is a good bill. There is no opposition. This part of the bill passed out of the committee 30 to zip. It is a good piece of legislation, it ought to be passed. That is why I support our bill and do not support the substitute.

Mr. BLILEY. Mr. Speaker, I have no further requests for time. I yield my remaining 1 minute back to the gentleman from California [Mr. THOMAS].

Mr. THOMAS. Mr. Speaker, I have 5 minutes and I have one speaker left. Under the rules we have the right to close.

Mr. BENTSEN. Mr. Speaker, I yield the balance of my time to the chief sponsor of the amendment, the gentleman from Michigan [Mr. DINGELL], the ranking member of the Committee on Commerce.

(Mr. DINGELL asked and was given permission to revise and extend his remarks.)

Mr. DINGELL. My colleagues, this has been a good debate. I think we owe a great debt of gratitude to the distinguished gentlewoman from New Jersey [Mrs. ROUKEMA] for the leadership which she has shown in this matter which has brought us to where we are tonight, and I would urge my colleague to appreciate her great effort in this matter.

Having said that, it is very important to us to look at the situation we confront here. As an old friend of mine once observed, the perfect good is the enemy of the good. That means that, if we load this bill down with a vast plethora of amendments, we are liable to get no bill at all.

I yield to no man in my devotion to the concept that we must change the medical practice in this country to afford greater opportunity in this country to afford greater opportunity in this country and greater security to all the people.

The fact is that we had that opportunity before us in the last Congress and it was rejected. My Republican colleagues have made a great talk about what it was that we did in those days and what we are doing tonight. The hard fact of the matter is that neither of these bills solves the problem.

But the real fact is that the bill and the substitute which is offered by the Democratic Members has the ability to solve the problems in large part of some 25 million Americans who need portability and who need protection against prohibitions on preexisting conditions in insurance policies. It also does something else. It ups the amount of deductibility to 80 percent for individuals and small business. That is extremely important in terms of making health insurance available to large numbers of people who would otherwise be denied that benefit.

So I urge my colleagues to support the simpler and the cleaner bill, and I would urge them to recognize that the special interest amendments which are inserted in the Republican bill accomplish nothing but benefiting special interests and denying people the real opportunity to access to meaningful health insurance.

Mr. Speaker, let us look a little bit at what is in the Republican bill. First of all, it is loaded down like a Christmas tree, and I am satisfied that it will wind up with the same fate of a Christmas tree, dumped on the lawn at the conclusion of the discussion. It affords no chance for workers who lose their jobs to have a choice of plans. It makes no guarantees of businesses with more than 50 workers. It preempts State laws that protect consumers. It limits the deductibility of insurance premiums only to 50 percent. It has the controversial medical savings plans which do only one thing, and that is to benefit the insurance companies that have spent millions of dollars lobbying for this particular benefit for themselves, to benefit those who are healthy and those who have money, not those who are ill and who have need.

It has controversial medical malpractice law changes. Now I happen to think we need some changes in medical malpractice, but I did not think that we need the changes that are here. It also makes it harder to catch and to punish wrongdoers. Perhaps one of the worst things that it does is that it repeals protections that we invested in seniors some years ago to prevent them from being ripped off by useless, duplicative health insurance policies under which they pay for the same benefits which they are getting from Medicare, but in which they are prohibited from collecting benefits because of clauses in the legislation and because the prior liability goes to the Medicare policies.

There are also controversial provisions in here which override State insurance laws.

Mr. Speaker, the hard fact is that tonight we should be working to make it simple. We should be working to make this a proposal which will go to the President, which will pass quickly through the House and Senate, which will move easily through conference, and which will go to the President for quick and easy signature. To risk veto or to arrive at a situation where we do not help the some 25 million people who are dependent on the question of portability and who are afflicted with the problems of not being able to have preexisting conditions treated under their health insurance plans or under health insurance plans which would be made available under this legislation is both unwise and unnecessary and inconsistent with our responsibilities to the people.

I would hope that soon we will be able to address a really meaningful proposal for health insurance for all the people, to see to it that we provide that last element of security for the American people, which every American finds to be troublesome in the extreme, because it is an essential and important part of the security net which Americans think that every American should have. Regrettably, that choice is not before us. Regrettably, the Republican Members of this body have chosen not to move forward on that.

President Clinton tried to do that 2 years ago and it was rejected overwhelmingly on this side of the aisle. I would urge my colleagues to recognize that a little that we can get quickly which will really help people is a lot better than an illusory lot which will help no one and not become law and not help anybody.

I would urge my colleagues to therefore vote for the substitute which the Democratic Members will be offering tonight and to do something which is going to benefit all of the people and which will be of significant benefit to some 25 million who will derive benefits under the portability and under the preexisting provisions.

I urge my colleagues to vote in the interests of the country. I urge them to vote for the substitute. I urge them to vote for a proposal which will give us significant progress, rather than the assurance of further confusion, further controversy, and possible veto and loss of this legislation in the Senate or in a conference between the House and Senate.

Mr. Speaker, I yield myself 3 minutes, and ask unanimous consent to revise and extend my remarks.

Mr. Speaker, we are faced today with a simple choice:

Will the House give the American people what they want—a straightforward, simple, and uncontroversial bill to reform health insurance, a bill that can go to conference with the Senate quickly and be enacted into law?

Or will the House doom the chances for enacting such a bill by erecting a Christmas tree, decorated with all manner of controversial ornaments?

I want to commend my colleague from New Jersey, Mrs. ROUKEMA, for recognizing the simplicity of this equation early on, and for introducing in the House the companion to Senator KASSEBAUM's bill in the Senate. The Kassebaum-Roukema bill has enjoyed widespread and bipartisan support. It has been endorsed by 135 organizations, including the

AMA, the American Hospital Association, the Independent Insurance Agents, the National Association of Manufacturers, and the Healthcare Leadership Council.

Many of us have tried, on a bipartisan basis, to persuade the leadership to keep this health insurance bill limited only to the Roukema-Kassebaum bill and to tax deductibility of health insurance for the self-employed, another uncontroversial provision with broad support. But in spite of the very public pleas from our side of the aisle, as well as from Representative ROUKEMA, Senator KASSEBAUM, and Senator BENNETT on the Republican side, we have ended up instead with a Christmas tree.

The Dingell-Spratt-Bentsen substitute incorporates the Roukema bill as title I. The amendment is very simple. It ends discrimination against people with preexisting conditions so they can get health insurance. It guarantees that Americans who lose or change their jobs can get health insurance. It requires health insurance companies to renew people's policies. And in title II, it increases the health insurance tax deduction for self-employed individuals from 30 percent to 80 percent, a major priority for small businesses and family farmers.

By voting for the substitute, my friends, you will be telling your constituents that you want the House to pass a bill that can be signed and become law. By voting against it, you will be telling them that they will have wait longer for health insurance reform—and how long? Perhaps years?—because you can't say no to the special interests who want to load this bill up with controversial add-ons and thereby kill its chances for passage.

Now I know that many of my colleagues, on both sides of the aisle, don't happen to think that each and every one of these provisions added by the Republican leadership is bad. Medical savings accounts, antitrust relief, malpractice reform—there are strongly held views on both sides of these issues. But regardless of our personal views on any of them, one thing is clear: they are all controversial; they all weigh this bill down; and they all significantly reduce the chances of enacting the kind of simple health insurance reform the American people are demanding.

Mr. Speaker, I urge my colleagues:

Don't kill this chance for health insurance reform by passing a Christmas tree instead of a clean bill. Support a clean bill by supporting the substitute. Vote "yes" on Dingell-Spratt-Bentsen.

Mr. THOMAS. Mr. Speaker, it is my privilege and honor to yield the remainder of the majority's time on this substitute to the Speaker of the House, the gentleman from Georgia [Mr. GINGRICH].

Mr. GINGRICH. Mr. Speaker, I thank my friend from California for yielding me the time to close, and I say I always rise with some slight trepidation after my dear friend from Michigan, who has been a leader in the House and is a very effective articulator of his side.

Mr. Speaker, I would say to him, however, that to describe as a Christmas tree a series of things the American people want is different than describing as a Christmas tree things only politicians want. And I do plead guilty to the charge that on a bipartisan basis we tried to reach out and actually listen to the American people, and that some people are very grateful to us for that.

Let me start, for example, with the Alzheimer's Association. The Alzheimer's Association wrote us and said:

> The Alzheimer's Association is writing in general support of the provisions in H.R. 3160 to clarify the Tax Code so that taxpayers may deduct their long-term care expenses as medical expenses. We are particularly pleased to note the committee's addition of specific language to assure that this deduction is available to taxpayers who are incurring expenses for care for persons who are cognitively impaired.

They go on to say:

> This change in the Tax Code has had strong bipartisan support for a number of years and has appeared in virtually every version of health reform legislation seriously considered over the last two Congresses.

Now, maybe to some of our friends that is a Christmas tree. But if one has a parent with Alzheimer's, if one has a loved one with Alzheimer's, or if one has a child with a chronic disease, or a child born with a genetic defect that requires permanent long-term care, this provision is a good step in the right direction, and we should be proud that we listened to the American people.

The American Health Care Association, largely representing folks who are involved in nursing homes, an area where we have a growing population and as more Americans live beyond 80 years of age there will be even more Americans, they said: ''We applaud and support your efforts to enact health insurance reform legislation that also addresses long-term care.''

Now, that is very important. And yes, it is true we added it to the bill because we listened. We think that, while the start in the Senate was a useful start and we respect the work of the other body, we do not think the House is bound automatically to simply say, oh, please send us something that we can rubber stamp.

□ 2200

The American Farm Bureau Federation wrote, and they said:

> A provision of the Health Coverage Availability and Affordability Act of 1996, one which deals with cooperative insurance purchasing arrangements, is particularly important to the 4.5-million-member families of the American Farm Bureau Federation. Farmers are, by and large, self-employed, and as such must purchase health insurance for themselves and their families. Many join together in cooperative purchasing arrangements in order to obtain quality health insurance plans at affordable rates. The Farm Bureau applauds and supports your effort on this issue and the section of the legislation that would facilitate voluntary insurance purchasing cooperatives so that individuals and small companies can negotiate and receive the same price advantage that many larger businesses presently receive.

So, yes, it is true we listened to the Farm Bureau, and we listened to the rural families of America and to the small family farmers.

The National Federation of Independent Businesses, and I am particularly surprised that so many of my friends who normally rail against the rich and declare class warfare and worry about the giant corporations, that they could get a letter like this from the National Federation of Independent Businesses and ignore it.

Here is what the National Federation of Independent Businesses said:

> As the House prepares to take up health care reform, I am writing to let you know how important the small employer pooling provisions of the Health Coverage Availability and Affordability Act are to the members of the National Federation of Independent Businesses. NFIB is seeking to correct a basic unfairness in our current health system, the fact that big business is allowed to buy health insurance under a different set of rules than small business. Because of the Employment Retirement Income Security Act, large self-insured businesses are exempted from State law, in their health plans, while small business is stuck with State insurance coverage mandates, premium taxes, and other forms of regulation. This inequity between big business and small business in large part explains why the premiums of corporate America are going down while small business premiums are going up. State mandates alone can increase premiums for small business by 30 percent. The Health Coverage Availability and Affordability Act would stop this unfairness by allowing small firms to band together across State lines to purchase health insurance with nearly the same exemption from State law that big business has. Achieving this is NFIB's highest health reform priority. Any substitute amendment that does not directly address this inequity between big and small businesses is unacceptable to the more than 600,000 members of the National Federation of Independent Businesses. I hope you will stand up for small business and oppose efforts to remove the small employer pooling provisions of the Health Coverage Availability and Affordability Act. Passage of these pooling provisions will drive coverage up and premiums down for small business.

I particularly congratulate the gentleman from Illinois [Mr. FAWELL], who has done such yeoman work in that area.

The Chamber of Commerce said here were the returns of their poll: 97.8 percent said they needed small employer pooling; 97.1 percent said they needed to allow self-employed individuals to fully deduct the cost of their health coverage; 96 percent said they needed administrative simplification; 92 percent said they wanted medical malpractice reform.

Let me say to my good friends on the left, yes, it is true, we listened to the American people. We heard the American people say that access was a start but access was not enough, you also have to have affordability because the truth is if you do not keep the price down, you do not have access if you are too poor to pay the premium.

So just passing some Washington law with a Washington rule for a Washington bureaucrat, that does not mean that a small business or a family farm can actually pay for it, does not get the job done. So we went to part 2, which was affordability. We guaranteed

accessibility, and we added affordability.

And there is a third part. We had strong provisions on fraud, and I particularly want to congratulate the gentleman from Oklahoma [Mr. COBURN], who is a medical doctor, who is infuriated at the level of fraud that we have in the system today, and Dr. COBURN is a Representative from Oklahoma who has worked tirelessly in his first term to make sure that we have strong steps and strong penalties against fraud.

When the General Accounting Office reports that fraud may account for 10 percent of health care costs, that is $100 billion a year. We have anecdote after anecdote on this floor from Members who have had members of their family involved in situations of clear-cut fraud, when you watch on NBC as a woman reports that she called in to complain because they had charged her for her autopsy and, since she was still alive, she does not think she had one, and their answer was that must have been an EKG. She said, ''Honey, I did not have that either.''

We had one of our colleagues who walked up to me one day and said, you know, his mother had called him, she heard us talking about fraud, and she said she got billed for two mammograms. She called the doctor's office. She said, ''You did not have two mammograms.'' They said, ''Oh, yes. We must have done two mammograms.'' She said, ''I had a mastectomy 7 years ago. I know you did not do two mammograms.'' Their next comment was, ''What do you care?'' The Government will pay the bill.''

What this bill establishes is it directs the Secretary of Health and Human Services to establish a system for senior citizens to turn in fraud and to give senior citizens the power to help us police the system so people engaged in ripping off you, the taxpayer, and rip off the consumer of Medicare is better protected and has a better incentive to turn in fraud.

I would say if you want accountability, we have it. If you want access, we have better access. We give twice as long a period as Kennedy-Kassebaum between insurance without losing coverage, twice as long. We have a better system of access, and it is far more affordable under our bill than it is under the substitute.

So I would simply say to my friends, do not be partisan about this. Here is an occasion where we started with a bill that was bipartisan in the Senate. We have improved the bill. Medical savings accounts is, in fact, an issue of great concern to some people. It is a brand-new idea. We believe it will help things.

I want the House to know that if the President sends up a veto signal, we are not going to risk vetoing coverage for all Americans in medical savings accounts, but we want to make the case. We want to try to convince him that he ought to be willing to sign it.

There are other items in here. Malpractice reform, my good friend admitted we need to do something, too, on malpractice reform. The trial lawyers should not be ripping America off.

I talked about a week ago to the American dental association. It occurred to me, if dentists acted like the Bar, they would be urging every child to get cavities. There would be commercials to eat sugar and not brush your teeth. Just think about it. It is terrible. A patient walks into a doctor's office. They should both be on the same team, fighting the disease, and there is a lawyer running an ad that says, ''Why don't you walk in there as a potential plaintiff and see if you can't find a good excuse to sue?'' It is culturally sick to have this kind of litigation, conflict-ridden system. We take the first step down the road.

If the President sends up a veto signal, maybe we would have to back down. But we want a chance to convince him this is wrong to favor the trial lawyers over the patients and the doctors.

But all I would say to my friends is, the substitute is well-meaning, but it is inadequate. It is too little, it is too narrow, it is too small. We can do better.

We have listened, and we are doing better. This is a better bill than Kennedy-Kassebaum. This is a more complete bill. This offers better access. It is more affordable, and it guarantees greater accountability, and it is worthy of your consideration.

I will just close with this point: Five major leaders in the Senate yesterday announced their endorsement of this bill. And this bill will almost certainly be offered in the Senate as the substitute for the earlier well-meaning, but weaker, bill that Kennedy-Kassebaum introduced, and, with our help, we can send a signal to the Senate. Let us get the job done a lot better, and let us do it for a lot more people. That is why we should vote ''no'' on the substitute and ''yes'' on final passage.

Mrs. MINK of Hawaii. Mr. Speaker, I rise to speak in favor of the Democratic substitute to H.R. 3103.

Why are we considering H.R. 3103? H.R. 3103 was reported with only nine cosponsors. The Roukema bill, which the Democratic substitute is based on, has 193 cosponsors. Seldom do we have legislation with such widespread support. Instead of hearing the Roukema bill, we are spending time on legislation loaded with controversy and doomed to fail.

We now have before us an opportunity to provide relief for hardworking Americans enslaved to their health care policies.

The core of the Democratic substitute is twofold. First it will guarantee individuals leaving a job, where they are covered by group insurance, to be able to obtain group or individual insurance at their next job; and second, it will forbid insurance companies from denying coverage because of preexisting conditions. These are two very simple concepts with little opposition and if implemented would result in enormous social benefits.

In addition, both the Republican bill and the Democratic substitute increase the permitted health insurance tax deduction for self-employed individuals. The levels allotted in the Democratic substitute, however, are significantly higher. Health insurance costs for the self-employed are often a heavy burden. Tax deductions at the levels proposed in the Democratic substitute would ease this burden.

H.R. 1303 on the other hand contains many provisions which are not well thought out and will be harmful to the overall health care objectives.

One of these proposals relates to medical malpractice. Congress should not set maximum monetary amounts that can be awarded for pain and suffering, and for punitive damages. I cannot support this anti-consumer provisions.

With respect to Medical Savings Accounts, I took a hard look at this proposal. It seemed like a good idea to give individuals the option to contribute to a tax deductible savings account which must be used for medical purposes and also require them to enroll in a catastrophic health care plan with relatively lower premiums and a high yearly deductible.

Two questions came to mind: First, will this reform help the uninsured; and second, will this reform divide the pool of insured resulting in the systematic breakdown of the insurance system.

Medical Savings Accounts would not be attractive for the high risk and the poor, those who need health care the most, because they would be unable to afford the high yearly deductible over a extended period of time. If the poor did enroll in this plan they would be unlikely to obtain preventive care because it would have to be paid for from their account or from their own pocket.

Meanwhile, the healthy and wealthy, who do not have a problem obtaining health insurance, would be more likely to choose a Medical Savings Account because they can afford the high deductible. The different choices of these demographic groups will result in the healthy vacating the traditional insurance pool leaving only high-risk individuals remaining. The pool will be concentrated with high-risk individuals and costs will rise causing insurance to be unaffordable for many. Fewer people who need coverage will be insured. The Republican proposal for Medical Savings Accounts will divide the insurance pool leading to an insurance system breakdown.

Moreover, I feel compelled to speak out against the multiple employer welfare arrangement [MEWA] provisions contained in this bill. I am concerned that the federal regulation provided will not be adequate and that by preempting established State systems, programs will be harmed.

As a result of these new MEWA provisions, I am concerned that Hawaii may no longer be granted an ERISA exemption for the Hawaii Prepaid Health Care Act. Majority committee staff indicated that Hawaii's ERISA exemption was included in the bill reported out of the Committee on Economic and Education Opportunities. However, due to the extreme handicap of having to evaluate, debate, and vote on a bill mere hours after it is printed and made public, I have been unable to confirm whether or not Hawaii's exemption was preserved. The Federal Government will not be able to take on this new responsibility, liability, and expense. The retention of State authority is critical. Not to do so is a fatal flaw.

Mr. Speaker, the Democratic substitute focuses solely on insurance portability and prohibiting denial of coverage due to preexisting

conditions. We must not load up this bill with controversial provisions that will incite opposition and thwart the enactment of valuable and the noncontroversial provisions in this bill.

This substitute will not overhaul the health care system but will provide greater health security and make a positive difference in the lives of millions of Americans. We must not allow this opportunity to slip through our fingers.

I urge a yes vote for the Democratic substitute.

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, I rise today as a member of the health profession to encourage my colleagues to support a comprehensive health care reform measure that would make appropriate health care accessible for all Americans. As we consider H.R. 3103, the Health Coverage Affordability and Availability Act, it is important that we realize that there is no clear consensus on the best means to attain universal coverage. Limitations on exclusions for preexisting conditions and guarantees for portability will help millions of Americans move away from job-lock and the terrifying prospect of losing health care coverage that comes with job loss or change brought about by corporate downsizing and other market forces.

As a nurse, it is my opinion that this Congress needs to continue to foster high standards in the health care industry and promote the economic and general welfare of Americans in the workplace. All year we have heard that the Medicare hospital trust fund is about to go bankrupt and therefore we have to make massive cuts in Medicare to save it. Now they propose taking the easiest money in Medicare—the money gained from fighting fraud—and spending it to give medical savings account tax breaks to younger people who are likely to be in the highest tax brackets and the healthiest members of our society.

Mr. Chairman, while considering health care legislation today, we as a Congress must keep the process simple. There is no place for adding on special interest amendments and pay backs that will sabotage the passage of good reforms. We must also remember the working poor of this Nation that are effectively priced-our of the health insurance market.

Mr. Chairman, I encourage my colleagues to support the Democratic substitute to H.R. 3103 because the substitute does not contain any of the bill's highly controversial provisions—such as medical savings accounts—that would jeopardize any possibility of enacting health insurance reform this year. The Kassebaum-Kennedy-Roukema bill, which assures health insurance portability, enjoys broad bipartisan support in both Chambers, and the President has endorsed it. We should not let this opportunity for enacting meaningful health reform slip away by loading down this bill with a number of controversial provisions. The only way to enact health reform is to support the Kassebaum-Kennedy-Roukema alternative which the substitute embodies.

I yield back the balance of my time.

Mr. VENTO. Mr. Speaker, I rise today to oppose the bill and support the Democratic substitute on this important issue of health insurance reform.

It is clear that there are serious problems with our current health care system. In 1994, Congress was working to address these problems and implement broad health care reforms, expanding access to health care coverage and reining in escalating health care costs. Those efforts were stymied, and during the past year and half Republicans have mostly concentrated on cutting back on health care, by attempting to slash Medicare and Medicaid. In fact half the specified savings in the GOP reconciliation plan was from health care, that is, Medicare, Medicaid, cuts.

In the absence of broader health care reforms, Americans are relying on us to at least enact some limited but important insurance reforms. There is some bipartisan support for many of the provisions before us today, but unfortunately, the Republican leadership are polarizing and threatening the enactment of these modest reforms. The GOP House leadership is seriously jeopardizing the bill by loading it up like a Christmas tree with controversial ornaments, like medical savings accounts and medical malpractice reform. These ornaments are a distraction from the issues and while they may be pretty to look at, we should certainly examine and consider these provisos separately, not as part of this basic agreed upon reforms.

In our dysfunctional health care system, insurance companies have too often taken steps to shift costs and deny health care coverage to people in order to lower their risk and increase their profit margin and competitiveness. The Democratic substitute is the best alternative today. It prohibits insurers and employers from limiting or denying coverage because of a preexisting condition. It would prohibit insurers from denying coverage to employers and prevent heath plans from excluding any employee on the basis of health status. Health plans would be required to renew coverage for groups and individuals as long as premiums are paid. The Democratic substitute would also guarantee that individuals who leave group coverage will be able to purchase individual health insurance policies.

Millions of Americans would benefit from such legislation. It would allow people who want to change their jobs to take their health insurance with them, ending the phenomenon of job lock. It would end the unfair insurance practice of employing preexisting conditions clauses to avoid coverage of categories of persons. These changes proposed in the Democratic substitute are needed to increase health care security for working American families.

However, the Republican proposal is disengenous and demonstrates today their policy path; solve health care problems by changing the topic. They have included a provision in their bill to establish medical savings accounts which will in essence drive health care costs up for most and balloon the deficit. This proposal will weaken the overall health system as healthier and wealthier people leave the traditional insurance risk pool. First of all most Americans cannot afford to put aside $2,000 a year into a tax-free account. People with existing health problems and without savings income would be left in the traditional insurance pool and will find it more difficult to afford escalating health care costs. I do not believe that this is the kind of change in the health care system that the American people want. This will further polarize and divide the concept of community rating. In fact, the main beneficiaries of this proposal will be the insurance companies.

For months, Republicans have delayed consideration of this bill until they were embarrassed into bringing it to the floor by the President's State of the Union statements. Now the Republicans are going to burden the bill by overloading the vehicle so that it will sink. The Republican political agenda apparently takes precedent over good people policy. The special interests wish list that the Republican leadership trys to satisfy, threatens the passage of the core insurance reforms necessary to secure health care coverage for millions of Americans. This is wrong and should be rejected.

Congress must respond to the needs of the American people and enact responsible health insurance reform, not sidetrack the issue and leave the American people in the lurch. I urge my colleagues to oppose the controversial provisions of the bill and support the Democratic substitute.

Mr. RICHARDSON. Mr. Speaker, voting for this substitute means that you are serious about allowing your constituents to have access to health insurance.

This substitute is simple policy. If you want to tell insurance companies they cannot deny Americans who have beat a life-threatening disease or condition insurance coverage, vote for this substitute.

If you want to allow hard working families in your district to keep their health care when they change jobs, vote for this substitute.

If you want to help small businesses and entrepreneurs afford health care, vote for this substitute.

This substitute is a bipartisan effort. Republicans and Democrats in the Senate agree on it.

A Republican Member introduced this bill in the House and over 170 Democrats have cosponsored it.

Mr. Speaker, this is not about partisan politics. It is about doing what is right for the American people. About giving working American families access to insurance coverage for themselves and their families.

The SPEAKER pro tempore (Mr. COMBEST). Pursuant to House Resolution 392, the previous question is ordered on the bill as amended.

The question is on the amendment in the nature of a substitute offered by the gentleman from Michigan [Mr. DINGELL].

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

Mr. BENTSEN. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make a point of order a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

The vote was taken by electronic device, and there were—yeas 192, nays 226, not voting 14, as follows:

[Roll No. 104]

YEAS—192

Abercrombie	Berman	Brown (FL)
Ackerman	Bevill	Brown (OH)
Andrews	Bishop	Cardin
Baesler	Boehlert	Chapman
Baldacci	Bonior	Clay
Barcia	Borski	Clayton
Barrett (WI)	Boucher	Clement
Becerra	Brewster	Clyburn
Beilenson	Browder	Collins (MI)
Bentsen	Brown (CA)	Condit

Conyers
Costello
Coyne
Cramer
Danner
de la Garza
DeFazio
DeLauro
Dellums
Deutsch
Dicks
Dingell
Dixon
Doggett
Doyle
Duncan
Durbin
Edwards
Engel
Evans
Farr
Fattah
Fazio
Filner
Flake
Foglietta
Ford
Frank (MA)
Franks (NJ)
Frelinghuysen
Frost
Furse
Gejdenson
Gephardt
Geren
Gibbons
Gonzalez
Green
Gutierrez
Hall (OH)
Hamilton
Harman
Hastings (FL)
Hefner
Hilliard
Hinchey
Holden
Hoyer
Jackson (IL)
Jackson-Lee (TX)
Jacobs
Jefferson
Johnson (SD)
Johnson, E.B.
Johnston
Kanjorski
Kaptur
Kennedy (MA)
Kennedy (RI)
Kennelly
Kildee
Kleczka
Klink
LaFalce
Lantos
Levin
Lewis (GA)
Lincoln
Lipinski
Lofgren
Lowey
Luther
Maloney
Manton
Markey
Martinez
Martini
Mascara
Matsui
McCarthy
McDermott
McHale
McKinney
Meehan
Meek
Menendez
Miller (CA)
Minge
Mink
Moakley
Mollohan
Moran
Murtha
Nadler
Oberstar
Obey
Olver
Ortiz
Orton
Owens
Pallone
Pastor
Payne (NJ)
Payne (VA)
Pelosi
Peterson (FL)
Peterson (MN)
Pickett
Pomeroy
Poshard
Quinn
Rahall
Rangel
Reed
Richardson
Rivers
Roberts
Roemer
Rose
Roukema
Roybal-Allard
Rush
Sabo
Sanders
Sawyer
Schroeder
Schumer
Scott
Serrano
Sisisky
Skaggs
Skelton
Slaughter
Spratt
Stark
Stenholm
Studds
Stupak
Tanner
Tejeda
Thompson
Thornton
Thurman
Torkildsen
Torres
Torricelli
Towns
Traficant
Velazquez
Vento
Visclosky
Volkmer
Walsh
Ward
Waters
Watt (NC)
Waxman
Wilson
Wise
Woolsey
Wynn
Yates

NAYS—226

Allard
Archer
Armey
Bachus
Baker (CA)
Baker (LA)
Ballenger
Barr
Barrett (NE)
Bartlett
Barton
Bass
Bateman
Bereuter
Bilbray
Bilirakis
Bliley
Blute
Boehner
Bonilla
Bono
Brownback
Bryant (TN)
Bunn
Bunning
Burr
Burton
Buyer
Callahan
Calvert
Camp
Campbell
Canady
Castle
Chabot
Chambliss
Chenoweth
Christensen
Chrysler
Clinger
Coble
Coburn
Collins (GA)
Combest
Cooley
Cox
Crane
Crapo
Cremeans
Cubin
Cunningham
Davis
Deal
DeLay
Diaz-Balart
Dickey
Doolittle
Dornan
Dreier
Dunn
Ehlers
Ehrlich
Emerson
English
Ensign
Everett
Ewing
Fawell
Fields (TX)
Flanagan
Foley
Forbes
Fox
Franks (CT)
Frisa
Funderburk
Gallegly
Ganske
Gekas
Gilchrest
Gillmor
Gilman
Gingrich
Goodlatte
Goodling
Gordon
Goss
Graham
Greenwood
Gunderson
Gutknecht
Hall (TX)
Hancock
Hansen
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Heineman
Herger
Hilleary
Hobson
Hoekstra
Hoke
Horn
Hostettler
Houghton
Hunter
Hutchinson
Hyde
Inglis
Istook
Johnson (CT)
Johnson, Sam
Jones
Kasich
Kelly
Kim
King
Kingston
Klug
Knollenberg
Kolbe
LaHood
Largent
Latham
LaTourette
Laughlin
Lazio
Leach
Lewis (CA)
Lewis (KY)
Lightfoot
Linder
Livingston
LoBiondo
Longley
Lucas
Manzullo
McCollum
McCrery
McDade
McHugh
McInnis
McIntosh
McKeon
Metcalf
Meyers
Mica
Miller (FL)
Molinari
Montgomery
Moorhead
Morella
Myers
Myrick
Nethercutt
Neumann
Ney
Norwood
Nussle
Oxley
Packard
Parker
Paxon
Petri
Pombo
Porter
Portman
Pryce
Quillen
Radanovich
Ramstad
Regula
Riggs
Rogers
Rohrabacher
Roth
Royce
Salmon
Sanford
Saxton
Scarborough
Schaefer
Schiff
Seastrand
Sensenbrenner
Shadegg
Shaw
Shays
Shuster
Skeen
Smith (MI)
Smith (NJ)
Solomon
Souder
Spence
Stearns
Stockman
Stump
Talent
Tate
Tauzin
Taylor (MS)
Taylor (NC)
Thomas
Thornberry
Tiahrt
Upton
Vucanovich
Waldholtz
Walker
Wamp
Watts (OK)
Weldon (FL)
Weller
White
Whitfield
Wicker
Williams
Wolf
Young (AK)
Young (FL)
Zeliff
Zimmer

NOT VOTING—14

Bryant (TX)
Coleman
Collins (IL)
Dooley
Eshoo
Fields (LA)
Fowler
McNulty
Neal
Ros-Lehtinen
Smith (TX)
Smith (WA)
Stokes
Weldon (PA)

□ 2225

Messrs. HILLEARY, NUSSLE, and STOCKMAN changed their vote from ''yea'' to ''nay.''

So the amendment in the nature of a substitute was rejected.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore (Mr. COMBEST). The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

□ 2230

MOTION TO RECOMMIT OFFERED BY MR. PALLONE

Mr. PALLONE. Mr. Speaker, I offer a motion to recommit.

The SPEAKER pro tempore (Mr. COMBEST). Is the gentleman opposed to the bill?

Mr. PALLONE. Yes, Mr. Speaker, I am.

The SPEAKER pro tempore. The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. PALLONE moves to recommit the bill, H.R. 3103, to the Committee on Ways and Means with instructions that the Committee report the bill back to the House forthwith with the following amendment:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Health Insurance Reform Act of 1996''.

TITLE I—HEALTH CARE ACCESS, PORTABILITY, AND RENEWABILITY

TABLE OF CONTENTS OF TITLE

Sec. 100. Definitions.

SUBTITLE A—GROUP MARKET RULES

Sec. 101. Guaranteed availability of health coverage.
Sec. 102. Guaranteed renewability of health coverage.
Sec. 103. Portability of health coverage and limitation on preexisting condition exclusions.
Sec. 104. Special enrollment periods.
Sec. 105. Disclosure of information.

SUBTITLE B—INDIVIDUAL MARKET RULES

Sec. 110. Individual health plan portability.
Sec. 111. Guaranteed renewability of individual health coverage.
Sec. 112. State flexibility in individual market reforms.
Sec. 113. Definition.

SUBTITLE C—COBRA CLARIFICATIONS

Sec. 121. Cobra clarification.

SUBTITLE D—PRIVATE HEALTH PLAN PURCHASING COOPERATIVES

Sec. 131. Private health plan purchasing cooperatives.

SUBTITLE E—APPLICATION AND ENFORCEMENT OF STANDARDS

Sec. 141. Applicability.
Sec. 142. Enforcement of standards.

SUBTITLE F—MISCELLANEOUS PROVISIONS

Sec. 191. Health coverage availability study.
Sec. 192. Effective date.
Sec. 193. Severability.

SEC. 100. DEFINITIONS.

As used in this title:

(1) BENEFICIARY.—The term ''beneficiary'' has the meaning given such term under section 3(8) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(8)).

(2) EMPLOYEE.—The term ''employee'' has the meaning given such term under section 3(6) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(6)).

(3) EMPLOYER.—The term ''employer'' has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(5)), except that such term shall include only employers of two or more employees.

(4) EMPLOYEE HEALTH BENEFIT PLAN.—

(A) IN GENERAL.—The term ''employee health benefit plan'' means any employee welfare benefit plan, governmental plan, or church plan (as defined under paragraphs (1), (32), and (33) of section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002 (1), (32), and (33))) that provides or pays for health benefits (such as provider and hospital benefits) for participants and beneficiaries whether—

(i) directly;

(ii) through a group health plan offered by a health plan issuer as defined in paragraph (8); or

(iii) otherwise.

(B) RULE OF CONSTRUCTION.—An employee health benefit plan shall not be construed to be a group health plan, an individual health plan, or a health plan issuer.

(C) ARRANGEMENTS NOT INCLUDED.—Such term does not include the following, or any combination thereof:

(i) Coverage only for accident, or disability income insurance, or any combination thereof.

(ii) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act).

(iii) Coverage issued as a supplement to liability insurance.

(iv) Liability insurance, including general liability insurance and automobile liability insurance.

(v) Workers compensation or similar insurance.

(vi) Automobile medical payment insurance.

(vii) Coverage for a specified disease or illness.

(viii) Hospital or fixed indemnity insurance.

(ix) Short-term limited duration insurance.

(x) Credit-only, dental-only, or vision-only insurance.

(xi) A health insurance policy providing benefits only for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(5) FAMILY.—

(A) IN GENERAL.—The term ''family'' means an individual, the individual's spouse, and the child of the individual (if any).

(B) CHILD.—For purposes of subparagraph (A), the term ''child'' means any individual who is a child within the meaning of section 151(c)(3) of the Internal Revenue Code of 1986.

(6) GROUP HEALTH PLAN.—

(A) IN GENERAL.—The term ''group health plan'' means any contract, policy, certificate or other arrangement offered by a health plan issuer to a group purchaser that provides or pays for health benefits (such as provider and hospital benefits) in connection with an employee health benefit plan.

(B) ARRANGEMENTS NOT INCLUDED.—Such term does not include the following, or any combination thereof;

(i) Coverage only for accident, or disability income insurance, or any combination thereof.

(ii) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act).

(iii) Coverage issued as a supplement to liability insurance.

(iv) Liability insurance, including general liability insurance and automobile liability insurance.

(v) Workers compensation or similar insurance.

(vi) Automobile medical payment insurance.

(vii) Coverage for a specified disease or illness.

(ix) Short-term limited duration insurance.

(x) Credit-only, dental-only, or vision-only insurance.

(xi) A health insurance policy providing benefits only for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(7) GROUP PURCHASER.—The term ''group purchaser'' means any person (as defined under paragraph (9) of section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(9)) or entity that purchases or pays for health benefits (such as provider or hospital benefits) on behalf of two or more participants or beneficiaries in connection with an employee health benefit plan. A health plan purchasing cooperative established under section 131 shall not be considered to be a group purchaser.

(8) HEALTH PLAN ISSUER.—The term ''health plan issuer'' means any entity that is licensed (prior to or after the date of enactment of this Act) by a State to offer a group health plan or an individual health plan.

(9) HEALTH STATUS.—The term ''health status'' includes. with respect to an individual, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), or disability.

(10) PARTICIPANT.—The term ''participant'' has the meaning given such term under section 3(7) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(7)).

(11) PLAN SPONSOR.—The term ''plan sponsor'' has the meaning given such term under section 3(16)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(16)(B)).

(12) SECRETARY.—The term ''Secretary'', unless specifically provided otherwise, means the Secretary of Labor.

(13) STATE.—The term ''State'' means each of the several States, the District of Columbia, Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

Subtitle A—Group Market Rules

SECTION 101. GUARANTEED AVAILABILITY OF HEALTH COVERAGE.

(a) IN GENERAL.—

(1) NONDISCRIMINATION.—Except as provided in subsection (b), section 102 and section 103—

(A) a health plan issuer offering a group health plan may not decline to offer whole group coverage to a group purchaser desiring to purchase such coverage; and

(B) an employee health benefit plan or a health plan issuer offering a group health plan may establish eligibility, continuation of eligibility, enrollment, or premium; contribution requirements under the terms of such plan, except that such requirements shall not be based on health status (as defined in section 100(9)).

(2) HEALTH PROMOTION AND DISEASE PREVENTION.—Nothing in this subsection shall prevent an employee health benefit plan or a health plan issuer from establishing premium; discounts or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(b) APPLICATION OF CAPACITY LIMITS.—

(1) IN GENERAL.—Subject to paragraph (2), a health plan issuer offering a group health plan may cease offering coverage to group purchasers under the plan if—

(A) the health plan issuer ceases to offer coverage to any additional group purchasers; and

(B) the health plan issuer can demonstrate to the applicable certifying authority (as defined in section 142(d)), if required, that its financial or provider capacity to serve previously covered participants and beneficiaries (and additional participants and beneficiaries who will be expected to enroll because of their affiliation with a group purchaser or such previously covered participants or beneficiaries) will be impaired if the health plan issuer is required to offer coverage to additional group purchasers.

Such health plan issuer shall be prohibited from offering coverage after a cessation in offering coverage under this paragraph for a 6-month period or until the health plan issuer can demonstrate to the applicable certifying authority (as defined in section 142(d)) that the health plan issuer has adequate capacity, whichever is later.

(2) FIRST-COME-FIRST-SERVED.—A health plan issuer offering a group health plan is only eligible to exercise the limitations provided for in paragraph (1) if the health plan issuer offers coverage to group purchasers under such plan on a first-come-first-served basis or other basis established by a State to ensure a fair opportunity to enroll in the plan and avoid risk selection.

(c) CONSTRUCTION.—

(1) MARKETING OF GROUP HEALTH PLANS.—Nothing in this section shall be construed to prevent a State from requiring health plan issuers offering group health plans to actively market such plans.

(2) INVOLUNTARY OFFERING OF GROUP HEALTH PLANS.—Nothing is this section shall be construed to require a health plan issuer to involuntarily offer group health plans in a particular market. For the purposes of this paragraph, the term ''market'' means either the large employer market or the small employer market (as defined under applicable State law, or if not so defined, an employer with not more than 50 employees).

SEC. 102. GUARANTEED RENEWABILITY OF HEALTH COVERAGE.

(a) IN GENERAL.—

(1) GROUP PURCHASER.—Subject to subsections (b) and (c), a group health plan shall be renewed or continued in force by a health plan issuer at the option of the group purchaser, except that the requirement of this subparagraph shall not apply in the case of—

(A) the nonpayment of premiums or contributions by the group purchaser in accordance with the terms of the group health plan or where the health plan issuer has not received timely premium payments;

(B) fraud or misrepresentation of material fact on the part of the group purchaser;

(C) the termination of the group health plan in accordance with subsection (b); or

(D) the failure of the group purchaser to meet contribution or participation requirements in accordance with paragraph (3).

(2) PARTICIPANT.—Subject to subsections (b) and (c), coverage under an employee health benefit plan or group health plan shall be renewed or continued in force, if the group purchaser elects to continue to provide coverage under such plan, at the option of the participant (or beneficiary where such right exists under the terms of the plan or under applicable law), except that the requirement of this paragraph shall not apply in the case of—

(A) the nonpayment of premiums or contributions by the participant or beneficiary in accordance with the terms of the employee health benefit plan or group health plan or where such plan has not received timely premium payments.

(B) fraud or misrepresentation of material fact on the part of the participant or beneficiary relating to an application for coverage or claim for benefits;

(C) the termination of the employee health benefit plan or group health plan;

(D) loss of eligibility for continuation coverage as described in part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.); or

(E) failure of a participant or beneficiary to meet requirements for eligibility for coverage under an employee health benefit plan or group health plan that are not prohibited by this title.

(3) RULES OF CONSTRUCTION.—Nothing in this subsection, nor in section 101(a), shall be construed to—

(A) preclude a health plan issuer from establishing employer contribution rules or group participation rules for group health plans as allowed under applicable State law;

(B) preclude a plan defined in section 3(37) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1102(37)) from establishing employer contribution rules or group participation rules; or

(C) permit individuals to decline coverage under an employee health benefit plan if such right is not otherwise available under such plan.

(b) TERMINATION OF GROUP HEALTH PLANS.—

(1) PARTICULAR TYPE OF GROUP HEALTH PLAN NOT OFFERED.—In any case in which a health plan issuer decides to discontinue offering a particular type of group health plan. A group health plan of such type may be discontinued by the health plan issuer only if—

(A) the health plan issuer provides notice to each group purchaser covered under a group health plan of this type (and participants and beneficiaries covered under such group health plan) of such discontinuation at least 90 days prior to the date of the discontinuation of such plan;

(B) the health plan issuer offers to each group purchaser covered under a group health plan of this type, the option to purchase any other group health plan currently being offered by the health plan issuer; and

(C) in exercising the option to discontinue a group health plan of this type and in offering one or more replacement plans, the

health plan issuer acts uniformly without regard to the health status of participants or beneficiaries covered under the group health plan, or new participants or beneficiaries who may become eligible for coverage under the group health plan.

(2) DISCONTINUANCE OF ALL GROUP HEALTH PLANS.—

(A) IN GENERAL.—In any case in which a health plan issuer elects to discontinue offering all group health plans in a State, a group health plan may be discontinued by the health plan issuer only if—

(i) the health plan issuer provides notice to the applicable certifying authority (as defined in section 142(d)) and to each group purchaser (and participants and beneficiaries covered under such group health plan) of such discontinuation at least 180 days prior to the date of the expiration of such plan, and

(ii) all group health plans issued or delivered for issuance in the State or discontinued and coverage under such plans is not renewed.

(B) APPLICATION OF PROVISIONS.—The provisions of this paragraph and paragraph (3) may be applied separately by a health plan issuer—

(i) to all group health plans offered to small employers (as defined under applicable State law, or if not so defined, an employer with not more than 50 employees); or

(ii) to all other group health plans offered by the health plan issuer in the State.

(3) PROHIBITION ON MARKET REENTRY.—In the case of a discontinuation under paragraph (2), the health plan issuer may not provide for the issuance of any group health plan in the market sector (as described in paragraph (2)(B)) in which issuance of such group health plan was discontinued in the State involved during the 5-year period beginning on the date of the discontinuation of the last group health plan not so renewed.

(C) TREATMENT OF NETWORK PLANS.—

(1) GEOGRAPHIC LIMITATIONS.—A network plan (as defined in paragraph (2)) may deny continued participation under such plan to participants or beneficiaries who neither live, reside, nor work in an area in which such network plan is offered, but only if such denial is applied uniformly, without regard to health status of particular participants or beneficiaries.

(2) NETWORK PLAN.—As used in paragraph (1), the term ''network plan'' means an employee health benefit plan or a group health plan that arranges for the financing and delivery of health care services to participants or beneficiaries covered under such plan, in whole or in part, through arrangements with providers.

(d) COBRA COVERAGE.—Nothing in subsection (a)(2)(E) or subsection (c) shall be construed to affect any right to COBRA continuation coverage as described in part 6 of subtitle B of title I of the employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.).

SEC. 103. PORTABILITY OF HEALTH COVERAGE AND LIMITATION ON PREEXISTING CONDITION EXCLUSIONS.

(a) IN GENERAL.—An employee health benefit plan or a health plan issuer offering a group health plan may impose a limitation or exclusion of benefits relating to treatment of a preexisting condition based on the fact that the condition existed prior to the coverage of the participant or beneficiary under the plan only if—

(1) the limitation or exclusion extends for a period of not more than 12 months after the date of enrollment in the plan;

(2) the limitation or exclusion does not apply to an individual who, within 30 days of the date of birth or placement for adoption (as determined under section 609(c)(3)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1169(c)(3)(B)), was covered under the plan; and

(3) the limitation or exclusion does not apply to a pregnancy.

(b) CREDITING OF PREVIOUS QUALIFYING COVERAGE.—

(1) IN GENERAL.—Subject to paragraph (4), an employee health benefit plan or a health plan issuer offering a group health plan shall provide that if a participant or beneficiary is in a period of previous qualifying coverage as of the date of enrollment under such plan, any period of exclusion or limitation of coverage with respect to a preexisting condition shall be reduced by 1 month for each month in which the participant or beneficiary was in the period of previous qualifying coverage. With respect to an individual described in subsection (a)(2) who maintains continuous coverage, no limitation or exclusion of benefits relating to treatment of a preexisting condition may be applied to a child within the child's first 12 months of life or within 12 months after the placement of a child for adoption.

(2) DISCHARGE OF DUTY.—An employee health benefit plan shall provide documentation of coverage to participants and beneficiaries who coverage is terminated under the plan. Pursuant to regulations promulgated by the Secretary, the duty of an employee health benefit plan to verify previous qualifying coverage with respect to a participant or beneficiary is effectively discharged when such employee health benefit plan provides documentation to a participant or beneficiary that includes the following information:

(A) the dates that the participant or beneficiary was covered under the plan; and

(B) the benefits and cost-sharing arrangement available to the participant or beneficiary under such plan.

An employee health benefit plan shall retain the documentation provided to a participant or beneficiary under subparagraphs (A) and (B) for at least the 12-month period following the date on which the participant or beneficiary ceases to be covered under the plan. Upon request, an employee health benefit plan shall provide a second copy of such documentation or such participant or beneficiary within the 12-month period following the date of such ineligibility.

(3) DEFINITIONS.—As used in this section:

(A) PREVIOUS QUALIFYING COVERAGE.—The term ''previous qualifying coverage'' means the period beginning on the date—

(i) a participant or beneficiary is enrolled under an employee health benefit plan or a group health plan, and ending on the date the participant or beneficiary is not so enrolled; or

(ii) an individual is enrolled under an individual health plan (as defined in section 113) or under a public or private health plan established under Federal or State law, and ending on the date the individual is not so enrolled;

for a continuous period of more than 30 days (without regard to any waiting period).

(B) LIMITATION OR EXCLUSION OF BENEFITS RELATING TO TREATMENT OF A PREEXISTING CONDITION.—The term ''limitation or exclusion of benefits relating to treatment of a preexisting condition'' means a limitation or exclusion of benefits imposed on an individual based on a preexisting condition of such individual.

(4) EFFECT OF PREVIOUS COVERAGE.—An employee health benefit plan or a health plan issuer offering a group health plan may impose a limitation or exclusion of benefits relating to the treatment of a preexisting condition, subject to the limits in subsection (a)(1), only to the extent that such service or benefit was not previously covered under the group health plan, employee health benefit plan, or individual health plan in which the participant or beneficiary was enrolled immediately prior to enrollment in the plan involved.

(c) LATE ENROLLEES.—Except as provided in section 104, with respect to a participant or beneficiary enrolling in an employee health benefit plan or group health plan during a time that is other than the first opportunity to enroll during an enrollment period of at least 30 days, coverage with respect to benefits or services relating to the treatment of a preexisting condition in accordance with subsection (a) and (b) may be excluded except the period of such exclusion may not exceed 18 months beginning on the date of coverage under the plan.

(d) AFFILIATION PERIODS.—With respect to a participant or beneficiary who would otherwise be eligible to receive benefits under an employee health benefit plan or a group health plan but for the operation of a preexisting condition limitation or exclusion, if such plan does not utilize a limitation or exclusion of benefits relating to the treatment of a preexisting condition, such plan may impose an affiliation period on such participant or beneficiary not to exceed 60 days (or in the case of a late participant or beneficiary described in subsection (c), 90 days) from the date on which the participant or beneficiary would otherwise be eligible to receive benefits under the plan. An employee health benefit plan or a health plan issuer offering a group health plan may also use alternative methods to address adverse section as approved by the applicable certifying authority (as defined in section 142(d)). During such an affiliation period, the plan may not be required to provide health care services or benefits and no premium shall be charged to the participant or beneficiary.

(e) PREEXISTING CONDITIONS.—For purposes of this section, the term ''preexisting condition'' means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the day before the effective date of the coverage (without regard to any waiting period).

(f) STATE FLEXIBILITY.—Nothing in this section shall be construed to preempt State laws that—

(1) require health plan issuers to impose a limitation or exclusion of benefits relating to the treatment of a preexisting condition for periods that are shorter than those provided for under this section; or

(2) allow individuals, participants, and beneficiaries to be considered to be in a period of previous qualifying coverage if such individual, participant, or beneficiary experiences a lapse in coverage that is greater than the 30-day period provided for under subsection (b)(3);

unless such laws are preempted by section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144).

SEC. 104. SPECIAL ENROLLMENT PERIODS.

In the case of a participant, beneficiary or family member who—

(1) through marriage, separation, divorce, death, birth or placement of a child for adoption, experiences a change in family composition affecting eligibility under a group health plan, individual health plan, or employee health benefit plan;

(2) experiences a change in employment status, as described in section 603(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1163(2)), that causes the loss of eligibility for coverage, other than COBRA continuation coverage under a group health plan, individual health plan, or employee health benefit plan; or

(3) experiences a loss of eligibility under a group health plan, individual health plan, or employee health benefit plan because of a change in the employment status of a family member;

each employee health benefit plan and each group health plan shall provide for a special enrollment period extending for a reasonable time after such event that would permit the participant to change the individual or family basis of coverage or to enroll in the plan if coverage would have been available to such individual, participant, or beneficiary but for failure to enroll during a previous enrollment period. Such a special enrollment period shall ensure that a child born or placed for adoption shall be deemed to be covered under the plan as of the date of such birth or placement for adoption if such child is enrolled within 30 days of the date of such birth or placement for adoption.

SEC. 105. DISCLOSURE OF INFORMATION.

(a) DISCLOSURE OF INFORMATION BY HEALTH PLAN ISSUER.—

(1) IN GENERAL.—In connection with the offering of any group health plan to a small employer (as defined under applicable State law, or if not so defined, an employer with not more than 50 employees), a health plan issuer shall make a reasonable disclosure to such employer, as part of its solicitation and sales materials, of—

(A) the provisions of such group health plan concerning the health plan issuer's right to change premium rates and the factors that may affect changes in premium rates.

(B) the provisions of such group health plan relating to renewability of coverage;

(C) the provisions of such group health plan relating to any preexisting condition provision; and

(D) descriptive information about the benefits and premiums available under all group health plans for which the employer is qualified.

Information shall be provided to small employers under this paragraph in a manner determined to be understandable by the average small employer, and shall be sufficiently accurate and comprehensive to reasonably inform small employers, participants and beneficiaries of their rights and obligations under the group health plan.

(2) EXCEPTION.—With respect to the requirement of paragraph (1), any information that is proprietary and trade secret information under applicable law shall not be subject to the disclosure requirements of such paragraph.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed to preempt State reporting and disclosure requirements to the extent that such requirements are not preempted under section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144).

(b) DISCLOSURE OF INFORMATION TO PARTICIPANTS AND BENEFICIARIES.—

(1) IN GENERAL.—Section 104(b)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1024(b)(1)) is amended in the matter following subparagraph (B)—

(A) by striking ''102(a)(1),'' and inserting ''102(a)(1) that is not a material reduction in covered services or benefits provided,''; and

(B) by adding at the end thereof the following new sentences: ''If there is a modification or change described in section 102(a)(1) that is a material reduction in covered services or benefits provided, a summary description of such modification or change shall be furnished to participants not later than 60 days after the date of the adoption of the modification or change. In the alternative, the plan sponsors may provide such description at regular intervals of not more than 90 days. The Secretary shall issue regulations within 180 days after the date of enactment of the Health Insurance Reform Act of 1996, providing alternative mechanisms to delivery by mail through which employee health benefit plans may notify participants of material reductions in covered services or benefits.''.

(2) PLAN DESCRIPTION AND SUMMARY.—Section 102(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1022(b)) is amended—

(A) by inserting ''including the office or title of the individual who is responsible for approving or denying claims for coverage of benefits'' after ''type of administration of the plan'';

(B) by inserting ''including the name of the organization responsible for financing claims'' after ''source of financing of the plan''; and

(C) by inserting ''including the office, contact, or title of the individual at the Department of Labor through which participants may seek assistance or information regarding their rights under this Act and title I of the Health Insurance Reform Act of 1996 with respect to health benefits that are not offered through a group health plan.'' after ''benefits under the plan''.

Subtitle B—Individual Market Rules

SEC. 110. INDIVIDUAL HEALTH PLAN PORTABILITY.

(a) LIMITATION ON REQUIREMENTS.—

(1) IN GENERAL.—Except as provided in subsections (b) and (c), a health plan issuer described in paragraph (3) may not, with respect to an eligible individual (as defined in subsection (b)) desiring to enroll in an individual health plan—

(A) decline to offer coverage to such individual, or deny enrollment to such individual based on the health status of the individual; or

(B) impose a limitation or exclusion of benefits otherwise covered under the plan for the individual based on a preexisting condition unless such limitation or exclusion could have been imposed if the individual remained covered under a group health plan or employee health benefit plan (including providing credit for previous coverage in the manner provided under subtitle A).

(2) HEALTH PROMOTION AND DISEASE PREVENTION.—Nothing in this subsection shall be construed to prevent a health plan issuer offering an individual health plan from establishing premium discounts or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion or disease prevention.

(3) HEALTH PLAN ISSUER.—A health plan issuer described in this paragraph in a health plan issuer that issues or renews individual health plans.

(4) PREMIUMS.—Nothing in this subsection shall be construed to affect the determination of a health plan issuer as to the amount of the premium payable under an individual health plan under applicable State law.

(b) DEFINITION OF ELIGIBLE INDIVIDUAL.—As used in subsection (a)(1), the term ''eligible individual'' means an individual who—

(1) was a participant or beneficiary enrolled under one or more group health plans, employee health benefit plans, or public plans established under Federal or State law, for not less than 18 months (without a lapse in coverage of more than 30 consecutive days) immediately prior to the date on which the individual desired to enroll in the individual health plan.

(2) is not eligible for coverage under a group health plan or an employee health benefit plan;

(3) has not had coverage terminated under a group health plan or employee health benefit plan for failure to make required premium payments or contributions, or for fraud or misrepresentation of material fact; and

(4) has, if applicable, accepted and exhausted the maximum required period of continuous coverage as described in section 602(2)(A) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1162(2)(A)) or under an equivalent State program.

(c) APPLICABLE OF CAPACITY LIMIT.—

(1) IN GENERAL.—Subject to paragraph (2), a health plan issuer offering coverage to individuals under an individual health plan may cease enrolling individuals under the plan if—

(A) the health plan issuer ceases to enroll any new individuals; and

(B) the health plan issuer can demonstrate to the applicable certifying authority (as defined in section 142(d)), if required, that its financial or provider capacity to serve previously covered individuals will be impaired if the health plan issuer is required to enroll additional individuals.

Such a health plan issuer shall be prohibited from offering coverage after a cessation in offering coverage under this paragraph for a 6-month period or until the health plan issuer can demonstrate to the applicable certifying authority (as defined in section 142(d)) that the health plan issuer has adequate capacity, whichever is later.

(2) FIRST-COME-FIRST-SERVED.—A health plan issuer offering coverage to individuals under an individual health plan is only eligible to exercise the limitations provided for in paragraph (1) if the health plan issuer provides for enrollment of individuals under such plan on a first-come-first-served basis or other basis established by a State to ensure a fair opportunity to enroll in the plan and avoid risk selection.

(d) MARKET REQUIREMENT.—

(1) IN GENERAL.—The provisions of subsection (a) shall not be construed to require that a health plan issuer offering group health plans to group purchasers offer individual health plans to individuals.

(2) CONVERSION POLICIES.—A health plan issuer offering group health plans to group purchasers under this title shall not be deemed to be a health plan issuer offering an individual health plan solely because such health plan issuer offers a conversion policy.

(3) MARKETING OF PLANS.—Nothing in this section shall be construed to prevent a State from requiring health plan issuers offering coverage to individuals under an individual health plan to actively market such plan.

SEC. 111. GUARANTEED RENEWABILITY OF INDIVIDUAL HEALTH COVERAGE.

(a) IN GENERAL.—Subject to subsections (b) and (c), coverage for individuals under an individual health plan shall be renewed or continued in force by a health plan issuer at the option of the individual, except that the requirement of this subsection shall not apply in the case of—

(1) the nonpayment of premiums or contributions by the individual in accordance with the terms of the individual health plan or where the health plan issuer has not received timely premium payments;

(2) fraud or misrepresentation of material fact on the part of the individual; or

(3) the termination of the individual health plan in accordance with subsection (b).

(b) TERMINATION OF INDIVIDUAL HEALTH PLANS.—

(1) PARTICULAR TYPE OF INDIVIDUAL HEALTH PLAN NOT OFFERED.—In any case in which a health plan issuer decides to discontinue offering a particular type of individual health plan to individuals, an individual health plan may be discontinued by the health plan issuer only if—

(A) the health plan issuer provides notice to each individual covered under the plan of such discontinuation at least 90 days prior to the date of the expiration of the plan.

(B) the health plan issuer offers to each individual covered under the plan the option to purchase any other individual health plan currently being offered by the health plan issuer to individuals; and

(C) in exercising the option to discontinue the individual health plan and in offering one or more replacement plans, the health plan issuer acts uniformly without regard to the health status of particular individuals.

(21) DISCONTINUANCE OF ALL INDIVIDUAL HEALTH PLANS.—In any case in which a health plan issuer elects to discontinue all individual health plans in a State, an individual health plan may be discontinued by the health plan issuer only if—

(A) the health plan issuer provides notice to the applicable certifying authority (as defined in section 142(d)) and to each individual covered under the plan of such discontinuation at least 180 days prior to the date of the discontinuation of the plan; and

(B) all individual health plans issued or delivered for issuance in the State are discontinued and coverage under such plans is not renewed.

(3) PROHIBITION ON MARKET REENTRY.—In the case of a discontinuation under paragraph (2), the health plan issuer may not provide for the issuance of any individual health plan in the State involved during the 5-year period beginning on the date of the discontinuation of the last plan not so renewed.

(c) TREATMENT OF NETWORK PLANS.—

(1) GEOGRAPHIC LIMITATIONS.—A health plan issuer which offers a network plan (as defined in paragraph (2)) may deny continued participation under the plan to individuals who neither live, reside, nor work in an area in which the individual health plan is offered, but only if such denial is applied uniformly, without regard to health status of particular individuals.

(2) NETWORK PLAY.—As used in paragraph (1), the term ''network plan'' means an individual health plan that arranges for the financing and delivery of health care services to individuals covered under such health plan, in whole or in part, through arrangements with providers.

SEC. 112. STATE FLEXIBILITY IN INDIVIDUAL MARKET REFORMS.

(a) IN GENERAL.—With respect to any State law with respect to which the Governor of the State notifies the Secretary of Health and Human Services that such State law will achieve the goals of sections 110 and 111, and that is in effect on, or enacted after, the date of enactment of this Act (such as laws providing for guaranteed issue, open enrollment by one or more health plan issuers, high-risk pools, or mandatory conversion policies), such State law shall apply in lieu of the standards described in sections 110 and 111 unless the Secretary of Health and Human Services determines, after considering the criteria described in subsection (b)(1), in consultation with the Governor and Insurance Commissioner or chief insurance regulatory official of the State, that such State law does not achieve the goals of providing access to affordable health care coverage for those individuals described in sections 110 and 111.

(b) DETERMINATION.—

(1) IN GENERAL.—In making a determination under subsection (a), the Secretary of Health and Human Services shall only—

(A) evaluate whether the State law or program provides guaranteed access to affordable coverage to individuals described in sections 110 and 111;

(B) evaluate whether the State law or program provides coverage for preexisting conditions (as defined in section 103(e)) that were covered under the individuals' previous group health plan or employee health benefit plan for individuals described in sections 110 and 111.

(C) evaluate whether the State law or program provides individuals described in sections 110 and 111 with a choice of health plans or a health plan providing comprehensive coverage, and

(D) evaluate whether the application of the standards described in sections 110 and 111 will have an adverse impact on the number of individuals in such State having access to affordable coverage.

(2) NOTICE OF INTENT.—If, within 6 months after the date of enactment of this Act, the Governor of a State notifies the Secretary of Health and Human Services that the State intends to enact a law, or modify an existing law, described in subsection (a), the Secretary of Health and Human Services may not make a determination under such subsection until the expiration of the 12-month period beginning on the date on which such notification is made, or until January 1, 1998, whichever is later. With respect to a State that provides notice under this paragraph and that has a legislature that does not meet within the 12-month period beginning on the date of enactment of this Act, the Secretary shall not make a determination under subsection (a) prior to January 1, 1998.

(3) NOTICE TO STATE.—If the Secretary of Health and Human Services determines that a State law or program does not achieve the goals described in subsection (a), the Secretary of Health and Human Services shall provide the State with adequate notice and reasonable opportunity to modify such law or program to achieve such goals prior to making a final determination under subsection (a).

(c) ADOPTION OF NAIC MODEL.—If, not later than 9 months after the date of enactment of this Act—

(1) the National Association of Insurance Commissioners (hereafter referred to as the ''NAIC''), through a process which the Secretary of Health and Human Services determines has included consultation with representatives of the insurance industry and consumer groups, adopts a model standard or standards for reform of the individual health insurance market, and

(2) the Secretary of Health and Human Services determines, within 30 days of the adoption of such NAIC standard or standards, that such standards comply with the goals of sections 110 and 111:

a State that elects to adopt such model standards or substantially adopt such model standards shall be deemed to have met the requirements of sections 110 and 111 and shall be subject to a determination under subsection (a).

SEC. 113. DEFINITION.

(a) IN GENERAL.—As used this title, the term ''individual health plan'' means any contract, policy, certificate or other arrangement offered to individuals by a health plan issuer that provides or pays for health benefits (such as provider and hospital benefits) and that is not a group health plan under section 2(6).

(b) ARRANGEMENTS NOT INCLUDED.—Such term does not include the following, or any combination thereof:

(1) Coverage only for accident, or disability income insurance, or any combination thereof.

(2) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act).

(3) Coverage issued as a supplement to liability insurance.

(4) Liability insurance, including general liability insurance and automobile liability insurance.

(5) Workers' compensation or similar insurance.

(6) Automobile medical payment insurance.

(7) Coverage for a specified disease or illness.

(8) Hospital of fixed indemnity insurance.

(9) Short-term limited duration insurance.

(10) Credit-only, dental-only, or vision-only insurance.

(11) A health insurance policy providing benefits only for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

Subtitle C—COBRA Clarifications

SEC. 121. COBRA CLARIFICATIONS.

(a) PUBLIC HEALTH SERVICE ACT.—

(1) PERIOD OF COVERAGE.—Section 2202(2) of the Public Health Service Act (42 U.S.C. 300bb–2(2)) is amended—

(A) in subparagraph (A)—

(i) by transferring the sentence immediately preceding clause (iv) so as to appear immediately following such clause (iv); and

(ii) in the last sentence (as so transferred)—

(I) by inserting '', or a beneficiary-family member of the individual,'' after ''an individual''; and

(II) by striking ''at the time of a qualifying event described in section 2203(2)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this title'';

(B) in subparagraph (D)(i), by inserting before '', or'' the following: '', except that the exclusion or limitation contained in this clause shall not be considered to apply to a plan under which a preexisting condition or exclusion does not apply to an individual otherwise eligible for continuation coverage under this section because of the provision of the Health Insurance Reform Act of 1996'', and

(C) in subparagraph (E), by striking ''at the time of a qualifying event described in section 2203(2)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this title'',

(2) ELECTION.—Section 2205(1)(C) of the Public Health Service Act (42 U.S.C. 300bb–5(1)(C)) is amended—

(A) in clause (i), by striking ''or'' at the end thereof.

(B) in clause (ii), by striking the period and inserting '', or'', and

(C) by adding at the end thereof the following new clause:

''(iii) in the case of an individual described in the last sentence of section 2202(2)(A), or a beneficiary-family member of the individual, the date such individual is determined to have been disabled.''.

(3) NOTICES.—Section 2206(3) of the Public Health Service Act (42 U.S.C. 300bb–6(3)) is amended by striking ''at the time of a qualifying event described in section 2203(2)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this title''.

(4) BIRTH OR ADOPTION OF A CHILD.—Section 2208(3)(A) of the Public Health Service Act (42 U.S.C. 300bb–8(3)(A)) is amended by adding at the end thereof the following new flush sentence:

''Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continued coverage under this title.''.

(b) EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(1) PERIOD OF COVERAGE.—Section 602(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1162(2)) is amended—

(A) in the last sentence of subparagraph (A)—

(i) by inserting '', or a beneficiary-family member of the individual.'' after ''an individual''; and

(ii) by striking ''at the time of a qualifying event described in section 603(2)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this part'',

(B) in subparagraph (D)(i), by inserting before, '', or'' the following '', except that the exclusion or limitation contained in this clause shall not be considered to apply to a plan under which a preexisting condition or exclusion does not apply to an individual otherwise eligible for continuation coverage under this section because of the provision of the Health Insurance Reform Act of 1996''; and

(C) in subparagraph (E), by striking ''at the time of a qualifying event described in section 603(2)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this part''.

(2) ELECTION.—Section 605(1)(C) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1165(1)(C)) is amended—

(A) in clause (i), by striking ''or'' at the end thereof;

(B) in clause (ii), by striking the period and inserting '', or''; and

(C) by adding at the end thereof the following new clause:

''(iii) in the case of an individual described in the last sentence of section 602(2)(A), or a beneficiary-family member of the individual, the date such individual is determined to have been disabled.''.

(3) NOTICES.—Section 606(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1166(3)) is amended by striking ''at the time of a qualifying event described in section 603(2)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this part''.

(4) BIRTH OR ADOPTION OF A CHILD.—Section 607(3)(A) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1167(3)) is amended by adding at the end thereof the following new flush sentence:

''Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continued coverage under this part.''.

(c) INTERNAL REVENUE CODE OF 1986.—

(1) PERIOD OF COVERAGE.—Section 4980B(f)(2)(B) of the Internal Revenue Code of 1986 is amended—

(A) in the last sentence of clause (i) by striking ''at the time of a qualifying event described in paragraph (3)(B)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this section''.

(B) in clause (iv)(I), by inserting before '', or'' the following: '', except that the exclusion or limitation contained in this subclause shall not be considered to apply to a plan under which a preexisting condition or exclusion does not apply to an individual otherwise eligible for continuation coverage under this subsection because of the provision of the Health Insurance Reform Act of 1996''; and

(C) in clause (v), by striking ''at the time of a qualifying event described in paragraph (3)(B)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this section''.

(2) ELECTION.—Section 4980B(f)(5)(A)(ii) of the Internal Revenue Code of 1986 is amended—

(A) in subclause (I), by striking ''or'' at the end thereof;

(B) in subclause (II), by striking the period and inserting '', or'', and

(C) by adding at the end thereof the following new subclause:

''(III) in the case of an qualified beneficiary described in the last sentence of paragraph (2)(B)(i), the date such individual is determined to have been disabled.''.

(3) NOTICES.—Section 4980B(f)(6)(C) of the Internal Revenue Code of 1986 is amended by striking ''at the time of a qualifying event described in paragraph (3)(B)'' and inserting ''at any time during the initial 18-month period of continuing coverage under this section''.

(4) BIRTH OR ADOPTION OF A CHILD.—Section 4980B(g)(1)(A) of the Internal Revenue Code of 1986 is amended by adding at the end thereof the following new flush sentence:

''Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continued coverage under this section.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to qualifying events occurring on or after the date of enactment of this Act for plan years beginning after December 31, 1997.

(e) NOTIFICATION OF CHANGES.—Not later than 60 days prior to the date on which this section becomes effective, each group health plan (covered under title XXII of the Public Health Service Act, part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, and section 4980B(f) of the Internal Revenue Code of 1986) shall notify each qualified beneficiary who has elected continuation coverage under such title, part or section of the amendments made by this section.

Subtitle D—Private Health Plan Purchasing Cooperatives

SEC. 131. PRIVATE HEALTH PLAN PURCHASING COOPERATIVES.

(a) DEFINITION.—As used in this title, the term ''health plan purchasing cooperative'' means a group of individuals or employers that, on a voluntary basis and in accordance with this section, form a cooperative for the purpose of purchasing individual health plans or group health plans offered by health plan issuers. A health plan issuer, agent, broker or any other individual or entity engaged in the sale of insurance may not underwrite a cooperative.

(b) CERTIFICATION.—

(1) IN GENERAL.—If a group described in subsection (a) desires to form a health plan purchasing cooperative in accordance with this section and such group appropriately notifies the State and the Secretary of such desire, the State, upon a determination that such group meets the requirements of this section, shall certify the group as a health plan purchasing cooperative. The State shall make a determination of whether such group meets the requirements of this section in a timely fashion. Each such cooperative shall also be registered with the Secretary.

(2) STATE REFUSAL TO CERTIFY.—If a State fails to implement a program for certifying health plan purchasing cooperatives in accordance with the standards under this title, the Secretary shall certify and oversee the operations of such cooperative in such State.

(3) INTERSTATE COOPERATIVES.—For purposes of this section a health plan purchasing cooperative operating in more than one State shall be certified by the State in which the cooperative is domiciled. States may enter into cooperative agreements for the purpose of certifying and overseeing the operation of such cooperatives. For purposes of this subsection, a cooperative shall be considered to be domiciled in the State in which most of the members of the cooperative reside.

(c) BOARD OF DIRECTORS.—

(1) IN GENERAL.—Each health plan purchasing cooperative shall be governed by a Board of Directors that shall be responsible for ensuring the performance of the duties of the cooperative under this section. The Board shall be composed of a board cross-section of representatives of employers, employees, and individuals participating in the cooperative. A health plan issuer, agent, broker or any other individual or entity engaged in the sale of individual health plans or group health plans may not hold or control any right to vote with respect to a cooperative.

(2) LIMITATION ON COMPENSATION.—A health plan purchasing cooperative may not provide compensation to members of the Board of Directors. The cooperative may provide reimbursements to such members for the reasonable and necessary expenses incurred by the members in the performance of their duties as members of the Board.

(3) CONFLICT OF INTEREST.—No member of the Board of Directors (or family members of such members) nor any management personnel of the cooperative may be employed by, be a consultant of, be a member of the board of directors or, be affiliated with an agent of, or otherwise be a representative of any health plan issuer, health care provider, or agent or broker. Nothing in the preceding sentence shall limit a member of the Board from purchasing coverage offered through the cooperative.

(d) MEMBERSHIP AND MARKETING AREA.—

(1) MEMBERSHIP.—A health plan purchasing cooperative may establish limits on the maximum size of employers who may become members of the cooperative, and may determine whether to permit individuals to become members. Upon the establishment of such membership requirements, the cooperative shall, except as provided in subparagraph (B), accept all employers (or individuals) residing within the area served by the cooperative who meet such requirements as members on a first-come, first-served basis, or on another basis established by the State to ensure equitable access to the cooperative.

(2) MARKETING AREA.—A State may establish rules regarding the geographic area that must be served by a health plan purchasing cooperative. With respect to a State that has not established such rules, a health plan purchasing cooperative operating in the State shall define the boundaries of the area to be served by the cooperative, except that such boundaries may not be established on the basis of health status of the populations that reside in the area.

(e) DUTIES AND RESPONSIBILITIES.—

(1) IN GENERAL.—A health plan purchasing cooperative shall—

(A) enter into agreements with multiple, unaffiliated health plan issuers, except that the requirement of this subparagraph shall not apply in regions (such as remote or frontier areas) in which compliance with such requirement is not possible.

(B) enter into agreements with employers and individuals who become members of the cooperative;

(C) participate in any program of risk-adjustment or reinsurance, or any similar program, that is established by the State.

(D) prepare and disseminate comparative health plan materials (including information about cost, quality, benefits, and other information concerning group health plans and individual health plans offered through the cooperative);

(E) actively market to all eligible employers and individuals residing within the service area; and

(F) act as an ombudsman for group health plan or individual health plan enrollees.

(2) PERMISSIBLE ACTIVITIES.—A health plan purchasing cooperative may perform such other functions as necessary to further the purposes of this title, including—

(A) collecting and distributing premiums and performing other administrative functions;

(B) collecting and analyzing surveys of enrollee satisfaction;

(C) charging membership fee to enrollees (such fees may not be based on health status) and charging participation fees to health plan issuers;

(D) cooperating with (or accepting as members) employers who provide health benefits directly to participants and beneficiaries only for the purpose of negotiating with providers, and

(E) negotiating with health care providers and health plan issuers.

(f) LIMITATIONS ON COOPERATIVE ACTIVITIES.—A health plan purchasing cooperative shall not—

(1) perform any activity relating to the licensing of health plan issuers.

(2) assume financial risk directly or indirectly on behalf of members of a health plan purchasing cooperative relating to any group health plan or individual health plan;

(3) establish eligibility, continuation of eligibility, enrollment, or premium contribution requirements for participants, beneficiaries, or individuals based on health status;

(4) operate on a for-profit or other basis where the legal structure of the cooperative permits profits to be made and not returned to the members of the cooperative, except that a for-profit health plan purchasing cooperative may be formed by a nonprofit organization—

(A) in which membership in such organization is not based on health status; and

(B) that accepts as members all employers or individuals on a first-come, first-served basis, subject to any established limit on the maximum size of and employer that may become a member; or

(5) perform any other activities that conflict or are inconsistent with the performance of its duties under this title.

(g) LIMITED PREEMPTIONS OF CERTAIN STATE LAWS.—

(1) IN GENERAL.—With respect to a health plan purchasing cooperative that meets the requirements of this section, State fictitious group laws shall be preempted.

(2) HEALTH PLAN ISSUERS.—

(A) RATING.—With respect to a health plan issuer offering a group health plan or individual health plan through a health plan purchasing cooperative that meets the requirements of this section. State premium rating requirement laws, except to the extent provided under subparagraph (B), shall be preempted unless such laws permit premium rates negotiated by the cooperative to be less than rates that would otherwise be permitted under State law, if such rating differential is not based on differences in health status or demographic factors.

(B) EXCEPTION.—State laws referred to in subparagraph (A) shall not be preempted if such laws—

(i) prohibit the variance of premium rates among employers, plan sponsors, or individuals that are members of health plan purchasing cooperative in excess of the amount of such variations that would be permitted under such State rating laws among employers, plan sponsors, and individuals that are not members of the cooperative; and

(ii) prohibit a percentage increase in premium rates for a new rating period that is in excess of that which would be permitted under State rating laws.

(C) BENEFITS.—Except as provided in subparagraph (D), a health plan issuer offering a group health plan or individual health plan through a health plan purchasing cooperative shall comply with all State mandated benefit laws that require the offering of any services, category or care, or services of any class or type of provider.

(D) EXCEPTION.—In those states that have enacted laws authorizing the issuance of alternative benefit plans to small employers, health plan issuers may offer such alternative benefit plans through a health plan purchasing cooperative that meets the requirements of this section.

(h) RULES OF CONSTRUCTION.—Nothing in this section shall be construed to—

(1) require that a State organize, operate, or otherwise create health plan purchasing cooperatives;

(2) otherwise require the establishment of health plan purchasing cooperatives.

(3) require individuals, plan sponsors, or employers to purchase group health plans or individual health plans through a health plan purchasing cooperative;

(4) require that a health plan purchasing cooperative be the only type of purchasing arrangement permitted to operate in a State.

(5) confer authority upon a State that the State would not otherwise have to regulate health plan issuers or employee health benefits plans, or

(6) confer authority up a State (or the Federal Government) that the State (or Federal Government) would not otherwise have to regulate group purchasing arrangements, coalitions, or other similar entities that do not desire to become a health plan purchasing cooperative in accordance with this section.

(i) APPLICATION OF ERISA.—For purposes of enforcement only, the requirements of parts 4 and 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1101) shall apply to a health pan purchasing cooperative as if such plan were an employee welfare benefit plan.

SUBTITLE E—APPLICATION AND ENFORCEMENT OF STANDARDS

SEC. 141. APPLICABILITY.

(a) CONSTRUCTION.—

(1) ENFORCEMENT.—

(A) IN GENERAL.—A requirement or standard imposed under this title on a group health plan or individual health plan offered by a health plan issuer shall be deemed to be a requirement or standard imposed on the health plan issuer. Such requirements or standards shall be enforced by the State insurance commissioner for the State involved or the official or officials designated by the State to enforce the requirements of this title. In the case of a group health plan offered by a health plan issuer in connection with an employee health benefit plan, the requirements of standards imposed under the title shall be enforced with respect to the health plan issuer by the State insurance commissioner for the State involved or the official of officials designated by the State to enforce the requirements of this title.

(B) LIMITATION.—Except as provided in subsection (c), the Secretary shall not enforce the requirements or standards of this title as they relate to health plan issuers, group health plans, or individual health plans. In no case shall a Sate enforce the requirements or standards of this title as they relate to employee health benefit plans.

(2) PREEMPTION OF STATE LAW.—Nothing in this title shall be construed to prevent a State from establishing, implementing, or continuing in effect standards and requirements—

(A) not prescribed in this title; or

(B) related to the issuance, renewal, or portability of health insurance or the establishment or operation of group purchasing arrangements, that are consistent with, and are not in direct conflict with, this title and provide greater protection or benefit to participants, beneficiaries or individuals.

(b) RULE OF CONSTRUCTION.—Nothing in this title shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144).

(c) CONTINUATION.—Nothing in this title shall be construed as requiring a group health plan or an employee health benefit plan to provide benefits to a particular participant or beneficiary in excess of those provided under the terms of such plan.

SEC. 202. ENFORCEMENT OF STANDARDS.

(a) HEALTH PLAN ISSUERS.—Each State shall require that each group health plan and individual health plan issued, sold, renewed, offered for sale or operated in such State by a health plan issuer meet the standards established under this title pursuant to an enforcement plan filed by the State with the Secretary. A State shall submit such information as required by the Secretary demonstrating effective implementation of the State enforcement law.

(b) EMPLOYEE HEALTH BENEFIT PLANS.—With respect to employee health benefit plans, the Secretary shall enforce the reform standards established under this title in the same manner as provided for under sections 502, 504, 506, and 510 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132, 1134, 1136, and 1140). The civil penalties contained in paragraphs (1) and (2) of section 502(c) of such Act (29 U.S.C. 1132(c) (1) and (2)) shall apply to any information required by the Secretary to be disclosed and reported under this section.

(c) FAILURE TO IMPLEMENT PLAN.—In the case of the failure of a State to substantially enforce the standards and requirements set forth in this title with respect to group health plans and individual health plans as provided for under the State enforcement plan filed under subsection (a), the Secretary, in consultation with the Secretary of Health and Human Services, shall implement an enforcement plan meeting the standards of this title in such State. In the case of a State that fails to substantially enforce the standards and requirements set forth in this title, each health plan issuer operating in such State shall be subject to civil enforcement as provided for under sections 502, 504, 506, and 510 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132, 1134, 1136, and 1140). The civil penalties contained in paragraphs (1) and (2) of section 502(c) of such Act (29 U.S.C. 1132(c) (1) and (2)) shall apply to any information required by the Secretary to be disclosed and reported under this section.

(d) APPLICABLE CERTIFYING AUTHORITY.—As used in this title, the term ''applicable certifying authority''means, with respect to—

(1) health plan issuers, the State insurance commissioner or official or officials designated by the State to enforce the requirements of this title for the State involved; and

(2) an employee health benefit, plan, the Secretary.

(e) REGULATIONS.—The Secretary may promulgate such regulations as may be necessary or appropriate to carry out this title.

(f) TECHNICAL AMENDMENT.—Section 508 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1138) is amended by inserting ''and under the Health Insurance Reform Act of 1996'' before the period.

Subtitle F—Miscellaneous Provisions

SEC. 191. HEALTH COVERAGE AVAILABILITY STUDY.

(a) IN GENERAL.—The Secretary of Health and Human Services, in consultation with the Secretary, representatives of State officials, consumers, and other representatives of individuals and entities that have expertise in health insurance and employee benefits, shall conclude a two-part study, and prepare and submit reports, in accordance with this section.

(b) EVALUATION OF AVAILABILITY.—Not later than January 1, 1998, the Secretary of

Health and Human Services shall prepare and submit to the appropriate committees of Congress a report, concerning—

(1) an evaluation, based on the experience of States, expert opinions, and such additional data as may be available, of the various mechanisms used to ensure the availability of reasonably priced health coverage to employers purchasing group coverage and to individuals purchasing coverage on a nongroup basis; and

(2) whether standards that limit the variation in premiums will further the purposes of this Act.

(c) EVALUATION OF EFFECTIVENESS.—Not later than January 1, 1999, the Secretary of Health and Human Services shall prepare and submit to the appropriate committees of Congress a report, concerning the effectiveness of the provisions of this Act and the various State laws, in ensuring the availability of reasonably priced health coverage to employers purchasing group coverage and individuals purchasing coverage on a nongroup basis.

SEC. 192. EFFECTIVE DATE.

Except as otherwise provided for in this title, the provisions of this title shall apply as follows:

(1) With respect to group health plans and individual health plans, such provisions shall apply to plans offered, sold, issued, renewed, in effect, or operated on or after January 1, 1997, and

(2) With respect to employee health benefit plans, on the first day of the first plan year beginning on or after January 1, 1997.

SEC. 193. SEVERABILITY.

If any provision of this title or the application of such provision to any person or circumstance is held to be unconstitutional, the remainder of this title and the application of the provisions of such to any person or circumstance shall not be affected thereby.

Mr. ARCHER (during the reading). Mr. Speaker, I ask unanimous consent that the motion to recommit be considered as read and printed in the RECORD.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

Mr. PALLONE. Mr. Speaker, I have offered this motion to recommit with instructions with my colleague from Missouri [Ms. MCCARTHY] because I am concerned that we are about to go down a perilous path of ending any chances of health insurance reform. Our motion to recommit incorporates the Kennedy-Kassebaum-Roukema provisions without any additons. It would make it easier for workers who lose or change jobs to buy health coverage. It would limit the length of time that insurers could refuse to cover an applicant's preexisting medical problems.

Mr. Speaker, there are two distinct choices that we can make with this next vote. This House can make the decision to support this motion and do the right thing for the American people, or the House can vote against this motion and tell the American people that it is more important to keep promises with various special interests.

The Kennedy-Kassebaum-Roukema bill is crafted to keep premiums affordable, because it would not impact the insurance risk pool by encouraging healthy individuals to drop their coverage. It has bipartisan support in both the Senate and the House of Representatives. The President has indicated that he will support the Roukema bill. The motion to recommit will ensure that this legislation is enacted into law.

Mr. Speaker, why does the Republican leadership insist on messing up this legislation with controversial poison pill amendments? One of the provisions that the Republican leadership insists on including is the medical savings accounts, which will favor the wealthy and healthy. MSA's will be just another tax shelter for the rich. Americans who do not choose to join the MSA's because of the high risks involved will see their health insurance premiums increase. The MSA's, among other extraneous provisions, will guarantee the failure of any health insurance reform in this Congress. We all know this, Mr. Speaker. The gentlewoman from New Jersey [Mrs. ROUKEMA], who courageously took this floor tonight, has said as much. So has her counterpart in the other body, Senator KASSEBAUM. These women should not be vilified tonight. Instead, they should be thanked for doing the right thing for the American people.

Mr. Speaker, let us all do the right thing tonight. I urge a ''yes'' vote on the motion to recommit if Members want health insurance reform this year.

Mr. Speaker, I yield to the gentlewoman from Missouri [Ms. MCCARTHY].

Ms. MCCARTHY. Mr. Speaker, I join with the gentleman from New Jersey in moving to recommit this bill to committee with instruction to report the Roukema bill, H.R. 2893, for final passage. Kennedy-Kassebaum-Roukema has supported from the White House, from the American public, from the health care industry, and bipartisan support in the Senate. It is legislation which can be signed into law tonight.

To recommit puts sound public policy above special interests. To recommit assures American families of security by providing genuine health care reform. In a Congress that touts fiscal responsibility, to vote against this motion is fiscally irresponsible. I urge my colleagues to vote ''yes'' on this motion, to stand for true reform, to stand against special interests, to stand for the American people. Vote ''yes'' to recommit.

Mr. ARCHER. Mr. Speaker, I rise in opposition to the motion to recommit.

I yield to the gentleman from California [Mr. THOMAS], chairman of the Subcommittee on Health of the Committee on Ways and Means.

Mr. THOMAS. Mr. Speaker, I really do not know who to direct my remarks to, because apparently this motion to recommit is Dingell minus the increase for the self-employed. Two of our colleagues on the other side, the gentleman from North Dakota and the gentleman from Illinois [Mr. DURBIN], took the well and talked about how much better the Democrat substitute was because it did better for the self-employed. Now what we have here is Dingell lite.

Mr. Speaker, is it not interesting and, by the way how, cynical they were more for the self-employed if it was honey to attract people to the Democratic substitute, and so I guess I am addressing my remarks to the 10 Republicans who went for the improvement of Kassebaum because of the self-employed provision. That is out. It lasted 5 minutes. Show your commitment, it did not draw enough, so it is gone. It is not there because they believe in the self-employed and want to increase the deductibility, it was there to attract people. Since it did not get anybody, they pulled it out.

If you did not like Dingell, they will not like Dingell lite. Vote ''no'' on the motion to recommit.

Mr. ARCHER. Mr. Speaker, as I listen to this debate, I must say that I am puzzled by the reluctance of some Democrats to support a bill that will provide millions of Americans with increased access to health care insurance at a more affordable price. What a strange turnaround from 2 years ago when my friends across the aisle stood up and fought for a big government takeover of our nation's health care system. Here is a description of that plan that they offered and that they supported 2 years ago.

But tonight, they claim ours is too far-reaching, it should be shaved back. The same people who presented this to us in 1994. It is broken, they said. Health care is in crisis. We must fix it. The President and Hillary Clinton know just how to get that done. Well, the big government Democrat prescription for our Nation's health care ills was rejected by the American people and properly so.

Mr. Speaker, America has the best health care system in the world, no thanks to government, but thanks to our Nation's great private sector. The answer does not lie in a big-government takeover of health care. Rather, the way to provide the American people with health care that is more available and affordable is through a targeted measure that relies on the strength of the private sector, not the government, and that is what this bill does.

It is a strong bill, a solid bill, a bill that will bring help to millions of needy Americans, and it does it by relying on the private sector, not the Government. It is exactly the right dose of medicine to cure our health care ills. So why do some, thankfully not all, but some Democrats oppose it?

Mr. Speaker, I conclude the reason the Democrat leadership opposes this bill is because their big-government version of health care reform failed and they do not want to see the Republicans move forward with one that will succeed. They know that the American people support each and every one of the targeted reforms that we have proposed, but the Democrat leadership and their trial lawyer friends have rejected

a bipartisan approach to health care reform and instead offer only obstruction and opposition.

The Democrat opposition stems from sour grapes and special interests. Mr. Speaker, sour grapes and special interests. The bill we have today before us is a landmark. It is a bill that brings me great pride and satisfaction, and this is a very proud day for the House and for the Nation. Health care reform is moving forward, and I predict it will be signed into law. We look forward to working with the President and the Senate on this bill. It will be our only chance to improve America's health care system. We must be careful not to let it slip away, without making as many changes as we can reasonably on behalf of the American people.

Too much medicine is bad for the patient, but too little will not help the patient get better. This bill is the right does of medicine. Vote ''no'' on the motion to recommit and ''aye'' on the bill.

The SPEAKER pro tempore. Without objection, the previous question is ordered on the motion to recommit.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to recommit.

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

RECORDED VOTE

Mr. PALLONE. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. Pursuant to the provisions of clause 5 of rule XV, the Chair announces that he will reduce to a minimum of 5 minutes the period of time within which a vote by electronic device will be taken on the question of final passage.

The vote was taken by electronic device, and there were—ayes 182, noes 236, not voting 13, as follows:

[Roll No. 105]

AYES—182

Abercrombie
Ackerman
Andrews
Baesler
Baldacci
Barcia
Barrett (WI)
Becerra
Beilenson
Bentsen
Berman
Bevill
Bishop
Bonior
Borski
Boucher
Browder
Brown (CA)
Brown (FL)
Brown (OH)
Cardin
Chapman
Clay
Clayton
Clement
Clyburn
Coleman
Collins (MI)
Condit
Conyers
Costello
Coyne
Cramer
Danner
de la Garza
DeFazio
DeLauro
Dellums
Deutsch
Dicks
Dingell
Dixon
Doggett
Dooley
Doyle
Durbin
Edwards
Engel
Evans
Farr
Fattah
Fazio
Filner
Flake
Foglietta
Ford
Frank (MA)
Frost
Furse
Gejdenson
Gephardt
Gibbons
Gonzalez
Green
Gutierrez
Hall (OH)
Hamilton
Harman
Hastings (FL)
Hefner
Hilliard
Hinchey
Holden
Hoyer
Jackson (IL)
Jackson-Lee (TX)
Jacobs
Jefferson
Johnson (SD)
Johnson, E. B.
Johnston
Kanjorski
Kaptur
Kennedy (MA)
Kennedy (RI)
Kennelly
Kildee
Kleczka
Klink
LaFalce
Lantos
Levin
Lewis (GA)
Lincoln
Lipinski
Lofgren
Lowey
Luther
Maloney
Manton
Markey
Mascara
Matsui
McCarthy
McDermott
McHale
McKinney
Meehan
Meek
Menendez
Miller (CA)
Minge
Mink
Moakley
Mollohan
Moran
Murtha
Nadler
Oberstar
Obey
Olver
Ortiz
Orton
Owens
Pallone
Pastor
Payne (NJ)
Payne (VA)
Pelosi
Peterson (FL)
Peterson (MN)
Pomeroy
Quinn
Rahall
Rangel
Reed
Richardson
Rivers
Roemer
Rose
Roukema
Roybal-Allard
Rush
Sabo
Sanders
Sawyer
Schroeder
Schumer
Scott
Serrano
Sisisky
Skaggs
Skelton
Slaughter
Spratt
Stark
Stenholm
Studds
Stupak
Tanner
Tejeda
Thompson
Thornton
Thurman
Torres
Torricelli
Towns
Traficant
Velazquez
Vento
Visclosky
Volkmer
Walsh
Ward
Waters
Watt (NC)
Waxman
Wilson
Wise
Woolsey
Wynn
Yates

NOES—236

Allard
Archer
Armey
Bachus
Baker (CA)
Baker (LA)
Ballenger
Barr
Barrett (NE)
Bartlett
Barton
Bass
Bateman
Bereuter
Bilbray
Bilirakis
Bliley
Blute
Boehlert
Boehner
Bonilla
Bono
Brewster
Brownback
Bryant (TN)
Bunn
Bunning
Burr
Burton
Buyer
Callahan
Calvert
Camp
Campbell
Canady
Castle
Chabot
Chambliss
Chenoweth
Christensen
Chrysler
Clinger
Coble
Coburn
Collins (GA)
Combest
Cooley
Cox
Crane
Crapo
Cremeans
Cubin
Cunningham
Davis
Deal
DeLay
Diaz-Balart
Dickey
Doolittle
Dornan
Dreier
Duncan
Dunn
Ehlers
Ehrlich
Emerson
English
Ensign
Everett
Ewing
Fawell
Fields (TX)
Flanagan
Foley
Forbes
Fox
Franks (CT)
Franks (NJ)
Frelinghuysen
Frisa
Funderburk
Gallegly
Ganske
Gekas
Geren
Gilchrest
Gillmor
Gilman
Goodlatte
Goodling
Gordon
Goss
Graham
Greenwood
Gunderson
Gutknecht
Hall (TX)
Hancock
Hansen
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Heineman
Herger
Hilleary
Hobson
Hoekstra
Hoke
Horn
Hostettler
Houghton
Hunter
Hutchinson
Hyde
Inglis
Istook
Johnson (CT)
Johnson, Sam
Jones
Kasich
Kelly
Kim
King
Kingston
Klug
Knollenberg
Kolbe
LaHood
Largent
Latham
LaTourette
Laughlin
Lazio
Leach
Lewis (CA)
Lewis (KY)
Lightfoot
Linder
Livingston
LoBiondo
Longley
Lucas
Manzullo
Martini
McCollum
McCrery
McDade
McHugh
McInnis
McIntosh
McKeon
Metcalf
Meyers
Mica
Miller (FL)
Molinari
Montgomery
Moorhead
Morella
Myers
Myrick
Nethercutt
Neumann
Ney
Norwood
Nussle
Oxley
Packard
Parker
Paxon
Petri
Pickett
Pombo
Porter
Portman
Poshard
Pryce
Quillen
Radanovich
Ramstad
Regula
Riggs
Roberts
Rogers
Rohrabacher
Roth
Royce
Salmon
Sanford
Saxton
Scarborough
Schaefer
Schiff
Seastrand
Sensenbrenner
Shadegg
Shaw
Shays
Shuster
Skeen
Smith (MI)
Smith (NJ)
Solomon
Souder
Spence
Stearns
Stockman
Stump
Talent
Tate
Tauzin
Taylor (MS)
Taylor (NC)
Thomas
Thornberry
Tiahrt
Torkildsen
Upton
Vucanovich
Waldholtz
Walker
Wamp
Watts (OK)
Weldon (FL)
Weller
White
Whitfield
Wicker
Williams
Wolf
Young (AK)
Young (FL)
Zeliff
Zimmer

NOT VOTING—13

Bryant (TX)
Collins (IL)
Eshoo
Fields (LA)
Fowler
Martinez
McNulty
Neal
Ros-Lehtinen
Smith (TX)
Smith (WA)
Stokes
Weldon (PA)

☐ 2257

So the motion to recommit was rejected.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore (Mr. COMBEST). The question is on the passage of the bill.

Pursuant to House Resolution 392, the yeas and nays are ordered.

The yeas and nays were ordered.

The SPEAKER pro tempore. This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 267, nays 151, not voting 14, as follows:

[Roll No. 106]

YEAS—267

Allard
Archer
Armey
Bachus
Baesler
Baker (CA)
Baker (LA)
Ballenger
Barcia
Barr
Barrett (NE)
Bartlett
Barton
Bass
Bateman
Bereuter
Bilbray
Bilirakis
Bliley
Blute
Boehlert
Boehner
Bonilla
Bono
Brewster
Browder
Brownback
Bryant (TN)
Bunn
Bunning
Burr
Burton
Buyer
Callahan
Calvert
Camp
Campbell
Canady
Castle
Chabot
Chambliss
Chenoweth
Christensen
Chrysler
Clement
Clinger
Coble
Coburn
Collins (GA)
Combest
Condit
Cooley
Cox
Cramer
Crane
Crapo
Cremeans
Cubin
Cunningham
Danner
Davis
de la Garza
Deal
DeLay
Diaz-Balart
Dickey
Dooley
Doolittle
Dreier
Duncan
Dunn
Ehlers
Ehrlich
Emerson
English
Ensign
Everett
Ewing
Fawell
Fields (TX)
Flanagan
Foley
Forbes
Fox
Franks (CT)
Franks (NJ)
Frelinghuysen
Frisa
Funderburk
Gallegly
Ganske
Gekas
Geren
Gilchrest
Gillmor
Gilman
Gingrich
Goodlatte
Goodling
Gordon
Goss
Graham
Greenwood
Gunderson
Gutknecht
Hall (OH)
Hall (TX)
Hamilton
Hancock
Hansen
Harman
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Hefner
Heineman
Herger
Hilleary
Hobson
Hoekstra
Hoke
Holden
Horn
Hostettler
Houghton
Hunter
Hutchinson
Hyde
Inglis
Istook
Jacobs
Johnson (CT)
Johnson, Sam
Jones
Kasich
Kelly
Kim
King
Kingston
Klug
Knollenberg
Kolbe
LaHood
Largent
Latham
LaTourette
Laughlin
Lazio
Leach
Lewis (CA)
Lewis (KY)
Lightfoot
Lincoln
Linder
Livingston
LoBiondo
Longley
Lucas
Manzullo
Martini
McCollum
McCrery
McDade
McHale
McHugh
McInnis
McIntosh
McKeon
Metcalf
Meyers
Mica
Miller (FL)

Minge
Molinari
Montgomery
Moorhead
Moran
Morella
Myers
Myrick
Nethercutt
Neumann
Ney
Norwood
Nussle
Orton
Oxley
Packard
Parker
Pastor
Paxon
Payne (VA)
Peterson (MN)
Petri
Pickett
Pombo
Porter
Portman
Poshard
Pryce
Quillen
Quinn
Radanovich
Ramstad
Regula
Riggs
Roberts
Rogers
Rohrabacher
Rose
Roth
Royce
Salmon
Sanford
Saxton
Scarborough
Schaefer
Schiff
Seastrand
Sensenbrenner
Shadegg
Shaw
Shays
Shuster
Sisisky
Skeen
Smith (MI)
Smith (NJ)
Solomon
Souder
Spence
Stearns
Stenholm
Stockman
Studds
Stump
Talent
Tanner
Tate
Tauzin
Taylor (MS)
Taylor (NC)
Thomas
Thornberry
Thornton
Tiahrt
Torkildsen
Traficant
Upton
Vucanovich
Waldholtz
Walker
Walsh
Wamp
Watts (OK)
Weldon (FL)
Weller
White
Whitfield
Wicker
Wolf
Young (AK)
Young (FL)
Zeliff
Zimmer

NAYS—151

Abercrombie
Ackerman
Andrews
Baldacci
Barrett (WI)
Becerra
Beilenson
Bentsen
Berman
Bevill
Bishop
Bonior
Borski
Boucher
Brown (CA)
Brown (FL)
Brown (OH)
Cardin
Chapman
Clay
Clayton
Clyburn
Coleman
Collins (MI)
Conyers
Costello
Coyne
DeFazio
DeLauro
Dellums
Deutsch
Dicks
Dingell
Dixon
Doggett
Doyle
Durbin
Edwards
Engel
Evans
Farr
Fattah
Fazio
Filner
Flake
Foglietta
Ford
Frank (MA)
Frost
Furse
Gejdenson
Gephardt
Gibbons
Gonzalez
Green
Gutierrez
Hastings (FL)
Hilliard
Hinchey
Hoyer
Jackson (IL)
Jackson-Lee (TX)
Jefferson
Johnson (SD)
Johnson, E. B.
Johnston
Kanjorski
Kaptur
Kennedy (MA)
Kennedy (RI)
Kennelly
Kildee
Kleczka
Klink
LaFalce
Lantos
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Luther
Maloney
Manton
Markey
Martinez
Mascara
Matsui
McCarthy
McDermott
McKinney
Meehan
Meek
Menendez
Miller (CA)
Mink
Moakley
Mollohan
Murtha
Nadler
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Payne (NJ)
Pelosi
Peterson (FL)
Pomeroy
Rahall
Rangel
Reed
Richardson
Rivers
Roemer
Roukema
Roybal-Allard
Rush
Sabo
Sanders
Sawyer
Schroeder
Schumer
Scott
Serrano
Skaggs
Slaughter
Spratt
Stark
Stupak
Tejeda
Thompson
Thurman
Torres
Torricelli
Towns
Velazquez
Vento
Visclosky
Volkmer
Ward
Waters
Watt (NC)
Waxman
Williams
Wilson
Wise
Woolsey
Wynn
Yates

NOT VOTING—14

Bryant (TX)
Collins (IL)
Dornan
Eshoo
Fields (LA)
Fowler
McNulty
Neal
Ros-Lehtinen
Skelton
Smith (TX)
Smith (WA)
Stokes
Weldon (PA)

□ 2305

Mr. KENNEDY of Massachusetts and Mr. FOGLIETTA changed their vote from ''yea'' to ''nay.''

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

PERSONAL EXPLANATION

Mr. Speaker, on rollcall No. 106, Passage of the Health Coverage Availability and Affordability Act, I was just outside the main door discussing a compromise with appropriators. Unfortunately, I missed the vote. Had I been present, I would have voted ''yea.''

RESIGNATION AS CONFEREE AND APPOINTMENT OF REPLACEMENT CONFEREE ON H.R. 3019, BALANCED BUDGET DOWNPAYMENT ACT, II

The SPEAKER pro tempore laid before the House the following resignation as a conferee:

HOUSE OF REPRESENTATIVES,
Washington, DC, March 28, 1996.

Hon. NEWT GINGRICH,
Speaker, U.S. House of Representatives, H232, The Capitol, Washington, DC.

DEAR MR. SPEAKER: Effective immediately, I hereby resign from the conference of H.R. 3019, the Omnibus Appropriations Act for Fiscal Year 1996, Conference Report.

Sincerely,

LOUIS STOKES,
Member of Congress.

The SPEAKER pro tempore. Without objection, the resignation is accepted and without objection, the Chair appoints the gentleman from Maryland [Mr. HOYER] to fill the resulting vacancy among the primary panel of conferees.

There was no objection.

The SPEAKER pro tempore. The clerk will notify the Senate of the change in conferees.

PARLIAMENTARY INQUIRIES

Mr. FAZIO of California. Mr. Speaker, I have a parliamentary inquiry. I have a question about the rule that is about to be brought before us on the farm bill.

The SPEAKER pro tempore. The gentleman will state his parliamentary inquiry.

Mr. FAZIO of California. Mr. Speaker, I would ask, is there a waiver in this rule of the unfunded mandate provision?

The SPEAKER pro tempore. When the rule is read, the gentleman will under stand it. There is a waiver of all points of order in the resolution.

Mr. FAZIO of California. Among all those points of order that were waived, is one of them the unfunded mandate provision, Mr. Speaker?

Mr. SPEAKER pro tempore. The gentleman will understand when the resolution is read.

Mr. FAZIO of California. Further parliamentary inquiry, Mr.Speaker. Is there an analysis available to the Members from the Congressional Budget Office that would inform us as to whether this was in fact an unfunded mandate that would require——

Mr. SOLOMON. Mr. Speaker, yes there is.

The SPEAKER pro tempore. The gentleman should address that question to the Committee on Rules.

Mr. SOLOMON. Yes, there is.

CONFERENCE REPORT ON H.R. 2854, FEDERAL AGRICULTURE IMPROVEMENT AND REFORM ACT OF 1996

Mr. SOLOMON. Mr. Speaker, by direction of the Committee on rules, I call up House Resolution 393 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H.RES. 393

Resolved, That upon adoption of this resolution it shall be in order to consider the conference report to accompany the bill (H.R. 2854) to modify the operation of certain agricultural programs. All points of order against the conference report and against its consideration are waived.

SEC. 2. Senate Concurrent Resolution 49 is hereby agreed to.

The SPEAKER pro tempore. The gentleman from New York [Mr. SOLOMON] is recognized for 1 hour.

Mr. SOLOMON. Mr. Speaker, for purposes of debate only, I yield the customary 30 minutes to the gentleman form Ohio [Mr. HALL], pending which I yield myself such time as I may consume. During consideration of this resolution, all time yielded is for the purpose of debate only.

(Mr. SOLOMON asked and was given permission to extend his remarks and include extraneous matter.)

Mr. SOLOMON. Mr. Speaker, I would say to the Members, if I could just have their attention, we will dispose of this rule in 10 minutes, at the most, with no vote necessary, since it is not controversial. So let us get on with it.

Mr. Speaker, the rule before the House today is necessary to permit the House to consider the conference report on the Federal Agriculture Improvement and Reform Act, or FAIR Act.

The rule waives all points of order against the conference report and against its consideration. The waivers are necessary in large part because the Senate passed a much broader bill than the House.

For example, the Senate bill and the conference report contain an extension of the Food Stamp Program, while there was no such provision in the original House bill.

The rule also provides for the adoption of a Senate concurrent Resolution which directs the enrolling clerk to correct an error in the conference report as filed.

Mr. Speaker, this conference report represents the culmination of a long effort to change the way farming is done in America.

Instead of having farmers produce to meet the requirements of Government programs, this bill is designed to move the Government out of the farming business, and let farmers start producing to meet the needs of consumers.