

Public Law 104-191
104th Congress

An Act

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

Aug. 21, 1996
[H.R. 3103]

Health Insurance
Portability and
Accountability
Act of 1996.
42 USC 201 note.

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 Insurance Portability and Accountability 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—HEALTH CARE ACCESS, PORTABILITY, AND RENEWABILITY

Subtitle A—Group Market Rules

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“PART 7—GROUP HEALTH PLAN PORTABILITY, ACCESS, AND RENEWABILITY REQUIREMENTS

“Sec. 701. Increased portability through limitation on preexisting condition exclusions.

“Sec. 702. Prohibiting discrimination against individual participants and beneficiaries based on health status.

“Sec. 703. Guaranteed renewability in multiemployer plans and multiple employer welfare arrangements.

“Sec. 704. Preemption; State flexibility; construction.

“Sec. 705. Special rules relating to group health plans.

“Sec. 706. Definitions.

“Sec. 707. Regulations.”

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“Sec. 2702. Prohibiting discrimination against individual participants and beneficiaries based on health status.

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"Sec. 2712. Guaranteed renewability of coverage for employers in the group market.

"Sec. 2713. Disclosure of information.

"Subpart 3—Exclusion of Plans; Enforcement; Preemption

"Sec. 2721. Exclusion of certain plans.

"Sec. 2722. Enforcement.

"Sec. 2723. Preemption; State flexibility; construction.

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Sec. 203. Beneficiary incentive programs.

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

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**TITLE I—HEALTH CARE ACCESS,
PORTABILITY, AND RENEWABILITY**

Subtitle A—Group Market Rules

PART 1—PORTABILITY, ACCESS, AND RENEWABILITY REQUIREMENTS

SEC. 101. THROUGH THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new part:

“PART 7—GROUP HEALTH PLAN PORTABILITY, ACCESS, AND RENEWABILITY REQUIREMENTS

“SEC. 701. INCREASED PORTABILITY THROUGH LIMITATION ON PREEXISTING CONDITION EXCLUSIONS. 29 USC 1181.

“(a) LIMITATION ON PREEXISTING CONDITION EXCLUSION PERIOD; CREDITING FOR PERIODS OF PREVIOUS COVERAGE.—Subject to subsection (d), a group health plan, and a health insurance issuer

offering group health insurance coverage, may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if—

“(1) such exclusion relates to a condition (whether physical or mental), 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 enrollment date;

“(2) such exclusion extends for a period of not more than 12 months (or 18 months in the case of a late enrollee) after the enrollment date; and

“(3) the period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage (if any, as defined in subsection (c)(1)) applicable to the participant or beneficiary as of the enrollment date.

“(b) DEFINITIONS.—For purposes of this part—

“(1) PREEXISTING CONDITION EXCLUSION.—

“(A) IN GENERAL.—The term ‘preexisting condition exclusion’ means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

“(B) TREATMENT OF GENETIC INFORMATION.—Genetic information shall not be treated as a condition described in subsection (a)(1) in the absence of a diagnosis of the condition related to such information.

“(2) ENROLLMENT DATE.—The term ‘enrollment date’ means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

“(3) LATE ENROLLEE.—The term ‘late enrollee’ means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during—

“(A) the first period in which the individual is eligible to enroll under the plan, or

“(B) a special enrollment period under subsection (f).

“(4) 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 period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

“(c) RULES RELATING TO CREDITING PREVIOUS COVERAGE.—

“(1) CREDITABLE COVERAGE DEFINED.—For purposes of this part, the term ‘creditable coverage’ means, with respect to an individual, coverage of the individual under any of the following:

“(A) A group health plan.

“(B) Health insurance coverage.

“(C) Part A or part B of title XVIII of the Social Security Act.

“(D) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928.

“(E) Chapter 55 of title 10, United States Code.

“(F) A medical care program of the Indian Health Service or of a tribal organization.

“(G) A State health benefits risk pool.

“(H) A health plan offered under chapter 89 of title 5, United States Code.

“(I) A public health plan (as defined in regulations).

“(J) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

Such term does not include coverage consisting solely of coverage of excepted benefits (as defined in section 706(c)).

“(2) NOT COUNTING PERIODS BEFORE SIGNIFICANT BREAKS IN COVERAGE.—

“(A) IN GENERAL.—A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

“(B) WAITING PERIOD NOT TREATED AS A BREAK IN COVERAGE.—For purposes of subparagraph (A) and subsection (d)(4), any period that an individual is in a waiting period for any coverage under a group health plan (or for group health insurance coverage) or is in an affiliation period (as defined in subsection (g)(2)) shall not be taken into account in determining the continuous period under subparagraph (A).

“(3) METHOD OF CREDITING COVERAGE.—

“(A) STANDARD METHOD.—Except as otherwise provided under subparagraph (B), for purposes of applying subsection (a)(3), a group health plan, and a health insurance issuer offering group health insurance coverage, shall count a period of creditable coverage without regard to the specific benefits covered during the period.

“(B) ELECTION OF ALTERNATIVE METHOD.—A group health plan, or a health insurance issuer offering group health insurance coverage, may elect to apply subsection (a)(3) based on coverage of benefits within each of several classes or categories of benefits specified in regulations rather than as provided under subparagraph (A). Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election a group health plan or issuer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category.

“(C) PLAN NOTICE.—In the case of an election with respect to a group health plan under subparagraph (B) (whether or not health insurance coverage is provided in connection with such plan), the plan shall—

“(i) prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made such election, and

“(ii) include in such statements a description of the effect of this election.

“(4) ESTABLISHMENT OF PERIOD.—Periods of creditable coverage with respect to an individual shall be established through

presentation of certifications described in subsection (e) or in such other manner as may be specified in regulations.

“(d) EXCEPTIONS.—

“(1) EXCLUSION NOT APPLICABLE TO CERTAIN NEWBORNS.—Subject to paragraph (4), a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage.

“(2) EXCLUSION NOT APPLICABLE TO CERTAIN ADOPTED CHILDREN.—Subject to paragraph (4), a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption.

“(3) EXCLUSION NOT APPLICABLE TO PREGNANCY.—A group health plan, and health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

“(4) LOSS IF BREAK IN COVERAGE.—Paragraphs (1) and (2) shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

“(e) CERTIFICATIONS AND DISCLOSURE OF COVERAGE.—

“(1) REQUIREMENT FOR CERTIFICATION OF PERIOD OF CREDITABLE COVERAGE.—

“(A) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide the certification described in subparagraph (B)—

“(i) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision,

“(ii) in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision, and

“(iii) on the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in clause (i) or (ii), whichever is later.

The certification under clause (i) may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

“(B) CERTIFICATION.—The certification described in this subparagraph is a written certification of—

“(i) the period of creditable coverage of the individual under such plan and the coverage (if any) under such COBRA continuation provision, and

“(ii) the waiting period (if any) (and affiliation period, if applicable) imposed with respect to the individual for any coverage under such plan.

“(C) ISSUER COMPLIANCE.—To the extent that medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under this paragraph if the health insurance issuer offering the coverage provides for such certification in accordance with this paragraph.

“(2) DISCLOSURE OF INFORMATION ON PREVIOUS BENEFITS.—In the case of an election described in subsection (c)(3)(B) by a group health plan or health insurance issuer, if the plan or issuer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under paragraph (1)—

“(A) upon request of such plan or issuer, the entity which issued the certification provided by the individual shall promptly disclose to such requesting plan or issuer information on coverage of classes and categories of health benefits available under such entity’s plan or coverage, and

“(B) such entity may charge the requesting plan or issuer for the reasonable cost of disclosing such information.

“(3) REGULATIONS.—The Secretary shall establish rules to prevent an entity’s failure to provide information under paragraph (1) or (2) with respect to previous coverage of an individual from adversely affecting any subsequent coverage of the individual under another group health plan or health insurance coverage.

“(f) SPECIAL ENROLLMENT PERIODS.—

“(1) INDIVIDUALS LOSING OTHER COVERAGE.—A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

“(A) 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 dependent.

“(B) 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, but only if the plan sponsor or issuer (if applicable) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time.

“(C) The employee’s or dependent’s coverage described in subparagraph (A)—

“(i) was under a COBRA continuation provision and the coverage under such provision was exhausted; or

“(ii) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employ-

ment) or employer contributions toward such coverage were terminated.

“(D) Under the terms of the plan, the employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in subparagraph (C)(i) or termination of coverage or employer contribution described in subparagraph (C)(ii).

“(2) FOR DEPENDENT BENEFICIARIES.—

“(A) IN GENERAL.—If—

“(i) a group health plan makes coverage available with respect to a dependent of an individual,

“(ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period), and

“(iii) a person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption,

the group health plan shall provide for a dependent special enrollment period described in subparagraph (B) during which the person (or, if not otherwise enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

“(B) DEPENDENT SPECIAL ENROLLMENT PERIOD.—A dependent special enrollment period under this subparagraph shall be a period of not less than 30 days and shall begin on the later of—

“(i) the date dependent coverage is made available, or

“(ii) the date of the marriage, birth, or adoption or placement for adoption (as the case may be) described in subparagraph (A)(iii).

“(C) NO WAITING PERIOD.—If an individual seeks to enroll a dependent during the first 30 days of such a dependent special enrollment period, the coverage of the dependent shall become effective—

“(i) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

“(ii) in the case of a dependent's birth, as of the date of such birth; or

“(iii) in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

“(g) USE OF AFFILIATION PERIOD BY HMOs AS ALTERNATIVE TO PREEXISTING CONDITION EXCLUSION.—

“(1) IN GENERAL.—In the case of a group health plan that offers medical care through health insurance coverage offered by a health maintenance organization, the plan may provide for an affiliation period with respect to coverage through the organization only if—

“(A) no preexisting condition exclusion is imposed with respect to coverage through the organization,

“(B) the period is applied uniformly without regard to any health status-related factors, and

“(C) such period does not exceed 2 months (or 3 months in the case of a late enrollee).

“(2) AFFILIATION PERIOD.—

“(A) DEFINED.—For purposes of this part, the term ‘affiliation 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. The organization is not required to provide health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

“(B) BEGINNING.—Such period shall begin on the enrollment date.

“(C) RUNS CONCURRENTLY WITH WAITING PERIODS.—An affiliation period under a plan shall run concurrently with any waiting period under the plan.

“(3) ALTERNATIVE METHODS.—A health maintenance organization described in paragraph (1) may use alternative methods, from those described in such paragraph, to address adverse selection as approved by the State insurance commissioner or official or officials designated by the State to enforce the requirements of part A of title XXVII of the Public Health Service Act for the State involved with respect to such issuer.

“SEC. 702. PROHIBITING DISCRIMINATION AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES BASED ON HEALTH STATUS. 29 USC 1182.

“(a) IN ELIGIBILITY TO ENROLL.—

“(1) IN GENERAL.—Subject to paragraph (2), a group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

“(A) Health status.

“(B) Medical condition (including both physical and mental illnesses).

“(C) Claims experience.

“(D) Receipt of health care.

“(E) Medical history.

“(F) Genetic information.

“(G) Evidence of insurability (including conditions arising out of acts of domestic violence).

“(H) Disability.

“(2) NO APPLICATION TO BENEFITS OR EXCLUSIONS.—To the extent consistent with section 701, paragraph (1) shall not be construed—

“(A) to require a group health plan, or group health insurance coverage, to provide particular benefits other than those provided under the terms of such plan or coverage, or

“(B) to prevent such a plan or coverage from establishing limitations or restrictions on the amount, level, extent,

or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

“(3) CONSTRUCTION.—For purposes of paragraph (1), rules for eligibility to enroll under a plan include rules defining any applicable waiting periods for such enrollment.

“(b) IN PREMIUM CONTRIBUTIONS.—

“(1) IN GENERAL.—A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

“(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed—

“(A) to restrict the amount that an employer may be charged for coverage under a group health plan; or

“(B) to prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

29 USC 1183.

“SEC. 703. GUARANTEED RENEWABILITY IN MULTIEMPLOYER PLANS AND MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.

“A group health plan which is a multiemployer plan or which is a multiple employer welfare arrangement may not deny an employer whose employees are covered under such a plan continued access to the same or different coverage under the terms of such a plan, 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 provisions;

“(4) because the plan is ceasing to offer any coverage in a geographic area;

“(5) in the case of a plan that offers benefits through a network plan, there is no longer any individual enrolled through the employer who lives, resides, or works in the service area of the network plan and the plan applies this paragraph uniformly without regard to the claims experience of employers or any health status-related factor in relation to such individuals or their dependents; and

“(6) 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.

29 USC 1191.

“SEC. 704. PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.

“(a) CONTINUED APPLICABILITY OF STATE LAW WITH RESPECT TO HEALTH INSURANCE ISSUERS.—

“(1) IN GENERAL.—Subject to paragraph (2) and except as provided in subsection (b), this part shall not be construed to supersede any provision of State law which establishes,

implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this part.

“(2) CONTINUED PREEMPTION WITH RESPECT TO GROUP HEALTH PLANS.—Nothing in this part shall be construed to affect or modify the provisions of section 514 with respect to group health plans.

“(b) SPECIAL RULES IN CASE OF PORTABILITY REQUIREMENTS.—

“(1) IN GENERAL.—Subject to paragraph (2), the provisions of this part relating to health insurance coverage offered by a health insurance issuer supersede any provision of State law which establishes, implements, or continues in effect a standard or requirement applicable to imposition of a preexisting condition exclusion specifically governed by section 701 which differs from the standards or requirements specified in such section.

“(2) EXCEPTIONS.—Only in relation to health insurance coverage offered by a health insurance issuer, the provisions of this part do not supersede any provision of State law to the extent that such provision—

“(A) substitutes for the reference to ‘6-month period’ in section 701(a)(1) a reference to any shorter period of time;

“(B) substitutes for the reference to ‘12 months’ and ‘18 months’ in section 701(a)(2) a reference to any shorter period of time;

“(C) substitutes for the references to ‘63 days’ in sections 701 (c)(2)(A) and (d)(4)(A) a reference to any greater number of days;

“(D) substitutes for the reference to ‘30-day period’ in sections 701 (b)(2) and (d)(1) a reference to any greater period;

“(E) prohibits the imposition of any preexisting condition exclusion in cases not described in section 701(d) or expands the exceptions described in such section;

“(F) requires special enrollment periods in addition to those required under section 701(f); or

“(G) reduces the maximum period permitted in an affiliation period under section 701(g)(1)(B).

“(c) RULES OF CONSTRUCTION.—Nothing in this part shall be construed as requiring a group health plan or health insurance coverage to provide specific benefits under the terms of such plan or coverage.

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

“(1) STATE LAW.—The term ‘State law’ includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

“(2) STATE.—The term ‘State’ includes a State, the Northern Mariana Islands, any political subdivisions of a State or such Islands, or any agency or instrumentality of either.

29 USC 1191a.

“SEC. 705. SPECIAL RULES RELATING TO GROUP HEALTH PLANS.

“(a) **GENERAL EXCEPTION FOR CERTAIN SMALL GROUP HEALTH PLANS.**—The requirements of this part shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year if, on the first day of such plan year, such plan has less than 2 participants who are current employees.

“(b) **EXCEPTION FOR CERTAIN BENEFITS.**—The requirements of this part shall not apply to any group health plan (and group health insurance coverage) in relation to its provision of excepted benefits described in section 706(c)(1).

“(c) **EXCEPTION FOR CERTAIN BENEFITS IF CERTAIN CONDITIONS MET.**—

“(1) **LIMITED, EXCEPTED BENEFITS.**—The requirements of this part shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits described in section 706(c)(2) if the benefits—

“(A) are provided under a separate policy, certificate, or contract of insurance; or

“(B) are otherwise not an integral part of the plan.

“(2) **NONCOORDINATED, EXCEPTED BENEFITS.**—The requirements of this part shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits described in section 706(c)(3) if all of the following conditions are met:

“(A) The benefits are provided under a separate policy, certificate, or contract of insurance.

“(B) There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor.

“(C) Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor.

“(3) **SUPPLEMENTAL EXCEPTED BENEFITS.**—The requirements of this part shall not apply to any group health plan (and group health insurance coverage) in relation to its provision of excepted benefits described in section 706(c)(4) if the benefits are provided under a separate policy, certificate, or contract of insurance.

“(d) **TREATMENT OF PARTNERSHIPS.**—For purposes of this part—

“(1) **TREATMENT AS A GROUP HEALTH PLAN.**—Any plan, fund, or program which would not be (but for this subsection) 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 (including items and services paid for as 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 (2)) as an employee welfare benefit plan which is a group health plan.

“(2) **EMPLOYER.**—In the case of a group health plan, the term ‘employer’ also includes the partnership in relation to any partner.

“(3) PARTICIPANTS OF GROUP HEALTH PLANS.—In the case of a group health plan, the term ‘participant’ also includes—

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

“(B) 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.

“SEC. 706. DEFINITIONS.

29 USC 1191b.

“(a) GROUP HEALTH PLAN.—For purposes of this part—

“(1) IN GENERAL.—The term ‘group health plan’ means an employee welfare benefit plan to the extent that the plan provides medical care (as defined in paragraph (2) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

“(2) MEDICAL CARE.—The term ‘medical care’ means amounts paid for—

“(A) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,

“(B) amounts paid for 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).

“(b) DEFINITIONS RELATING TO HEALTH INSURANCE.—For purposes of this part—

“(1) HEALTH INSURANCE COVERAGE.—The term ‘health insurance coverage’ means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

“(2) HEALTH INSURANCE ISSUER.—The term ‘health insurance issuer’ means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) 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)). Such term does not include a group health plan.

“(3) HEALTH MAINTENANCE ORGANIZATION.—The term ‘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.

“(4) GROUP HEALTH INSURANCE COVERAGE.—The term ‘group health insurance coverage’ means, in connection with a group health plan, health insurance coverage offered in connection with such plan.

“(c) EXCEPTED BENEFITS.—For purposes of this part, the term ‘excepted benefits’ means benefits under one or more (or any combination thereof) of the following:

“(1) BENEFITS NOT SUBJECT TO REQUIREMENTS.—

“(A) Coverage only for accident, or disability income insurance, or any combination thereof.

“(B) Coverage issued as a supplement to liability insurance.

“(C) Liability insurance, including general liability insurance and automobile liability insurance.

“(D) Workers’ compensation or similar insurance.

“(E) Automobile medical payment insurance.

“(F) Credit-only insurance.

“(G) Coverage for on-site medical clinics.

“(H) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

“(2) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED SEPARATELY.—

“(A) Limited scope dental or vision benefits.

“(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

“(C) Such other similar, limited benefits as are specified in regulations.

“(3) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS INDEPENDENT, NONCOORDINATED BENEFITS.—

“(A) Coverage only for a specified disease or illness.

“(B) Hospital indemnity or other fixed indemnity insurance.

“(4) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS SEPARATE INSURANCE POLICY.—Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan.

“(d) OTHER DEFINITIONS.—For purposes of this part—

“(1) COBRA CONTINUATION PROVISION.—The term ‘COBRA continuation provision’ means any of the following:

“(A) Part 6 of this subtitle.

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

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

“(2) HEALTH STATUS-RELATED FACTOR.—The term ‘health status-related factor’ means any of the factors described in section 702(a)(1).

“(3) NETWORK PLAN.—The term ‘network plan’ means health insurance coverage offered by a health insurance issuer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided,

in whole or in part, through a defined set of providers under contract with the issuer.

“(4) PLACED FOR ADOPTION.—The term ‘placement’, or being ‘placed’, for adoption, has the meaning given such term in section 609(c)(3)(B).

“SEC. 707. REGULATIONS.

29 USC 1191c.

“The Secretary, consistent with section 104 of the Health Care Portability and Accountability Act of 1996, may promulgate such regulations as may be necessary or appropriate to carry out the provisions of this part. The Secretary may promulgate any interim final rules as the Secretary determines are appropriate to carry out this part.”.

(b) ENFORCEMENT WITH RESPECT TO HEALTH INSURANCE ISSUERS.—Section 502(b) of such Act (29 U.S.C. 1132(b)) is amended by adding at the end the following new paragraph:

“(3) The Secretary is not authorized to enforce under this part any requirement of part 7 against a health insurance issuer offering health insurance coverage in connection with a group health plan (as defined in section 706(a)(1)). Nothing in this paragraph shall affect the authority of the Secretary to issue regulations to carry out such part.”.

(c) DISCLOSURE OF INFORMATION TO PARTICIPANTS AND BENEFICIARIES.—

(1) IN GENERAL.—Section 104(b)(1) of such Act (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) (other than a material reduction in covered services or benefits provided in the case of a group health plan (as defined in section 706(a)(1))),”; and

(B) by adding at the end 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 under a group health plan (as defined in section 706(a)(1)), a summary description of such modification or change shall be furnished to participants and beneficiaries 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 Portability and Accountability Act of 1996, providing alternative mechanisms to delivery by mail through which group health plans (as so defined) may notify participants and beneficiaries of material reductions in covered services or benefits.”.

(2) PLAN DESCRIPTION AND SUMMARY.—Section 102(b) of such Act (29 U.S.C. 1022(b)) is amended—

(A) by inserting “in the case of a group health plan (as defined in section 706(a)(1)), whether a health insurance issuer (as defined in section 706(b)(2)) is responsible for the financing or administration (including payment of claims) of the plan and (if so) the name and address of such issuer;” after “type of administration of the plan;” and

(B) by inserting “including the office at the Department of Labor through which participants and beneficiaries may seek assistance or information regarding their rights under this Act and the Health Insurance Portability and Accountability Act of 1996 with respect to health benefits that are offered through a group health plan (as defined in section 706(a)(1))” after “benefits under the plan”.

(d) TREATMENT OF HEALTH INSURANCE ISSUERS OFFERING HEALTH INSURANCE COVERAGE TO NONCOVERED PLANS.—Section 4(b) of such Act (29 U.S.C. 1003(b)) is amended by adding at the end (after and below paragraph (5)) the following:

“The provisions of part 7 of subtitle B shall not apply to a health insurance issuer (as defined in section 706(b)(2)) solely by reason of health insurance coverage (as defined in section 706(b)(1)) provided by such issuer in connection with a group health plan (as defined in section 706(a)(1)) if the provisions of this title do not apply to such group health plan.”

(e) REPORTING AND ENFORCEMENT WITH RESPECT TO CERTAIN ARRANGEMENTS.—

(1) IN GENERAL.—Section 101 of such Act (29 U.S.C. 1021) is amended—

(A) by redesignating subsection (g) as subsection (h), and

(B) by inserting after subsection (f) the following new subsection:

“(g) REPORTING BY CERTAIN ARRANGEMENTS.—The Secretary may, by regulation, require multiple employer welfare arrangements providing benefits consisting of medical care (within the meaning of section 706(a)(2)) which are not group health plans to report, not more frequently than annually, in such form and such manner as the Secretary may require for the purpose of determining the extent to which the requirements of part 7 are being carried out in connection with such benefits.”

(2) ENFORCEMENT.—

(A) IN GENERAL.—Section 502 of such Act (29 U.S.C. 1132) is amended—

(i) in subsection (a)(6), by striking “under subsection (c)(2) or (i) or (l)” and inserting “under paragraph (2), (4), or (5) of subsection (c) or under subsection (i) or (l)”; and

(ii) in the last 2 sentences of subsection (c), by striking “For purposes of this paragraph” and all that follows through “The Secretary and” and inserting the following:

“(5) The Secretary may assess a civil penalty against any person of up to \$1,000 a day from the date of the person’s failure or refusal to file the information required to be filed by such person with the Secretary under regulations prescribed pursuant to section 101(g).

“(6) The Secretary and”.

(B) TECHNICAL AND CONFORMING AMENDMENT.—Section 502(c)(1) of such Act (29 U.S.C. 1132(c)(1)) is amended by adding at the end the following sentence: “For purposes of this paragraph, each violation described in subparagraph (A) with respect to any single participant, and each violation described in subparagraph (B) with respect to any

single participant or beneficiary, shall be treated as a separate violation.”.

(3) COORDINATION.—Section 506 of such Act (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

“(c) COORDINATION OF ENFORCEMENT WITH STATES WITH RESPECT TO CERTAIN ARRANGEMENTS.—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 part 7 in connection with multiple employer welfare arrangements, providing medical care (within the meaning of section 706(a)(2)), which are not group health plans.”.

(f) CONFORMING AMENDMENTS.—

(1) Section 514(b) of such Act (29 U.S.C. 1144(b)) is amended by adding at the end the following new paragraph: “(9) For additional provisions relating to group health plans, see section 704.”.

(2)(A) Part 6 of subtitle B of title I of such Act (29 U.S.C. 1161 et seq.) is amended by striking the heading and inserting the following:

“PART 6—CONTINUATION COVERAGE AND ADDITIONAL STANDARDS FOR GROUP HEALTH PLANS”.

(B) The table of contents in section 1 of such Act is amended by striking the item relating to the heading for part 6 of subtitle B of title I and inserting the following:

“PART 6—CONTINUATION COVERAGE AND ADDITIONAL STANDARDS FOR GROUP HEALTH PLANS”.

(3) The table of contents in section 1 of such Act (as amended by the preceding provisions of this section) is amended by inserting after the items relating to part 6 the following new items:

“PART 7—GROUP HEALTH PLAN PORTABILITY, ACCESS, AND RENEWABILITY REQUIREMENTS

“Sec. 701. Increased portability through limitation on preexisting condition exclusions.

“Sec. 702. Prohibiting discrimination against individual participants and beneficiaries based on health status.

“Sec. 703. Guaranteed renewability in multiemployer plans and multiple employer welfare arrangements.

“Sec. 704. Preemption; State flexibility; construction.

“Sec. 705. Special rules relating to group health plans.

“Sec. 706. Definitions.”.

“Sec. 707. Regulations.”.

(g) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in this section, this section (and the amendments made by this section) shall apply with respect to group health plans for plan years beginning after June 30, 1997.

(2) DETERMINATION OF CREDITABLE COVERAGE.—

(A) PERIOD OF COVERAGE.—

(i) IN GENERAL.—Subject to clause (ii), no period before July 1, 1996, shall be taken into account under part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (as added by this section) in determining creditable coverage.

29 USC 1181
note.

(ii) SPECIAL RULE FOR CERTAIN PERIODS.—The Secretary of Labor, consistent with section 104, shall provide for a process whereby individuals who need to establish creditable coverage for periods before July 1, 1996, and who would have such coverage credited but for clause (i) may be given credit for creditable coverage for such periods through the presentation of documents or other means.

(B) CERTIFICATIONS, ETC.—

(i) IN GENERAL.—Subject to clauses (ii) and (iii), subsection (e) of section 701 of the Employee Retirement Income Security Act of 1974 (as added by this section) shall apply to events occurring after June 30, 1996.

(ii) NO CERTIFICATION REQUIRED TO BE PROVIDED BEFORE JUNE 1, 1997.—In no case is a certification required to be provided under such subsection before June 1, 1997.

(iii) CERTIFICATION ONLY ON WRITTEN REQUEST FOR EVENTS OCCURRING BEFORE OCTOBER 1, 1996.—In the case of an event occurring after June 30, 1996, and before October 1, 1996, a certification is not required to be provided under such subsection unless an individual (with respect to whom the certification is otherwise required to be made) requests such certification in writing.

(C) TRANSITIONAL RULE.—In the case of an individual who seeks to establish creditable coverage for any period for which certification is not required because it relates to an event occurring before June 30, 1996—

(i) the individual may present other credible evidence of such coverage in order to establish the period of creditable coverage; and

(ii) a group health plan and a health insurance issuer shall not be subject to any penalty or enforcement action with respect to the plan's or issuer's crediting (or not crediting) such coverage if the plan or issuer has sought to comply in good faith with the applicable requirements under the amendments made by this section.

(3) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—Except as provided in paragraph (2), in the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, part 7 of subtitle B of title I of Employee Retirement Income Security Act of 1974 (other than section 701(e) thereof) shall not apply to plan years beginning before the later of—

(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(B) July 1, 1997.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any require-

ment of such part shall not be treated as a termination of such collective bargaining agreement.

(4) **TIMELY REGULATIONS.**—The Secretary of Labor, consistent with section 104, shall first issue by not later than April 1, 1997, such regulations as may be necessary to carry out the amendments made by this section.

(5) **LIMITATION ON ACTIONS.**—No enforcement action shall be taken, pursuant to the amendments made by this section, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before January 1, 1998, or, if later, the date of issuance of regulations referred to in paragraph (4), if the plan or issuer has sought to comply in good faith with such requirements.

SEC. 102. THROUGH THE PUBLIC HEALTH SERVICE ACT.

(a) **IN GENERAL.**—The Public Health Service Act is amended by adding at the end the following new title:

**“TITLE XXVII—ASSURING PORTABILITY,
AVAILABILITY, AND RENEWABILITY
OF HEALTH INSURANCE COVERAGE**

“PART A—GROUP MARKET REFORMS

“Subpart 1—Portability, Access, and Renewability Requirements

**“SEC. 2701. INCREASED PORTABILITY THROUGH LIMITATION ON
PREEXISTING CONDITION EXCLUSIONS. 42 USC 300gg.**

**“(a) LIMITATION ON PREEXISTING CONDITION EXCLUSION PERIOD;
CREDITING FOR PERIODS OF PREVIOUS COVERAGE.**—Subject to subsection (d), a group health plan, and a health insurance issuer offering group health insurance coverage, may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if—

“(1) such exclusion relates to a condition (whether physical or mental), 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 enrollment date;

“(2) such exclusion extends for a period of not more than 12 months (or 18 months in the case of a late enrollee) after the enrollment date; and

“(3) the period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage (if any, as defined in subsection (c)(1)) applicable to the participant or beneficiary as of the enrollment date.

“(b) DEFINITIONS.—For purposes of this part—

“(1) PREEXISTING CONDITION EXCLUSION.—

“(A) IN GENERAL.—The term ‘preexisting condition exclusion’ means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

“(B) TREATMENT OF GENETIC INFORMATION.—Genetic information shall not be treated as a condition described in subsection (a)(1) in the absence of a diagnosis of the condition related to such information.

“(2) ENROLLMENT DATE.—The term ‘enrollment date’ means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

“(3) LATE ENROLLEE.—The term ‘late enrollee’ means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during—

“(A) the first period in which the individual is eligible to enroll under the plan, or

“(B) a special enrollment period under subsection (f).

“(4) 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 period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

“(c) RULES RELATING TO CREDITING PREVIOUS COVERAGE.—

“(1) CREDITABLE COVERAGE DEFINED.—For purposes of this title, the term ‘creditable coverage’ means, with respect to an individual, coverage of the individual under any of the following:

“(A) A group health plan.

“(B) Health insurance coverage.

“(C) Part A or part B of title XVIII of the Social Security Act.

“(D) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928.

“(E) Chapter 55 of title 10, United States Code.

“(F) A medical care program of the Indian Health Service or of a tribal organization.

“(G) A State health benefits risk pool.

“(H) A health plan offered under chapter 89 of title 5, United States Code.

“(I) A public health plan (as defined in regulations).

“(J) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

Such term does not include coverage consisting solely of coverage of excepted benefits (as defined in section 2791(c)).

“(2) NOT COUNTING PERIODS BEFORE SIGNIFICANT BREAKS IN COVERAGE.—

“(A) IN GENERAL.—A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

“(B) WAITING PERIOD NOT TREATED AS A BREAK IN COVERAGE.—For purposes of subparagraph (A) and subsection (d)(4), any period that an individual is in a waiting period for any coverage under a group health plan (or for group health insurance coverage) or is in an affiliation period (as defined in subsection (g)(2)) shall not be taken into

account in determining the continuous period under subparagraph (A).

“(3) METHOD OF CREDITING COVERAGE.—

“(A) STANDARD METHOD.—Except as otherwise provided under subparagraph (B), for purposes of applying subsection (a)(3), a group health plan, and a health insurance issuer offering group health insurance coverage, shall count a period of creditable coverage without regard to the specific benefits covered during the period.

“(B) ELECTION OF ALTERNATIVE METHOD.—A group health plan, or a health insurance issuer offering group health insurance, may elect to apply subsection (a)(3) based on coverage of benefits within each of several classes or categories of benefits specified in regulations rather than as provided under subparagraph (A). Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election a group health plan or issuer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category.

“(C) PLAN NOTICE.—In the case of an election with respect to a group health plan under subparagraph (B) (whether or not health insurance coverage is provided in connection with such plan), the plan shall—

“(i) prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made such election, and

“(ii) include in such statements a description of the effect of this election.

“(D) ISSUER NOTICE.—In the case of an election under subparagraph (B) with respect to health insurance coverage offered by an issuer in the small or large group market, the issuer—

“(i) shall prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the issuer has made such election, and

“(ii) shall include in such statements a description of the effect of such election.

“(4) ESTABLISHMENT OF PERIOD.—Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection (e) or in such other manner as may be specified in regulations.

“(d) EXCEPTIONS.—

“(1) EXCLUSION NOT APPLICABLE TO CERTAIN NEWBORNS.—Subject to paragraph (4), a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage.

“(2) EXCLUSION NOT APPLICABLE TO CERTAIN ADOPTED CHILDREN.—Subject to paragraph (4), a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption

before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption.

“(3) EXCLUSION NOT APPLICABLE TO PREGNANCY.—A group health plan, and health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

“(4) LOSS IF BREAK IN COVERAGE.—Paragraphs (1) and (2) shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

“(e) CERTIFICATIONS AND DISCLOSURE OF COVERAGE.—

“(1) REQUIREMENT FOR CERTIFICATION OF PERIOD OF CREDITABLE COVERAGE.—

“(A) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide the certification described in subparagraph (B)—

“(i) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision,

“(ii) in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision, and

“(iii) on the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in clause (i) or (ii), whichever is later.

The certification under clause (i) may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

“(B) CERTIFICATION.—The certification described in this subparagraph is a written certification of—

“(i) the period of creditable coverage of the individual under such plan and the coverage (if any) under such COBRA continuation provision, and

“(ii) the waiting period (if any) (and affiliation period, if applicable) imposed with respect to the individual for any coverage under such plan.

“(C) ISSUER COMPLIANCE.—To the extent that medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under this paragraph if the health insurance issuer offering the coverage provides for such certification in accordance with this paragraph.

“(2) DISCLOSURE OF INFORMATION ON PREVIOUS BENEFITS.—In the case of an election described in subsection (c)(3)(B) by a group health plan or health insurance issuer, if the plan or issuer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under paragraph (1)—

“(A) upon request of such plan or issuer, the entity which issued the certification provided by the individual shall promptly disclose to such requesting plan or issuer

information on coverage of classes and categories of health benefits available under such entity's plan or coverage, and

“(B) such entity may charge the requesting plan or issuer for the reasonable cost of disclosing such information.

“(3) REGULATIONS.—The Secretary shall establish rules to prevent an entity's failure to provide information under paragraph (1) or (2) with respect to previous coverage of an individual from adversely affecting any subsequent coverage of the individual under another group health plan or health insurance coverage.

“(f) SPECIAL ENROLLMENT PERIODS.—

“(1) INDIVIDUALS LOSING OTHER COVERAGE.—A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

“(A) 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 dependent.

“(B) 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, but only if the plan sponsor or issuer (if applicable) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time.

“(C) The employee's or dependent's coverage described in subparagraph (A)—

“(i) was under a COBRA continuation provision and the coverage under such provision was exhausted; or

“(ii) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated.

“(D) Under the terms of the plan, the employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in subparagraph (C)(i) or termination of coverage or employer contribution described in subparagraph (C)(ii).

“(2) FOR DEPENDENT BENEFICIARIES.—

“(A) IN GENERAL.—If—

“(i) a group health plan makes coverage available with respect to a dependent of an individual,

“(ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be

enrolled under the plan but for a failure to enroll during a previous enrollment period), and

“(iii) a person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption,

the group health plan shall provide for a dependent special enrollment period described in subparagraph (B) during which the person (or, if not otherwise enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

“(B) DEPENDENT SPECIAL ENROLLMENT PERIOD.—A dependent special enrollment period under this subparagraph shall be a period of not less than 30 days and shall begin on the later of—

“(i) the date dependent coverage is made available, or

“(ii) the date of the marriage, birth, or adoption or placement for adoption (as the case may be) described in subparagraph (A)(iii).

“(C) NO WAITING PERIOD.—If an individual seeks to enroll a dependent during the first 30 days of such a dependent special enrollment period, the coverage of the dependent shall become effective—

“(i) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

“(ii) in the case of a dependent’s birth, as of the date of such birth; or

“(iii) in the case of a dependent’s adoption or placement for adoption, the date of such adoption or placement for adoption.

“(g) USE OF AFFILIATION PERIOD BY HMOs AS ALTERNATIVE TO PREEXISTING CONDITION EXCLUSION.—

“(1) IN GENERAL.—A health maintenance organization which offers health insurance coverage in connection with a group health plan and which does not impose any preexisting condition exclusion allowed under subsection (a) with respect to any particular coverage option may impose an affiliation period for such coverage option, but only if—

“(A) such period is applied uniformly without regard to any health status-related factors; and

“(B) such period does not exceed 2 months (or 3 months in the case of a late enrollee).

“(2) AFFILIATION PERIOD.—

“(A) DEFINED.—For purposes of this title, the term ‘affiliation 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. The organization is not required to provide health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

“(B) BEGINNING.—Such period shall begin on the enrollment date.

“(C) RUNS CONCURRENTLY WITH WAITING PERIODS.—An affiliation period under a plan shall run concurrently with any waiting period under the plan.

“(3) ALTERNATIVE METHODS.—A health maintenance organization described in paragraph (1) may use alternative methods, from those described in such paragraph, to address adverse selection as approved by the State insurance commissioner or official or officials designated by the State to enforce the requirements of this part for the State involved with respect to such issuer.

“SEC. 2702. PROHIBITING DISCRIMINATION AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES BASED ON HEALTH STATUS.

42 USC 300gg-1.

“(a) IN ELIGIBILITY TO ENROLL.—

“(1) IN GENERAL.—Subject to paragraph (2), a group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

“(A) Health status.

“(B) Medical condition (including both physical and mental illnesses).

“(C) Claims experience.

“(D) Receipt of health care.

“(E) Medical history.

“(F) Genetic information.

“(G) Evidence of insurability (including conditions arising out of acts of domestic violence).

“(H) Disability.

“(2) NO APPLICATION TO BENEFITS OR EXCLUSIONS.—To the extent consistent with section 701, paragraph (1) shall not be construed—

“(A) to require a group health plan, or group health insurance coverage, to provide particular benefits other than those provided under the terms of such plan or coverage, or

“(B) to prevent such a plan or coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

“(3) CONSTRUCTION.—For purposes of paragraph (1), rules for eligibility to enroll under a plan include rules defining any applicable waiting periods for such enrollment.

“(b) IN PREMIUM CONTRIBUTIONS.—

“(1) IN GENERAL.—A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an

individual enrolled under the plan as a dependent of the individual.

“(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed—

“(A) to restrict the amount that an employer may be charged for coverage under a group health plan; or

“(B) to prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

“Subpart 2—Provisions Applicable Only to Health Insurance Issuers

42 USC 300gg-11.

“SEC. 2711. GUARANTEED AVAILABILITY OF COVERAGE FOR EMPLOYERS IN THE GROUP MARKET.

“(a) ISSUANCE OF COVERAGE IN THE SMALL GROUP MARKET.—

“(1) IN GENERAL.—Subject to subsections (c) through (f), each health insurance issuer that offers health insurance coverage in the small group market in a State—

“(A) must accept every small employer (as defined in section 2791(e)(4)) 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 period in which the individual first becomes eligible to enroll under the terms of the group health plan and may not place any restriction which is inconsistent with section 2702 on an eligible individual being a participant or beneficiary.

“(2) ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this section, the term ‘eligible individual’ means, with respect to a health insurance issuer that offers health insurance coverage to a small employer in connection with a group health plan 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 issuer under rules of the issuer which are uniformly applicable in a State to small employers in the small group market, and

“(C) in accordance with all applicable State laws governing such issuer and such market.

“(b) ASSURING ACCESS IN THE LARGE GROUP MARKET.—

“(1) REPORTS TO HHS.—The Secretary shall request that the chief executive officer of each State submit to the Secretary, by not later December 31, 2000, and every 3 years thereafter a report on—

“(A) the access of large employers to health insurance coverage in the State, and

“(B) the circumstances for lack of access (if any) of large employers (or one or more classes of such employers) in the State to such coverage.

“(2) TRIENNIAL REPORTS TO CONGRESS.—The Secretary, based on the reports submitted under paragraph (1) and such other information as the Secretary may use, shall prepare

and submit to Congress, every 3 years, a report describing the extent to which large employers (and classes of such employers) that seek health insurance coverage in the different States are able to obtain access to such coverage. Such report shall include such recommendations as the Secretary determines to be appropriate.

“(3) GAO REPORT ON LARGE EMPLOYER ACCESS TO HEALTH INSURANCE COVERAGE.—The Comptroller General shall provide for a study of the extent to which classes of large employers in the different States are able to obtain access to health insurance coverage and the circumstances for lack of access (if any) to such coverage. The Comptroller General shall submit to Congress a report on such study not later than 18 months after the date of the enactment of this title.

“(c) SPECIAL RULES FOR NETWORK PLANS.—

“(1) IN GENERAL.—In the case of a health insurance issuer that offers health insurance coverage in the small group market through a network plan, the issuer may—

“(A) limit the employers that may apply for such coverage to those with eligible individuals who live, work, or reside in the service area for such network plan; and

“(B) within the service area of such plan, deny such coverage to such employers if the issuer has demonstrated, if required, to the applicable State authority 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 dependents) or any health status-related factor relating to such employees and dependents.

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

“(d) APPLICATION OF FINANCIAL CAPACITY LIMITS.—

“(1) IN GENERAL.—A health insurance issuer may deny health insurance coverage in the small group market if the issuer has demonstrated, if required, 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 in the small group market in the State consistent with applicable State law and without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to such employees and dependents.

“(2) 180-DAY SUSPENSION UPON DENIAL OF COVERAGE.—A health insurance issuer upon denying health insurance coverage in connection with group health plans in accordance with paragraph (1) in a State may not offer coverage in connection with group health plans in the small group market in the State for a period of 180 days after the date such coverage

is denied or until the issuer has demonstrated to the applicable State authority, if required under applicable State law, that the issuer has sufficient financial reserves to underwrite additional coverage, whichever is later. An applicable State authority may provide for the application of this subsection on a service-area-specific basis.

“(e) EXCEPTION TO REQUIREMENT FOR FAILURE TO MEET CERTAIN MINIMUM PARTICIPATION OR CONTRIBUTION RULES.—

“(1) IN GENERAL.—Subsection (a) shall not be construed to preclude a health insurance issuer from establishing employer contribution rules or group participation rules for the offering of health insurance coverage in connection with a group health plan in the small group market, as allowed under applicable State law.

“(2) RULES DEFINED.—For purposes of paragraph (1)—

“(A) the term ‘employer contribution rule’ means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries; and

“(B) the term ‘group participation rule’ means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer.

“(f) EXCEPTION FOR COVERAGE OFFERED ONLY TO BONA FIDE ASSOCIATION MEMBERS.—Subsection (a) shall not apply to health insurance coverage offered by a health insurance issuer if such coverage is made available in the small group market only through one or more bona fide associations (as defined in section 2791(d)(3)).

42 USC 300gg-12.

“SEC. 2712. GUARANTEED RENEWABILITY OF COVERAGE FOR EMPLOYERS IN THE GROUP MARKET.

“(a) IN GENERAL.—Except as provided in this section, if a health insurance issuer offers health insurance coverage in the small or large group market in connection with a group health plan, the issuer must renew or continue in force such coverage at the option of the plan sponsor of the plan.

“(b) GENERAL EXCEPTIONS.—A health insurance issuer may nonrenew or discontinue health insurance coverage offered in connection with a group health plan in the small or large group market based only on one or more of the following:

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

“(2) FRAUD.—The plan sponsor 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 OF PARTICIPATION OR CONTRIBUTION RULES.—The plan sponsor has failed to comply with a material plan provision relating to employer contribution or group participation rules, as permitted under section 2711(e) in the case of the small group market or pursuant to applicable State law in the case of the large group market.

“(4) TERMINATION OF COVERAGE.—The issuer is ceasing to offer coverage in such market in accordance with subsection (c) and applicable State law.

“(5) MOVEMENT OUTSIDE SERVICE AREA.—In the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, there is no longer any enrollee in connection with such plan who lives, resides, or works in the service area of the issuer (or in the area for which the issuer is authorized to do business) and, in the case of the small group market, the issuer would deny enrollment with respect to such plan under section 2711(c)(1)(A).

“(6) ASSOCIATION MEMBERSHIP CEASES.—In the case of health insurance coverage that is made available in the small or large group market (as the case may be) only through one or more bona fide associations, the membership of an employer in the association (on the basis of which the coverage is provided) ceases but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any covered individual.

“(c) REQUIREMENTS FOR UNIFORM TERMINATION OF COVERAGE.—

“(1) PARTICULAR TYPE OF COVERAGE NOT OFFERED.—In any case in which an issuer decides to discontinue offering a particular type of group health insurance coverage offered in the small or large group market, coverage of such type may be discontinued by the issuer in accordance with applicable State law in such market only if—

“(A) the issuer provides notice to each plan sponsor 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 issuer offers to each plan sponsor provided coverage of this type in such market, the option to purchase all (or, in the case of the large group market, any) other health insurance coverage currently being offered by the issuer to a group health plan in such market; and

“(C) in exercising the option to discontinue coverage of this type and in offering the option of coverage under subparagraph (B), the issuer acts uniformly without regard to the claims experience of those sponsors or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.

“(2) DISCONTINUANCE OF ALL COVERAGE.—

“(A) IN GENERAL.—In any case in which a health insurance issuer 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 issuer only in accordance with applicable State law and if—

“(i) the issuer provides notice to the applicable State authority and to each plan sponsor (and participants and beneficiaries covered under such coverage) of such discontinuation at least 180 days prior to the date of the discontinuation 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 insur-

ance coverage in such market (or markets) is not renewed.

“(B) PROHIBITION ON MARKET REENTRY.—In the case of a discontinuation under subparagraph (A) in a market, the issuer 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, a health insurance issuer may modify the health insurance coverage for a product offered to a group health plan—

“(1) in the large group market; or

“(2) in the small group market if, for coverage that is available in such market other than only through one or more bona fide associations, such modification is consistent with State law and effective on a uniform basis among group health plans with that product.

“(e) APPLICATION TO COVERAGE OFFERED ONLY THROUGH ASSOCIATIONS.—In applying this section in the case of health insurance coverage that is made available by a health insurance issuer in the small or large group market to employers only through one or more associations, a reference to ‘plan sponsor’ is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer.

42 USC 300gg-13.

“SEC. 2713. DISCLOSURE OF INFORMATION.

“(a) DISCLOSURE OF INFORMATION BY HEALTH PLAN ISSUERS.—In connection with the offering of any health insurance coverage to a small employer, a health insurance issuer—

“(1) shall make a reasonable disclosure to such employer, as part of its solicitation and sales materials, of the availability of information described in subsection (b), and

“(2) upon request of such a small employer, provide such information.

“(b) INFORMATION DESCRIBED.—

“(1) IN GENERAL.—Subject to paragraph (3), with respect to a health insurance issuer offering health insurance coverage to a small employer, information described in this subsection is information concerning—

“(A) the provisions of such coverage concerning issuer’s right to change premium rates and the factors that may affect changes in premium rates;

“(B) the provisions of such coverage relating to renewability of coverage;

“(C) the provisions of such coverage relating to any preexisting condition exclusion; and

“(D) the benefits and premiums available under all health insurance coverage for which the employer is qualified.

“(2) FORM OF INFORMATION.—Information under this subsection shall be provided to small employers in a manner determined to be understandable by the average small employer, and shall be sufficient to reasonably inform small employers of their rights and obligations under the health insurance coverage.

“(3) EXCEPTION.—An issuer is not required under this section to disclose any information that is proprietary and trade secret information under applicable law.

“Subpart 3—Exclusion of Plans; Enforcement; Preemption

“SEC. 2721. EXCLUSION OF CERTAIN PLANS.

42 USC 300gg-21.

“(a) EXCEPTION FOR CERTAIN SMALL GROUP HEALTH PLANS.—The requirements of subparts 1 and 2 shall not apply to any group health plan (and health insurance coverage offered in connection with a group health plan) for any plan year if, on the first day of such plan year, such plan has less than 2 participants who are current employees.

“(b) LIMITATION ON APPLICATION OF PROVISIONS RELATING TO GROUP HEALTH PLANS.—

“(1) IN GENERAL.—The requirements of subparts 1 and 2 shall apply with respect to group health plans only—

“(A) subject to paragraph (2), in the case of a plan that is a nonfederal governmental plan, and

“(B) with respect to health insurance coverage offered in connection with a group health plan (including such a plan that is a church plan or a governmental plan).

“(2) TREATMENT OF NONFEDERAL GOVERNMENTAL PLANS.—

“(A) ELECTION TO BE EXCLUDED.—If the plan sponsor of a nonfederal governmental plan which is a group health plan to which the provisions of subparts 1 and 2 otherwise apply makes an election under this subparagraph (in such form and manner as the Secretary may by regulations prescribe), then the requirements of such subparts insofar as they apply directly to group health plans (and not merely to group health insurance coverage) shall not apply to such governmental plans for such period except as provided in this paragraph.

“(B) PERIOD OF ELECTION.—An election under subparagraph (A) shall apply—

“(i) for a single specified plan year, or

“(ii) in the case of a plan provided pursuant to a collective bargaining agreement, for the term of such agreement.

An election under clause (i) may be extended through subsequent elections under this paragraph.

“(C) NOTICE TO ENROLLEES.—Under such an election, the plan shall provide for—

“(i) notice to enrollees (on an annual basis and at the time of enrollment under the plan) of the fact and consequences of such election, and

“(ii) certification and disclosure of creditable coverage under the plan with respect to enrollees in accordance with section 2701(e).

“(c) EXCEPTION FOR CERTAIN BENEFITS.—The requirements of subparts 1 and 2 shall not apply to any group health plan (or group health insurance coverage) in relation to its provision of excepted benefits described in section 2791(c)(1).

“(d) EXCEPTION FOR CERTAIN BENEFITS IF CERTAIN CONDITIONS MET.—

“(1) LIMITED, EXCEPTED BENEFITS.—The requirements of subparts 1 and 2 shall not apply to any group health plan

(and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits described in section 2791(c)(2) if the benefits—

“(A) are provided under a separate policy, certificate, or contract of insurance; or

“(B) are otherwise not an integral part of the plan.

“(2) NONCOORDINATED, EXCEPTED BENEFITS.—The requirements of subparts 1 and 2 shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits described in section 2791(c)(3) if all of the following conditions are met:

“(A) The benefits are provided under a separate policy, certificate, or contract of insurance.

“(B) There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor.

“(C) Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor.

“(3) SUPPLEMENTAL EXCEPTED BENEFITS.—The requirements of this part shall not apply to any group health plan (and group health insurance coverage) in relation to its provision of excepted benefits described in section 2791(c)(4) if the benefits are provided under a separate policy, certificate, or contract of insurance.

“(e) TREATMENT OF PARTNERSHIPS.—For purposes of this part—

“(1) TREATMENT AS A GROUP HEALTH PLAN.—Any plan, fund, or program which would not be (but for this subsection) 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 (including items and services paid for as 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 (2)) as an employee welfare benefit plan which is a group health plan.

“(2) EMPLOYER.—In the case of a group health plan, the term ‘employer’ also includes the partnership in relation to any partner.

“(3) PARTICIPANTS OF GROUP HEALTH PLANS.—In the case of a group health plan, the term ‘participant’ also includes—

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

“(B) 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.

“SEC. 2722. ENFORCEMENT.

“(a) STATE ENFORCEMENT.—

“(1) STATE AUTHORITY.—Subject to section 2723, each State may require that health insurance issuers that issue, sell, renew, or offer health insurance coverage in the State in the small or large group markets meet the requirements of this part with respect to such issuers.

“(2) FAILURE TO IMPLEMENT PROVISIONS.—In the case of a determination by the Secretary that a State has failed to substantially enforce a provision (or provisions) in this part with respect to health insurance issuers in the State, the Secretary shall enforce such provision (or provisions) under subsection (b) insofar as they relate to the issuance, sale, renewal, and offering of health insurance coverage in connection with group health plans in such State.

“(b) SECRETARIAL ENFORCEMENT AUTHORITY.—

“(1) LIMITATION.—The provisions of this subsection shall apply to enforcement of a provision (or provisions) of this part only—

“(A) as provided under subsection (a)(2); and

“(B) with respect to group health plans that are non-Federal governmental plans.

“(2) IMPOSITION OF PENALTIES.—In the cases described in paragraph (1)—

“(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, any non-Federal governmental plan that is a group health plan and any health insurance issuer that fails to meet a provision of this part applicable to such plan or issuer is subject to a civil money penalty under this subsection.

“(B) LIABILITY FOR PENALTY.—In the case of a failure by—

“(i) a health insurance issuer, the issuer is liable for such penalty, or

“(ii) a group health plan that is a non-Federal governmental plan which is—

“(I) sponsored by 2 or more employers, the plan is liable for such penalty, or

“(II) not so sponsored, the employer is liable for such penalty.

“(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 shall take into account the previous record of compliance of the entity being assessed with the applicable provisions of this part and the gravity of the violation.

“(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 entities 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 entities 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 entity 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 (E).

“(E) JUDICIAL REVIEW.—

“(i) FILING OF ACTION FOR REVIEW.—Any entity 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 entity 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 by 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 the 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 entity 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.

“SEC. 2723. PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.

42 USC 300gg-23.

“(a) CONTINUED APPLICABILITY OF STATE LAW WITH RESPECT TO HEALTH INSURANCE ISSUERS.—

“(1) IN GENERAL.—Subject to paragraph (2) and except as provided in subsection (b), this part and part C insofar as it relates to this part shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this part.

“(2) CONTINUED PREEMPTION WITH RESPECT TO GROUP HEALTH PLANS.—Nothing in this part shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 with respect to group health plans.

“(b) SPECIAL RULES IN CASE OF PORTABILITY REQUIREMENTS.—

“(1) IN GENERAL.—Subject to paragraph (2), the provisions of this part relating to health insurance coverage offered by a health insurance issuer supersede any provision of State law which establishes, implements, or continues in effect a standard or requirement applicable to imposition of a preexisting condition exclusion specifically governed by section 701 which differs from the standards or requirements specified in such section.

“(2) EXCEPTIONS.—Only in relation to health insurance coverage offered by a health insurance issuer, the provisions of this part do not supersede any provision of State law to the extent that such provision—

“(i) substitutes for the reference to ‘6-month period’ in section 2701(a)(1) a reference to any shorter period of time;

“(ii) substitutes for the reference to ‘12 months’ and ‘18 months’ in section 2701(a)(2) a reference to any shorter period of time;

“(iii) substitutes for the references to ‘63’ days in sections 2701(c)(2)(A) and 2701(d)(4)(A) a reference to any greater number of days;

“(iv) substitutes for the reference to ‘30-day period’ in sections 2701(b)(2) and 2701(d)(1) a reference to any greater period;

“(v) prohibits the imposition of any preexisting condition exclusion in cases not described in section 2701(d) or expands the exceptions described in such section;

“(vi) requires special enrollment periods in addition to those required under section 2701(f); or

“(vii) reduces the maximum period permitted in an affiliation period under section 2701(g)(1)(B).

“(c) RULES OF CONSTRUCTION.—Nothing in this part shall be construed as requiring a group health plan or health insurance coverage to provide specific benefits under the terms of such plan or coverage.

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

“(1) STATE LAW.—The term ‘State law’ includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

“(2) STATE.—The term ‘State’ includes a State (including the Northern Mariana Islands), any political subdivisions of a State or such Islands, or any agency or instrumentality of either.

“PART C—DEFINITIONS; MISCELLANEOUS PROVISIONS

42 USC 300gg-91.

“SEC. 2791. DEFINITIONS.

“(a) GROUP HEALTH PLAN.—

“(1) DEFINITION.—The term ‘group health plan’ means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974) to the extent that the plan provides medical care (as defined in paragraph (2)) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

“(2) MEDICAL CARE.—The term ‘medical care’ means amounts paid for—

“(A) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,

“(B) amounts paid for 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).

“(3) TREATMENT OF CERTAIN PLANS AS GROUP HEALTH PLAN FOR NOTICE PROVISION.—A program under which creditable coverage described in subparagraph (C), (D), (E), or (F) of section 2701(c)(1) is provided shall be treated as a group health plan for purposes of applying section 2701(e).

“(b) DEFINITIONS RELATING TO HEALTH INSURANCE.—

“(1) HEALTH INSURANCE COVERAGE.—The term ‘health insurance coverage’ means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical

care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

“(2) HEALTH INSURANCE ISSUER.—The term ‘health insurance issuer’ means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) 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) of the Employee Retirement Income Security Act of 1974). Such term does not include a group health plan.

“(3) HEALTH MAINTENANCE ORGANIZATION.—The term ‘health maintenance organization’ means—

“(A) a Federally qualified health maintenance organization (as defined in section 1301(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.

“(4) GROUP HEALTH INSURANCE COVERAGE.—The term ‘group health insurance coverage’ means, in connection with a group health plan, health insurance coverage offered in connection with such plan.

“(5) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The term ‘individual health insurance coverage’ means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.

“(c) EXCEPTED BENEFITS.—For purposes of this title, the term ‘excepted benefits’ means benefits under one or more (or any combination thereof) of the following:

“(1) BENEFITS NOT SUBJECT TO REQUIREMENTS.—

“(A) Coverage only for accident, or disability income insurance, or any combination thereof.

“(B) Coverage issued as a supplement to liability insurance.

“(C) Liability insurance, including general liability insurance and automobile liability insurance.

“(D) Workers’ compensation or similar insurance.

“(E) Automobile medical payment insurance.

“(F) Credit-only insurance.

“(G) Coverage for on-site medical clinics.

“(H) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

“(2) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED SEPARATELY.—

“(A) Limited scope dental or vision benefits.

“(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

“(C) Such other similar, limited benefits as are specified in regulations.

“(3) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS INDEPENDENT, NONCOORDINATED BENEFITS.—

“(A) Coverage only for a specified disease or illness.

“(B) Hospital indemnity or other fixed indemnity insurance.

“(4) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS SEPARATE INSURANCE POLICY.—Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan.

“(d) OTHER DEFINITIONS.—

“(1) APPLICABLE STATE AUTHORITY.—The term ‘applicable State authority’ means, with respect to a health insurance issuer 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 issuer.

“(2) BENEFICIARY.—The term ‘beneficiary’ has the meaning given such term under section 3(8) of the Employee Retirement Income Security Act of 1974.

“(3) BONA FIDE ASSOCIATION.—The term ‘bona fide association’ means, with respect to health insurance coverage offered in a State, 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 any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee);

“(D) makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member);

“(E) does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

“(F) meets such additional requirements as may be imposed under State law.

“(4) 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, other than section 609 of such Act.

“(C) Title XXII of this Act.

“(5) EMPLOYEE.—The term ‘employee’ has the meaning given such term under section 3(6) of the Employee Retirement Income Security Act of 1974.

“(6) EMPLOYER.—The term ‘employer’ has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974, except that such term shall include only employers of two or more employees.

“(7) CHURCH PLAN.—The term ‘church plan’ has the meaning given such term under section 3(33) of the Employee Retirement Income Security Act of 1974.

“(8) **GOVERNMENTAL PLAN.**—(A) The term ‘governmental plan’ has the meaning given such term under section 3(32) of the Employee Retirement Income Security Act of 1974 and any Federal governmental plan.

“(B) **FEDERAL GOVERNMENTAL PLAN.**—The term ‘Federal governmental plan’ means a governmental plan established or maintained for its employees by the Government of the United States or by any agency or instrumentality of such Government.

“(C) **NON-FEDERAL GOVERNMENTAL PLAN.**—The term ‘non-Federal governmental plan’ means a governmental plan that is not a Federal governmental plan.

“(9) **HEALTH STATUS-RELATED FACTOR.**—The term ‘health status-related factor’ means any of the factors described in section 2702(a)(1).

“(10) **NETWORK PLAN.**—The term ‘network plan’ means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the issuer.

“(11) **PARTICIPANT.**—The term ‘participant’ has the meaning given such term under section 3(7) of the Employee Retirement Income Security Act of 1974.

“(12) **PLACED FOR ADOPTION DEFINED.**—The term ‘placed’, 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.

“(13) **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.

“(14) **STATE.**—The term ‘State’ means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

“(e) **DEFINITIONS RELATING TO MARKETS AND SMALL EMPLOYERS.**—For purposes of this title:

“(1) **INDIVIDUAL MARKET.**—

“(A) **IN GENERAL.**—The term ‘individual market’ means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

“(B) **TREATMENT OF VERY SMALL GROUPS.**—

“(i) **IN GENERAL.**—Subject to clause (ii), such terms includes coverage offered in connection with a group health plan that has fewer than two participants as current employees on the first day of the plan year.

“(ii) **STATE EXCEPTION.**—Clause (i) shall not apply in the case of a State that elects to regulate the coverage described in such clause as coverage in the small group market.

“(2) **LARGE EMPLOYER.**—The term ‘large employer’ means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the

preceding calendar year and who employs at least 2 employees on the first day of the plan year.

“(3) **LARGE GROUP MARKET.**—The term ‘large 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) through a group health plan maintained by a large employer.

“(4) **SMALL EMPLOYER.**—The term ‘small employer’ means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

“(5) **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) through a group health plan maintained by a small employer.

“(6) **APPLICATION OF CERTAIN RULES IN DETERMINATION OF EMPLOYER SIZE.**—For purposes of this subsection—

“(A) **APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.**—all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

“(B) **EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.**—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

“(C) **PREDECESSORS.**—Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

42 USC 300gg-92.

“SEC. 2792. REGULATIONS.

“The Secretary, consistent with section 104 of the Health Care Portability and Accountability Act of 1996, may promulgate such regulations as may be necessary or appropriate to carry out the provisions of this title. The Secretary may promulgate any interim final rules as the Secretary determines are appropriate to carry out this title.”

(b) **APPLICATION OF RULES BY CERTAIN HEALTH MAINTENANCE ORGANIZATIONS.**—Section 1301 of such Act (42 U.S.C. 300e) is amended by adding at the end the following new subsection:

“(d) An organization that offers health benefits coverage shall not be considered as failing to meet the requirements of this section notwithstanding that it provides, with respect to coverage offered in connection with a group health plan in the small or large group market (as defined in section 2791(e)), an affiliation period consistent with the provisions of section 2701(g).”

(c) **EFFECTIVE DATE.**—

(1) **IN GENERAL.**—Except as provided in this subsection, part A of title XXVII of the Public Health Service Act (as added by subsection (a)) shall apply with respect to group health plans, and health insurance coverage offered in connec-

42 USC 300gg note.

tion with group health plans, for plan years beginning after June 30, 1997.

(2) DETERMINATION OF CREDITABLE COVERAGE.—

(A) PERIOD OF COVERAGE.—

(i) IN GENERAL.—Subject to clause (ii), no period before July 1, 1996, shall be taken into account under part A of title XXVII of the Public Health Service Act (as added by this section) in determining creditable coverage.

(ii) SPECIAL RULE FOR CERTAIN PERIODS.—The Secretary of Health and Human Services, consistent with section 104, shall provide for a process whereby individuals who need to establish creditable coverage for periods before July 1, 1996, and who would have such coverage credited but for clause (i) may be given credit for creditable coverage for such periods through the presentation of documents or other means.

(B) CERTIFICATIONS, ETC.—

(i) IN GENERAL.—Subject to clauses (ii) and (iii), subsection (e) of section 2701 of the Public Health Service Act (as added by this section) shall apply to events occurring after June 30, 1996.

(ii) NO CERTIFICATION REQUIRED TO BE PROVIDED BEFORE JUNE 1, 1997.—In no case is a certification required to be provided under such subsection before June 1, 1997.

(iii) CERTIFICATION ONLY ON WRITTEN REQUEST FOR EVENTS OCCURRING BEFORE OCTOBER 1, 1996.—In the case of an event occurring after June 30, 1996, and before October 1, 1996, a certification is not required to be provided under such subsection unless an individual (with respect to whom the certification is otherwise required to be made) requests such certification in writing.

(C) TRANSITIONAL RULE.—In the case of an individual who seeks to establish creditable coverage for any period for which certification is not required because it relates to an event occurring before June 30, 1996—

(i) the individual may present other credible evidence of such coverage in order to establish the period of creditable coverage; and

(ii) a group health plan and a health insurance issuer shall not be subject to any penalty or enforcement action with respect to the plan's or issuer's crediting (or not crediting) such coverage if the plan or issuer has sought to comply in good faith with the applicable requirements under the amendments made by this section.

(3) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—Except as provided in paragraph (2)(B), in the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, part A of title XXVII of the Public Health Service Act (other than section 2701(e) thereof) shall not apply to plan years beginning before the later of—

(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(B) July 1, 1997.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement of such part shall not be treated as a termination of such collective bargaining agreement.

(4) **TIMELY REGULATIONS.**—The Secretary of Health and Human Services, consistent with section 104, shall first issue by not later than April 1, 1997, such regulations as may be necessary to carry out the amendments made by this section and section 111.

(5) **LIMITATION ON ACTIONS.**—No enforcement action shall be taken, pursuant to the amendments made by this section, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before January 1, 1998, or, if later, the date of issuance of regulations referred to in paragraph (4), if the plan or issuer has sought to comply in good faith with such requirements.

(d) **MISCELLANEOUS CORRECTION.**—Section 2208(1) of the Public Health Service Act (42 U.S.C. 300bb-8(1)) is amended by striking “section 162(i)(2)” and inserting “5000(b)”.

SEC. 103. REFERENCE TO IMPLEMENTATION THROUGH THE INTERNAL REVENUE CODE OF 1986.

For provisions amending the Internal Revenue Code of 1986 to provide for application and enforcement of rules for group health plans similar to those provided under the amendments made by section 101(a), see section 401.

SEC. 104. ASSURING COORDINATION.

The Secretary of the Treasury, the Secretary of Health and Human Services, and the Secretary of Labor shall ensure, through the execution of an interagency memorandum of understanding among such Secretaries, that—

(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which two or more such Secretaries have responsibility under this subtitle (and the amendments made by this subtitle and section 401) are administered so as to have the same effect at all times; and

(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.

Subtitle B—Individual Market Rules

SEC. 111. AMENDMENT TO PUBLIC HEALTH SERVICE ACT.

(a) **IN GENERAL.**—Title XXVII of the Public Health Service Act, as added by section 102(a) of this Act, is amended by inserting after part A the following new part:

"PART B—INDIVIDUAL MARKET RULES

"SEC. 2741. GUARANTEED AVAILABILITY OF INDIVIDUAL HEALTH INSURANCE COVERAGE TO CERTAIN INDIVIDUALS WITH PRIOR GROUP COVERAGE. 42 USC 300gg-41.**"(a) GUARANTEED AVAILABILITY.—**

"(1) IN GENERAL.—Subject to the succeeding subsections of this section and section 2744, each health insurance issuer that offers health insurance coverage (as defined in section 2791(b)(1)) in the individual market in a State may not, with respect to an eligible individual (as defined in subsection (b)) desiring to enroll in individual health insurance coverage—

"(A) decline to offer such coverage to, or deny enrollment of, such individual; or

"(B) impose any preexisting condition exclusion (as defined in section 2701(b)(1)(A)) with respect to such coverage.

"(2) SUBSTITUTION BY STATE OF ACCEPTABLE ALTERNATIVE MECHANISM.—The requirement of paragraph (1) shall not apply to health insurance coverage offered in the individual market in a State in which the State is implementing an acceptable alternative mechanism under section 2744.

"(b) ELIGIBLE INDIVIDUAL DEFINED.—In this part, the term 'eligible individual' means an individual—

"(1)(A) for whom, as of the date on which the individual seeks coverage under this section, the aggregate of the periods of creditable coverage (as defined in section 2701(c)) is 18 or more months and (B) whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan (or health insurance coverage offered in connection with any such plan);

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

"(3) with respect to whom the most recent coverage within the coverage period described in paragraph (1)(A) was not terminated based on a factor described in paragraph (1) or (2) of section 2712(b) (relating to nonpayment of premiums or fraud);

"(4) 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

"(5) who, if the individual elected such continuation coverage, has exhausted such continuation coverage under such provision or program.

"(c) ALTERNATIVE COVERAGE PERMITTED WHERE NO STATE MECHANISM.—

"(1) IN GENERAL.—In the case of health insurance coverage offered in the individual market in a State in which the State is not implementing an acceptable alternative mechanism under section 2744, the health insurance issuer may elect to limit the coverage offered under subsection (a) so long as it offers at least two different policy forms of health insurance coverage both of which—

“(A) are designed for, made generally available to, and actively marketed to, and enroll both eligible and other individuals by the issuer; and

“(B) meet the requirement of paragraph (2) or (3), as elected by the issuer.

For purposes of this subsection, policy forms which have different cost-sharing arrangements or different riders shall be considered to be different policy forms.

“(2) CHOICE OF MOST POPULAR POLICY FORMS.—The requirement of this paragraph is met, for health insurance coverage policy forms offered by an issuer in the individual market, if the issuer offers the policy forms for individual health insurance coverage with the largest, and next to largest, premium volume of all such policy forms offered by the issuer in the State or applicable marketing or service area (as may be prescribed in regulation) by the issuer in the individual market in the period involved.

“(3) CHOICE OF 2 POLICY FORMS WITH REPRESENTATIVE COVERAGE.—

“(A) IN GENERAL.—The requirement of this paragraph is met, for health insurance coverage policy forms offered by an issuer in the individual market, if the issuer offers a lower-level coverage policy form (as defined in subparagraph (B)) and a higher-level coverage policy form (as defined in subparagraph (C)) each of which includes benefits substantially similar to other individual health insurance coverage offered by the issuer in that State and each of which is covered under a method described in section 2744(c)(3)(A) (relating to risk adjustment, risk spreading, or financial subsidization).

“(B) LOWER-LEVEL OF COVERAGE DESCRIBED.—A policy form is described in this subparagraph if the actuarial value of the benefits under the coverage is at least 85 percent but not greater than 100 percent of a weighted average (described in subparagraph (D)).

“(C) HIGHER-LEVEL OF COVERAGE DESCRIBED.—A policy form is described in this subparagraph if—

“(i) the actuarial value of the benefits under the coverage is at least 15 percent greater than the actuarial value of the coverage described in subparagraph (B) offered by the issuer in the area involved; and

“(ii) the actuarial value of the benefits under the coverage is at least 100 percent but not greater than 120 percent of a weighted average (described in subparagraph (D)).

“(D) WEIGHTED AVERAGE.—For purposes of this paragraph, the weighted average described in this subparagraph is the average actuarial value of the benefits provided by all the health insurance coverage issued (as elected by the issuer) either by that issuer or by all issuers in the State in the individual market during the previous year (not including coverage issued under this section), weighted by enrollment for the different coverage.

“(4) ELECTION.—The issuer elections under this subsection shall apply uniformly to all eligible individuals in the State for that issuer. Such an election shall be effective for policies offered during a period of not shorter than 2 years.

“(5) ASSUMPTIONS.—For purposes of paragraph (3), 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.

“(d) SPECIAL RULES FOR NETWORK PLANS.—

“(1) IN GENERAL.—In the case of a health insurance issuer that offers health insurance coverage in the individual market through a network plan, the issuer may—

“(A) limit the individuals who may be enrolled under such coverage to those who live, reside, or work within the service area for such network plan; and

“(B) within the service area of such plan, deny such coverage to such individuals if the issuer has demonstrated, if required, to the applicable State authority that—

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

“(ii) it is applying this paragraph uniformly to individuals without regard to any health status-related factor of such individuals and without regard to whether the individuals are eligible individuals.

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

“(e) APPLICATION OF FINANCIAL CAPACITY LIMITS.—

“(1) IN GENERAL.—A health insurance issuer may deny health insurance coverage in the individual market to an eligible individual if the issuer has demonstrated, if required, 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 individuals in the individual market in the State consistent with applicable State law and without regard to any health status-related factor of such individuals and without regard to whether the individuals are eligible individuals.

“(2) 180-DAY SUSPENSION UPON DENIAL OF COVERAGE.—An issuer upon denying individual health insurance coverage in any service area in accordance with paragraph (1) may not offer such coverage in the individual market within such service area for a period of 180 days after the date such coverage is denied or until the issuer has demonstrated, if required under applicable State law, to the applicable State authority that the issuer has sufficient financial reserves to underwrite additional coverage, whichever is later. A State may provide for the application of this paragraph on a service-area-specific basis.

“(e) MARKET REQUIREMENTS.—

“(1) IN GENERAL.—The provisions of subsection (a) shall not be construed to require that a health insurance issuer offering health insurance coverage only in connection with group health plans or through one or more bona fide associations, or both, offer such health insurance coverage in the individual market.

“(2) **CONVERSION POLICIES.**—A health insurance issuer offering health insurance coverage in connection with group health plans under this title shall not be deemed to be a health insurance issuer offering individual health insurance coverage solely because such issuer offers a conversion policy.

“(f) **CONSTRUCTION.**—Nothing in this section shall be construed—

“(1) to restrict the amount of the premium rates that an issuer may charge an individual for health insurance coverage provided in the individual market under applicable State law; or

“(2) to prevent a health insurance issuer offering health insurance coverage in the individual market from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

42 USC 300gg-42.

“**SEC. 2742. GUARANTEED RENEWABILITY OF INDIVIDUAL HEALTH INSURANCE COVERAGE.**

“(a) **IN GENERAL.**—Except as provided in this section, a health insurance issuer that provides individual health insurance coverage to an individual shall renew or continue in force such coverage at the option of the individual.

“(b) **GENERAL EXCEPTIONS.**—A health insurance issuer may nonrenew or discontinue health insurance coverage of an individual in the individual market based only on one or more of the following:

“(1) **NONPAYMENT OF PREMIUMS.**—The individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received 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 PLAN.**—The issuer is ceasing to offer coverage in the individual market in accordance with subsection (c) and applicable State law.

“(4) **MOVEMENT OUTSIDE SERVICE AREA.**—In the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, the individual no longer resides, lives, or works in the service area (or in an area for which the issuer is authorized to do business) but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor of covered individuals.

“(5) **ASSOCIATION MEMBERSHIP CEASES.**—In the case of health insurance coverage that is made available in the individual market only through one or more bona fide associations, the membership of the individual in the association (on the basis of which the coverage is provided) ceases but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor of covered individuals.

“(c) **REQUIREMENTS FOR UNIFORM TERMINATION OF COVERAGE.**—

“(1) **PARTICULAR TYPE OF COVERAGE NOT OFFERED.**—In any case in which an issuer decides to discontinue offering a particular type of health insurance coverage offered in the individual

market, coverage of such type may be discontinued by the issuer only if—

“(A) the issuer provides notice to each covered individual provided coverage of this type in such market of such discontinuation at least 90 days prior to the date of the discontinuation of such coverage;

“(B) the issuer offers to each individual in the individual market provided coverage of this type, the option to purchase any other individual health insurance coverage currently being offered by the issuer for individuals in such market; and

“(C) in exercising the option to discontinue coverage of this type and in offering the option of coverage under subparagraph (B), the issuer acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for such coverage.

“(2) DISCONTINUANCE OF ALL COVERAGE.—

“(A) IN GENERAL.—Subject to subparagraph (C), in any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the individual market in a State, health insurance coverage may be discontinued by the issuer only if—

“(i) the issuer provides notice to the applicable State authority and to each individual 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 are discontinued and coverage under such health insurance coverage in such market is not renewed.

“(B) PROHIBITION ON MARKET REENTRY.—In the case of a discontinuation under subparagraph (A) in the individual market, the issuer 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, a health insurance issuer may modify the health insurance coverage for a policy form offered to individuals in the individual market so long as such modification is consistent with State law and effective on a uniform basis among all individuals with that policy form.

“(e) APPLICATION TO COVERAGE OFFERED ONLY THROUGH ASSOCIATIONS.—In applying this section in the case of health insurance coverage that is made available by a health insurance issuer in the individual market to individuals only through one or more associations, a reference to an ‘individual’ is deemed to include a reference to such an association (of which the individual is a member).

“SEC. 2743. CERTIFICATION OF COVERAGE.

“The provisions of section 2701(e) shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as it applies to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.

42 USC 300gg-44.

“SEC. 2744. STATE FLEXIBILITY IN INDIVIDUAL MARKET REFORMS.

“(a) WAIVER OF REQUIREMENTS WHERE IMPLEMENTATION OF ACCEPTABLE ALTERNATIVE MECHANISM.—

“(1) IN GENERAL.—The requirements of section 2741 shall not apply with respect to health insurance coverage offered in the individual market in the State so long as a State is found to be implementing, in accordance with this section and consistent with section 2746(b), an alternative mechanism (in this section referred to as an ‘acceptable alternative mechanism’)—

“(A) under which all eligible individuals are provided a choice of health insurance coverage;

“(B) under which such coverage does not impose any preexisting condition exclusion with respect to such coverage;

“(C) under which such choice of coverage includes at least one policy form of coverage that is comparable to comprehensive health insurance coverage offered in the individual market in such State or that is comparable to a standard option of coverage available under the group or individual health insurance laws of such State; and

“(D) in a State which is implementing—

“(i) a model act described in subsection (c)(1),

“(ii) a qualified high risk pool described in subsection (c)(2), or

“(iii) a mechanism described in subsection (c)(3).

“(2) PERMISSIBLE FORMS OF MECHANISMS.—A private or public individual health insurance mechanism (such as a health insurance coverage pool or programs, mandatory group conversion policies, guaranteed issue of one or more plans of individual health insurance coverage, or open enrollment by one or more health insurance issuers), or combination of such mechanisms, that is designed to provide access to health benefits for individuals in the individual market in the State in accordance with this section may constitute an acceptable alternative mechanism.

“(b) APPLICATION OF ACCEPTABLE ALTERNATIVE MECHANISMS.—

“(1) PRESUMPTION.—

“(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, a State is presumed to be implementing an acceptable alternative mechanism in accordance with this section as of July 1, 1997, if, by not later than April 1, 1997, the chief executive officer of a State—

“(i) notifies the Secretary that the State has enacted or intends to enact (by not later than January 1, 1998, or July 1, 1998, in the case of a State described in subparagraph (B)(ii)) any necessary legislation to provide for the implementation of a mechanism reasonably designed to be an acceptable alternative mechanism as of January 1, 1998, (or, in the case of a State described in subparagraph (B)(ii), July 1, 1998); and

“(ii) provides the Secretary with such information as the Secretary may require to review the mechanism and its implementation (or proposed implementation) under this subsection.

“(B) DELAY PERMITTED FOR CERTAIN STATES.—

“(i) EFFECT OF DELAY.—In the case of a State described in clause (ii) that provides notice under subparagraph (A)(i), for the presumption to continue on and after July 1, 1998, the chief executive officer of the State by April 1, 1998—

“(I) must notify the Secretary that the State has enacted any necessary legislation to provide for the implementation of a mechanism reasonably designed to be an acceptable alternative mechanism as of July 1, 1998; and

“(II) must provide the Secretary with such information as the Secretary may require to review the mechanism and its implementation (or proposed implementation) under this subsection.

“(ii) STATES DESCRIBED.—A State described in this clause is a State that has a legislature that does not meet within the 12-month period beginning on the date of enactment of this Act.

“(C) CONTINUED APPLICATION.—In order for a mechanism to continue to be presumed to be an acceptable alternative mechanism, the State shall provide the Secretary every 3 years with information described in subparagraph (A)(ii) or (B)(i)(II) (as the case may be).

“(2) NOTICE.—If the Secretary finds, after review of information provided under paragraph (1) and in 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 is not an acceptable alternative mechanism or is not (or no longer) being implemented, the Secretary—

“(A) shall notify the State of—

“(i) such preliminary determination, and

“(ii) the consequences under paragraph (3) of a failure to implement such a mechanism; and

“(B) shall permit the State a reasonable opportunity in which to modify the mechanism (or to adopt another mechanism) in a manner so that may be an acceptable alternative mechanism or to provide for implementation of such a mechanism.

“(3) FINAL DETERMINATION.—If, after providing notice and opportunity under paragraph (2), the Secretary finds that the mechanism is not an acceptable alternative mechanism or the State is not implementing such a mechanism, the Secretary shall notify the State that the State is no longer considered to be implementing an acceptable alternative mechanism and that the requirements of section 2741 shall apply to health insurance coverage offered in the individual market in the State, effective as of a date specified in the notice.

“(4) LIMITATION ON SECRETARIAL AUTHORITY.—The Secretary shall not make a determination under paragraph (2) or (3) on any basis other than the basis that a mechanism is not an acceptable alternative mechanism or is not being implemented.

“(5) FUTURE ADOPTION OF MECHANISMS.—If a State, after January 1, 1997, submits the notice and information described in paragraph (1), unless the Secretary makes a finding described in paragraph (3) within the 90-day period beginning on the date of submission of the notice and information, the

mechanism shall be considered to be an acceptable alternative mechanism for purposes of this section, effective 90 days after the end of such period, subject to the second sentence of paragraph (1).

“(c) PROVISION RELATED TO RISK.—

“(1) ADOPTION OF NAIC MODELS.—The model act referred to in subsection (a)(1)(D)(i) is the Small Employer and Individual Health Insurance Availability Model Act (adopted by the National Association of Insurance Commissioners on June 3, 1996) insofar as it applies to individual health insurance coverage or the Individual Health Insurance Portability Model Act (also adopted by such Association on such date).

“(2) QUALIFIED HIGH RISK POOL.—For purposes of subsection (a)(1)(D)(ii), a ‘qualified high risk pool’ described in this paragraph is a high risk pool that—

“(A) provides to all eligible individuals health insurance coverage (or comparable coverage) that does not impose any preexisting condition exclusion with respect to such coverage for all eligible individuals, and

“(B) provides for premium rates and covered benefits for such coverage consistent with standards included in the NAIC Model Health Plan for Uninsurable Individuals Act (as in effect as of the date of the enactment of this title).

“(3) OTHER MECHANISMS.—For purposes of subsection (a)(1)(D)(iii), a mechanism described in this paragraph—

“(A) provides for risk adjustment, risk spreading, or a risk spreading mechanism (among issuers or policies of an issuer) or otherwise provides for some financial subsidization for eligible individuals, including through assistance to participating issuers; or

“(B) is a mechanism under which each eligible individual is provided a choice of all individual health insurance coverage otherwise available.

42 USC
300gg-61.

“SEC. 2761. ENFORCEMENT.

“(a) STATE ENFORCEMENT.—

“(1) STATE AUTHORITY.—Subject to section 2746, each State may require that health insurance issuers that issue, sell, renew, or offer health insurance coverage in the State in the individual market meet the requirements established under this part with respect to such issuers.

“(2) FAILURE TO IMPLEMENT REQUIREMENTS.—In the case of a State that fails to substantially enforce the requirements set forth in this part with respect to health insurance issuers in the State, the Secretary shall enforce the requirements of this part under subsection (b) insofar as they relate to the issuance, sale, renewal, and offering of health insurance coverage in the individual market in such State.

“(b) SECRETARIAL ENFORCEMENT AUTHORITY.—The Secretary shall have the same authority in relation to enforcement of the provisions of this part with respect to issuers of health insurance coverage in the individual market in a State as the Secretary has under section 2722(b)(2) in relation to the enforcement of the provisions of part A with respect to issuers of health insurance coverage in the small group market in the State.

“SEC. 2762. PREEMPTION.42 USC
300gg-62.

“(a) IN GENERAL.—Subject to subsection (b), nothing in this part (or part C insofar as it applies to this part) shall be construed to prevent a State from establishing, implementing, or continuing in effect standards and requirements unless such standards and requirements prevent the application of a requirement of this part.

“(b) RULES OF CONSTRUCTION.—Nothing in this part (or part C insofar as it applies to this part) 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. 2763. GENERAL EXCEPTIONS.42 USC
300gg-63.

“(a) EXCEPTION FOR CERTAIN BENEFITS.—The requirements of this part shall not apply to any health insurance coverage in relation to its provision of excepted benefits described in section 2791(c)(1).

“(b) EXCEPTION FOR CERTAIN BENEFITS IF CERTAIN CONDITIONS MET.—The requirements of this part shall not apply to any health insurance coverage in relation to its provision of excepted benefits described in paragraph (2), (3), or (4) of section 2791(c) if the benefits are provided under a separate policy, certificate, or contract of insurance.”.

(b) EFFECTIVE DATE.—42 USC
300gg-41 note.

(1) IN GENERAL.—Except as provided in this subsection, part B of title XXVII of the Public Health Service Act (as inserted by subsection (a)) shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market after June 30, 1997, regardless of when a period of creditable coverage occurs.

(2) APPLICATION OF CERTIFICATION RULES.—The provisions of section 102(d)(2) of this Act shall apply to section 2743 of the Public Health Service Act in the same manner as it applies to section 2701(e) of such Act.

Subtitle C—General and Miscellaneous Provisions

SEC. 191. HEALTH COVERAGE AVAILABILITY STUDIES.42 USC 300gg
note.**(a) STUDIES.—**

(1) STUDY ON EFFECTIVENESS OF REFORMS.—The Secretary of Health and Human Services shall provide for a study on the effectiveness of the provisions of this title 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 non-group basis.

(2) STUDY ON ACCESS AND CHOICE.—The Secretary also shall provide for a study on—

(A) the extent to which patients have direct access to, and choice of, health care providers, including specialty providers, within a network plan, as well as the opportunity to utilize providers outside of the network plan, under the various types of coverage offered under the provisions of this title; and

(B) the cost and cost-effectiveness to health insurance issuers of providing access to out-of-network providers, and the potential impact of providing such access on the cost

and quality of health insurance coverage offered under provisions of this title.

(3) **CONSULTATION.**—The studies under this subsection shall be conducted in consultation with the Secretary of Labor, representatives of State officials, consumers, and other representatives of individuals and entities that have expertise in health insurance and employee benefits.

(b) **REPORTS.**—Not later than January 1, 2000, the Secretary shall submit to the appropriate committees of Congress a report on each of the studies under subsection (a).

SEC. 192. REPORT ON MEDICARE REIMBURSEMENT OF TELEMEDICINE.

The Health Care Financing Administration shall complete its ongoing study of Medicare reimbursement of all telemedicine services and submit a report to Congress on Medicare reimbursement of telemedicine services by not later than March 1, 1997. The report shall—

(1) utilize data compiled from the current demonstration projects already under review and gather data from other ongoing telemedicine networks;

(2) include an analysis of the cost of services provided via telemedicine; and

(3) include a proposal for Medicare reimbursement of such services.

SEC. 193. ALLOWING FEDERALLY-QUALIFIED HMOS TO OFFER HIGH DEDUCTIBLE PLANS.

Section 1301(b) of the Public Health Service Act (42 U.S.C. 300e(b)) is amended by adding at the end the following new paragraph:

“(6) A health maintenance organization that otherwise meets the requirements of this title may offer a high-deductible health plan (as defined in section 220(c)(2) of the Internal Revenue Code of 1986).”.

SEC. 194. VOLUNTEER SERVICES PROVIDED BY HEALTH PROFESSIONALS AT FREE CLINICS.

Section 224 of the Public Health Service Act (42 U.S.C. 233) is amended by adding at the end the following subsection:

“(o)(1) For purposes of this section, a free clinic health professional shall in providing a qualifying health service to an individual be deemed to be an employee of the Public Health Service for a calendar year that begins during a fiscal year for which a transfer was made under paragraph (6)(D). The preceding sentence is subject to the provisions of this subsection.

“(2) In providing a health service to an individual, a health care practitioner shall for purposes of this subsection be considered to be a free clinic health professional if the following conditions are met:

“(A) The service is provided to the individual at a free clinic, or through offsite programs or events carried out by the free clinic.

“(B) The free clinic is sponsoring the health care practitioner pursuant to paragraph (5)(C).

“(C) The service is a qualifying health service (as defined in paragraph (4)).

“(D) Neither the health care practitioner nor the free clinic receives any compensation for the service from the individual

or from any third-party payor (including reimbursement under any insurance policy or health plan, or under any Federal or State health benefits program). With respect to compliance with such condition:

“(i) The health care practitioner may receive repayment from the free clinic for reasonable expenses incurred by the health care practitioner in the provision of the service to the individual.

“(ii) The free clinic may accept voluntary donations for the provision of the service by the health care practitioner to the individual.

“(E) Before the service is provided, the health care practitioner or the free clinic provides written notice to the individual of the extent to which the legal liability of the health care practitioner is limited pursuant to this subsection (or in the case of an emergency, the written notice is provided to the individual as soon after the emergency as is practicable). If the individual is a minor or is otherwise legally incompetent, the condition under this subparagraph is that the written notice be provided to a legal guardian or other person with legal responsibility for the care of the individual.

“(F) At the time the service is provided, the health care practitioner is licensed or certified in accordance with applicable law regarding the provision of the service.

“(3)(A) For purposes of this subsection, the term ‘free clinic’ means a health care facility operated by a nonprofit private entity meeting the following requirements:

“(i) The entity does not, in providing health services through the facility, accept reimbursement from any third-party payor (including reimbursement under any insurance policy or health plan, or under any Federal or State health benefits program).

“(ii) The entity, in providing health services through the facility, either does not impose charges on the individuals to whom the services are provided, or imposes a charge according to the ability of the individual involved to pay the charge.

“(iii) The entity is licensed or certified in accordance with applicable law regarding the provision of health services.

“(B) With respect to compliance with the conditions under subparagraph (A), the entity involved may accept voluntary donations for the provision of services.

“(4) For purposes of this subsection, the term ‘qualifying health service’ means any medical assistance required or authorized to be provided in the program under title XIX of the Social Security Act, without regard to whether the medical assistance is included in the plan submitted under such program by the State in which the health care practitioner involved provides the medical assistance. References in the preceding sentence to such program shall as applicable be considered to be references to any successor to such program.

“(5) Subsection (g) (other than paragraphs (3) through (5)) and subsections (h), (i), and (l) apply to a health care practitioner for purposes of this subsection to the same extent and in the same manner as such subsections apply to an officer, governing board member, employee, or contractor of an entity described in subsection (g)(4), subject to paragraph (6) and subject to the following:

“(A) The first sentence of paragraph (1) applies in lieu of the first sentence of subsection (g)(1)(A).

“(B) This subsection may not be construed as deeming any free clinic to be an employee of the Public Health Service for purposes of this section.

“(C) With respect to a free clinic, a health care practitioner is not a free clinic health professional unless the free clinic sponsors the health care practitioner. For purposes of this subsection, the free clinic shall be considered to be sponsoring the health care practitioner if—

“(i) with respect to the health care practitioner, the free clinic submits to the Secretary an application meeting the requirements of subsection (g)(1)(D); and

“(ii) the Secretary, pursuant to subsection (g)(1)(E), determines that the health care practitioner is deemed to be an employee of the Public Health Service.

“(D) In the case of a health care practitioner who is determined by the Secretary pursuant to subsection (g)(1)(E) to be a free clinic health professional, this subsection applies to the health care practitioner (with respect to the free clinic sponsoring the health care practitioner pursuant to subparagraph (C)) for any cause of action arising from an act or omission of the health care practitioner occurring on or after the date on which the Secretary makes such determination.

“(E) Subsection (g)(1)(F) applies to a health care practitioner for purposes of this subsection only to the extent that, in providing health services to an individual, each of the conditions specified in paragraph (2) is met.

“(6)(A) For purposes of making payments for judgments against the United States (together with related fees and expenses of witnesses) pursuant to this section arising from the acts or omissions of free clinic health professionals, there is authorized to be appropriated \$10,000,000 for each fiscal year.

“(B) The Secretary shall establish a fund for purposes of this subsection. Each fiscal year amounts appropriated under subparagraph (A) shall be deposited in such fund.

Reports.

“(C) Not later than May 1 of each fiscal year, the Attorney General, in consultation with the Secretary, shall submit to the Congress a report providing an estimate of the amount of claims (together with related fees and expenses of witnesses) that, by reason of the acts or omissions of free clinic health professionals, will be paid pursuant to this section during the calendar year that begins in the following fiscal year. Subsection (k)(1)(B) applies to the estimate under the preceding sentence regarding free clinic health professionals to the same extent and in the same manner as such subsection applies to the estimate under such subsection regarding officers, governing board members, employees, and contractors of entities described in subsection (g)(4).

“(D) Not later than December 31 of each fiscal year, the Secretary shall transfer from the fund under subparagraph (B) to the appropriate accounts in the Treasury an amount equal to the estimate made under subparagraph (C) for the calendar year beginning in such fiscal year, subject to the extent of amounts in the fund.

Effective date.

“(7)(A) This subsection takes effect on the date of the enactment of the first appropriations Act that makes an appropriation under paragraph (6)(A), except as provided in subparagraph (B)(i).

“(B)(i) Effective on the date of the enactment of the Health Insurance Portability and Accountability Act of 1996—

“(I) the Secretary may issue regulations for carrying out this subsection, and the Secretary may accept and consider applications submitted pursuant to paragraph (5)(C); and

“(II) reports under paragraph (6)(C) may be submitted to the Congress.

“(ii) For the first fiscal year for which an appropriation is made under subparagraph (A) of paragraph (6), if an estimate under subparagraph (C) of such paragraph has not been made for the calendar year beginning in such fiscal year, the transfer under subparagraph (D) of such paragraph shall be made notwithstanding the lack of the estimate, and the transfer shall be made in an amount equal to the amount of such appropriation.”

SEC. 195. FINDINGS; SEVERABILITY.

42 USC 300gg
note.

(a) **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 preexisting condition exclusions 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.

(b) **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—PREVENTING HEALTH CARE FRAUD AND ABUSE; ADMINISTRATIVE SIMPLIFICATION

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) (relat-

ing 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 Insurance Portability and Accountability 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).

“(D) APPLICATION.—Nothing in subparagraph (C)(iii) shall be construed to limit the availability of recoveries and forfeitures obtained under title I of the Employee Retirement Income Security Act of 1974 for the purpose of providing equitable or remedial relief for employee welfare benefit plans, and for participants and beneficiaries under such plans, as authorized under such title.

“(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.—Not later than January 1, the Secretary and the Attorney General shall submit jointly a report to Congress which identifies—

“(A) the amounts appropriated to the Trust Fund for the previous fiscal year under paragraph (2)(A) and the source of such amounts; and

“(B) the amounts appropriated from the Trust Fund for such year under paragraph (3) and the justification for the expenditure of such amounts.

“(6) GAO REPORT.—Not later than January 1 of 2000, 2002, and 2004, the Comptroller General of the United States shall submit a report to Congress which—

“(A) identifies—

“(i) the amounts appropriated to the Trust Fund for the previous two fiscal years under paragraph (2)(A) and the source of such amounts; and

“(ii) the amounts appropriated from the Trust Fund for such fiscal years under paragraph (3) and the justification for the expenditure of such amounts;

“(B) identifies any expenditures from the Trust Fund with respect to activities not involving the Medicare program under title XVIII;

“(C) identifies any savings to the Trust Fund, and any other savings, resulting from expenditures from the Trust Fund; and

“(D) analyzes such other aspects of the operation of the Trust Fund as the Comptroller General of the United States considers appropriate.”

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

42 USC 1395ddd.

“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 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, 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 complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement; 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) Procedures for identifying, evaluating, and resolving organizational conflicts of interest that are generally applicable to Federal acquisition and procurement.

“(2) Competitive procedures to be used—

“(A) when entering into new contracts under this section;

Regulations.

“(B) when entering into contracts that may result in the elimination of responsibilities of an individual fiscal intermediary or carrier under section 202(b) of the Health Insurance Portability and Accountability Act of 1996; and

“(C) at any other time considered appropriate by the Secretary,

except that the Secretary may continue to 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) Procedures under which 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.

The Secretary may enter into such contracts without regard to final rules having been promulgated.

Regulations.

“(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:

“(1) 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)).”.

42 USC 1395b-5.

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 in or who have engaged in acts or omissions which constitute grounds for the imposition of a sanction under section 1128, 1128A, or 1128B of the Social Security Act, or who have otherwise engaged in fraud and abuse against the Medicare program under title XVIII of such act 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 ANTIFRAUD 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 (as defined in subsection (f))”.

(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).”.

42 USC 1320a-7b note.

(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

42 USC 1320a-7d.

“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

Federal Register, publication.

Federal Register, publication.

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, in consultation with the Attorney General, 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 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 issue to a party requesting an advisory opinion by not later than 60 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.

“(6) APPLICATION OF SUBSECTION.—This subsection shall apply to requests for advisory opinions made on or after the date which is 6 months after the date of enactment of this section and before the date which is 4 years after such date of enactment.

“(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 under title XVIII 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 for an offense which occurred after the date of the enactment of the Health Insurance Portability and Accountability 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 for an offense which occurred after the date of the enactment of the Health Insurance Port-

ability and Accountability 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 for an offense which occurred after the date of the enactment of the Health Insurance Portability and Accountability 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, 1997.

42 USC 1395mm
note.

SEC. 216. ADDITIONAL EXCEPTION TO ANTI-KICKBACK PENALTIES FOR RISK-SHARING 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, through a risk-sharing arrangement, 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.”.

(b) **NEGOTIATED RULEMAKING FOR RISK-SHARING EXCEPTION.**—

42 USC 1320a-
7b note.

(1) **ESTABLISHMENT.**—

(A) **IN GENERAL.**—The Secretary of Health and Human Services (in this subsection referred to as the “Secretary”) shall establish, on an expedited basis and using a negotiated rulemaking process under subchapter 3 of chapter 5 of title 5, United States Code, standards relating to the exception for risk-sharing arrangements to the anti-kickback penalties described in section 1128B(b)(3)(F) of the Social Security Act, as added by subsection (a).

(B) **FACTORS TO CONSIDER.**—In establishing standards relating to the exception for risk-sharing arrangements to the anti-kickback penalties under subparagraph (A), the Secretary—

(i) shall consult with the Attorney General and representatives of the hospital, physician, other health practitioner, and health plan communities, and other interested parties; and

(ii) shall take into account—

(I) the level of risk appropriate to the size and type of arrangement;

(II) the frequency of assessment and distribution of incentives;

(III) the level of capital contribution; and

(IV) the extent to which the risk-sharing arrangement provides incentives to control the cost and quality of health care services.

(2) **PUBLICATION OF NOTICE.**—In carrying out the rulemaking process under this subsection, the Secretary shall publish the notice provided for under section 564(a) of title 5, United States Code, by not later than 45 days after the date of the enactment of this Act.

(3) **TARGET DATE FOR PUBLICATION OF RULE.**—As part of the notice under paragraph (2), and for purposes of this subsection, the “target date for publication” (referred to in section 564(a)(5) of such title) shall be January 1, 1997.

(4) **ABBREVIATED PERIOD FOR SUBMISSION OF COMMENTS.**—In applying section 564(c) of such title under this subsection, “15 days” shall be substituted for “30 days”.

(5) **APPOINTMENT OF NEGOTIATED RULEMAKING COMMITTEE AND FACILITATOR.**—The Secretary shall provide for—

(A) the appointment of a negotiated rulemaking committee under section 565(a) of such title by not later than 30 days after the end of the comment period provided for under section 564(c) of such title (as shortened under paragraph (4)), and

(B) the nomination of a facilitator under section 566(c) of such title by not later than 10 days after the date of appointment of the committee.

(6) **PRELIMINARY COMMITTEE REPORT.**—The negotiated rulemaking committee appointed under paragraph (5) shall report to the Secretary, by not later than October 1, 1996, regarding the committee’s progress on achieving a consensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before one month before the target date for publication of the rule. If the committee reports that the committee has failed to make significant progress toward such consensus or is unlikely to reach such consensus by the target date, the Secretary may terminate such process and provide for the publication of a rule under this subsection through such other methods as the Secretary may provide.

(7) **FINAL COMMITTEE REPORT.**—If the committee is not terminated under paragraph (6), the rulemaking committee shall submit a report containing a proposed rule by not later than one month before the target publication date.

(8) **INTERIM, FINAL EFFECT.**—The Secretary shall publish a rule under this subsection in the Federal Register by not later than the target publication date. Such rule shall be effective and final immediately on an interim basis, but is subject to change and revision after public notice and opportunity for a period (of not less than 60 days) for public comment. In connection with such rule, the Secretary shall specify the process for the timely review and approval of applications of entities to be certified as provider-sponsored organizations pursuant to such rules and consistent with this subsection.

(9) **PUBLICATION OF RULE AFTER PUBLIC COMMENT.**—The Secretary shall provide for consideration of such comments and republication of such rule by not later than 1 year after the target publication date.

(c) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply to written agreements entered into on or after January 1, 1997, without regard to whether regulations have been issued to implement such amendments.

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

Federal Register,
publication.

42 USC 1320a-
7b note.

(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.

42 USC 1320a-7
note.

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), and shall maintain a database of the information collected under this section.

42 USC 1320a-7e.

“(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, who is the subject of a final adverse action, 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 with respect to 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 the database maintained under this section 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 such 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) COORDINATION WITH NATIONAL PRACTITIONER DATA BANK.—The Secretary shall implement this section in such a manner as to avoid duplication with the reporting requirements established for the National Practitioner Data Bank under the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101 et seq.).

“(g) DEFINITIONS AND SPECIAL RULES.—For purposes of this section:

“(1) FINAL ADVERSE ACTION.—

“(A) IN GENERAL.—The term ‘final adverse action’ includes:

“(i) Civil judgments against a health care provider, supplier, or practitioner in Federal or State court related to the delivery of a health care item or service.

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

“(iii) Actions by Federal or State agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners, including—

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

“(II) any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise, or

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

“(iv) Exclusion from participation in Federal or State health care programs (as defined in sections 1128B(f) and 1128(h), respectively).

“(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 Insurance Portability and Accountability 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 (5 U.S.C. App.) 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) 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 subsection (h)(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.”

(e) 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)), as amended by subsection (b), 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;

(3) in subparagraph (D), by striking the semicolon and inserting “, or”; and

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

“(E) is for a pattern of medical or other items or services that a person knows or should know are not medically necessary;”.

(f) 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”.

(g) 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).”.

(h) 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

(C) 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 Insurance Portability and Accountability 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.”

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

42 USC 1320a-7a note.

SEC. 232. 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.

42 USC 1320a-7a note.

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;

“(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 and willfully 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 knowingly and willfully embezzles, steals, or otherwise without authority 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 24(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 and willfully—

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

“(2) makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false writing or document knowing the same to contain any materially 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 24(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.—(1) 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—

“(A) 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; or

“(B) requiring a custodian of records to give testimony concerning the production and authentication of such records.

“(2) A subpoena under this subsection 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.

“(3) The production of records shall not be required under this section at any place more than 500 miles distant from the

place where the subpoena for the production of such records is served.

“(4) Witnesses summoned under this section shall be paid the same fees and mileage that are paid witnesses in the courts of the United States.

“(b) SERVICE.—A subpoena issued under this section may be served by any person who is at least 18 years of age and is 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 concerning the production and authentication of such records. 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 after all restoration payments (if any) have 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.

(3) **RESTORATION PAYMENT.**—Notwithstanding any other provision of law, if the Federal health care offense referred to in paragraph (1) resulted in a loss to an employee welfare benefit plan within the meaning of section 3(1) of the Employee Retirement Income Security Act of 1974, the Secretary of the Treasury shall transfer to such employee welfare benefit plan, from the amount realized from the forfeiture of property referred to in paragraph (1), an amount equal to such loss. For purposes of paragraph (1), the term “restoration payment” means the amount transferred to an employee welfare benefit plan pursuant to this paragraph.

SEC. 250. RELATION TO ERISA AUTHORITY.

29 USC 1136
note.

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. 261. PURPOSE.

42 USC 1320d
note.

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. 262. 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:

42 USC 1320d.

“(1) **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.

“(2) **HEALTH CARE CLEARINGHOUSE.**—The term ‘health care clearinghouse’ means a public or private entity that processes or facilitates the processing of nonstandard data elements of health information into standard data elements.

“(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 health care 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 an individual or group plan that provides, or pays the cost of, medical care (as such term is defined in section 2791 of the Public Health Service Act). Such term includes the following, and any combination thereof:

“(A) A group health plan (as defined in section 2791(a) of the Public Health Service Act), but only if the plan—

“(i) has 50 or more participants (as defined in section 3(7) of the Employee Retirement Income Security Act of 1974); or

“(ii) is administered by an entity other than the employer who established and maintains the plan.

“(B) A health insurance issuer (as defined in section 2791(b) of the Public Health Service Act).

“(C) A health maintenance organization (as defined in section 2791(b) of the Public Health Service Act).

“(D) Part A or part B of the Medicare program under title XVIII.

“(E) The medicaid program under title XIX.

“(F) A Medicare supplemental policy (as defined in section 1882(g)(1)).

“(G) 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).

“(H) 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.

“(I) The health care program for active military personnel under title 10, United States Code.

“(J) The veterans health care program under chapter 17 of title 38, United States Code.

“(K) The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), as defined in section 1072(4) of title 10, United States Code.

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

“(M) 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 health care 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:

42 USC 1320d-1.

“(1) A health plan.

“(2) A health care 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.

“(3) CONSULTATION REQUIREMENT.—

“(A) IN GENERAL.—A standard may not be adopted under this part unless—

“(i) in the case of a standard that has been developed, adopted, or modified by a standard setting organization, the organization consulted with each of the organizations described in subparagraph (B) in the course of such development, adoption, or modification; and

“(ii) in the case of any other standard, the Secretary, in complying with the requirements of subsection (f), consulted with each of the organizations described in subparagraph (B) before adopting the standard.

“(B) ORGANIZATIONS DESCRIBED.—The organizations referred to in subparagraph (A) are the following:

“(i) The National Uniform Billing Committee.

“(ii) The National Uniform Claim Committee.

“(iii) The Workgroup for Electronic Data Interchange.

“(iv) The American Dental Association.

“(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 transactions with respect to the following:

“(A) Health claims or equivalent encounter information.

“(B) Health claims attachments.

“(C) Enrollment and disenrollment in a health plan.

“(D) Eligibility for a health plan.

“(E) Health care payment and remittance advice.

“(F) Health plan premium payments.

“(G) First report of injury.

“(H) Health claim 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 paragraph (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 health care clearinghouse, if it is part of a larger organization, has policies and security procedures which isolate the activities of the health care 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) ELECTRONIC SIGNATURE.—

“(1) 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).

“(2) EFFECT OF COMPLIANCE.—Compliance with the standards adopted under paragraph (1) shall be deemed to satisfy Federal and State statutory requirements for written signatures with respect to the transactions referred to in subsection (a)(1).

“(f) 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

42 USC 1320d-3.

“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 Insurance Portability and Accountability 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 12 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.—

42 USC 1320d-4.

“(1) IN GENERAL.—If a person desires to conduct a transaction referred to in section 1173(a)(1) with a health plan as a standard transaction—

“(A) the health plan may not refuse to conduct such transaction as a standard transaction;

“(B) the insurance plan may not delay such transaction, or otherwise adversely affect, or attempt to adversely affect, the person or the transaction on the ground that the transaction is a standard transaction; and

“(C) the information transmitted and received in connection with the transaction shall be in the form of standard data elements of health information.

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

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

“(B) submitting nonstandard data elements to a health care clearinghouse for processing into standard data elements and transmission by the health care clearinghouse, and receiving standard data elements through the health care clearinghouse.

“(3) TIMETABLE FOR COMPLIANCE.—Paragraph (1) shall not be construed to require a health plan to comply with any standard, implementation specification, or modification to a standard or specification adopted or established by the Secretary under sections 1172 through 1174 at any time prior to the date on which the plan is required to comply with the standard or specification under subsection (b).

“(b) COMPLIANCE WITH STANDARDS.—

“(1) INITIAL COMPLIANCE.—

“(A) IN GENERAL.—Not later than 24 months after the date on which an initial standard or implementation specification is adopted or established under sections 1172 and 1173, each person to whom the standard or implementation specification applies shall comply with the standard or specification.

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

“(2) COMPLIANCE WITH MODIFIED STANDARDS.—If the Secretary adopts a modification to a standard or implementation specification under this part, each person to whom the standard or implementation specification applies shall comply with the modified standard or implementation specification at such time as the Secretary determines appropriate, taking into account the time needed to comply due to the nature and extent of the modification. The time determined appropriate under the preceding sentence may not be earlier than the last day of the 180-day period beginning on the date such modification is adopted. The Secretary may extend the time for compliance for small health plans, if the Secretary determines that such extension is appropriate.

“(3) CONSTRUCTION.—Nothing in this subsection shall be construed to prohibit any person from complying with a standard or specification by—

“(A) submitting nonstandard data elements to a health care clearinghouse for processing into standard data elements and transmission by the health care clearinghouse; or

“(B) receiving standard data elements through a health care clearinghouse.

“GENERAL PENALTY FOR FAILURE TO COMPLY WITH REQUIREMENTS
AND STANDARDS

42 USC 1320d-5.

“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— 42 USC 1320d-6.

“(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, be fined not more than \$250,000, imprisoned not more than 10 years, or both.

“EFFECT ON STATE LAW

“SEC. 1178. (a) GENERAL EFFECT.—

42 USC 1320d-7.

“(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) is a provision the Secretary determines—

“(i) is necessary—

“(I) to prevent fraud and abuse;

“(II) to ensure appropriate State regulation of insurance and health plans;

“(III) for State reporting on health care delivery or costs; or

“(IV) for other purposes; or

“(ii) addresses controlled substances; or

“(B) subject to section 264(c)(2) of the Health Insurance Portability and Accountability Act of 1996, relates to the privacy of individually identifiable health information.

“(b) PUBLIC HEALTH.—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.

“(c) STATE REGULATORY REPORTING.—Nothing in this part shall limit the ability of a State to require a health plan to report, or to provide access to, information for management audits, financial audits, program monitoring and evaluation, facility licensure or certification, or individual licensure or certification.

“PROCESSING PAYMENT TRANSACTIONS BY FINANCIAL INSTITUTIONS

42 USC 1320d-8.

“SEC. 1179. To the extent that an entity is engaged in activities of a financial institution (as defined in section 1101 of the Right to Financial Privacy Act of 1978), or is engaged in authorizing, processing, clearing, settling, billing, transferring, reconciling, or collecting payments, for a financial institution, this part, and any standard adopted under this part, shall not apply to the entity with respect to such activities, including the following:

“(1) The use or disclosure of information by the entity for authorizing, processing, clearing, settling, billing, transferring, reconciling or collecting, a payment for, or related to, health plan premiums or health care, where such payment is made by any means, including a credit, debit, or other payment card, an account, check, or electronic funds transfer.

“(2) The request for, or the use or disclosure of, information by the entity with respect to a payment described in paragraph (1)—

“(A) for transferring receivables;

“(B) for auditing;

“(C) in connection with—

“(i) a customer dispute; or

- “(ii) an inquiry from, or to, a customer;
- “(D) in a communication to a customer of the entity regarding the customer’s transactions, payment card, account, check, or electronic funds transfer;
- “(E) for reporting to consumer reporting agencies; or
- “(F) for complying with—
 - “(i) a civil or criminal subpoena; or
 - “(ii) a Federal or State law regulating the entity.”.

(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 health care 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 health care 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. 263. 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 Insurance Portability and Accountability 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 Insurance Portability and Accountability 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;

Reports.

“(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;

Reports.

“(C) shall report to the Secretary not later than 4 years after the date of the enactment of the Health Insurance Portability and Accountability 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 Insurance Portability and Accountability Act of 1996, and annually thereafter, the Committee shall submit to the Congress, and make public, a report regarding the implementation of part C of title XI of the Social Security Act. Such report shall address the following subjects, to the extent that the Committee determines appropriate: Reports.

“(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 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.

“(E) The extent to which timetables under such part are being met.”.

SEC. 264. RECOMMENDATIONS WITH RESPECT TO PRIVACY OF CERTAIN HEALTH INFORMATION.

42 USC 1320d-2
note.

(a) **IN GENERAL.**—Not later than the date that is 12 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the Committee on Labor and Human Resources and the Committee on Finance of the Senate and the Committee on Commerce and the Committee on Ways and Means of the House of Representatives detailed recommendations on standards with respect to the privacy of individually identifiable health information.

(b) **SUBJECTS FOR RECOMMENDATIONS.**—The recommendations under subsection (a) shall address at least the following:

(1) The rights that an individual who is a subject of individually identifiable health information should have.

(2) The procedures that should be established for the exercise of such rights.

(3) The uses and disclosures of such information that should be authorized or required.

(c) **REGULATIONS.**—

(1) **IN GENERAL.**—If legislation governing standards with respect to the privacy of individually identifiable health information transmitted in connection with the transactions described in section 1173(a) of the Social Security Act (as added by section 262) is not enacted by the date that is 36 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall promulgate final regulations containing such standards not later than the date that is 42 months after the date of the enactment of this Act. Such regulations shall address at least the subjects described in subsection (b). Regulations.

(2) **PREEMPTION.**—A regulation promulgated under paragraph (1) shall not supercede a contrary provision of State

law, if the provision of State law imposes requirements, standards, or implementation specifications that are more stringent than the requirements, standards, or implementation specifications imposed under the regulation.

(d) CONSULTATION.—In carrying out this section, the Secretary of Health and Human Services shall consult with—

- (1) 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
- (2) the Attorney General.

Subtitle G—Duplication and Coordination of Medicare-Related Plans

SEC. 271. DUPLICATION AND COORDINATION OF MEDICARE-RELATED PLANS.

(a) TREATMENT OF CERTAIN HEALTH INSURANCE POLICIES AS NONDUPLICATIVE.—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 (other than a Medicare supplemental 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) do not apply to such a policy.

“(v) For purposes of this subparagraph, a health insurance policy (or a rider to an insurance contract which is not a health insurance policy) is not considered to ‘duplicate’ health benefits under this title or under another health insurance policy if it—

“(I) provides health care benefits only for long-term care, nursing home care, home health care, or community-based care, or any combination thereof,

“(II) coordinates against or excludes items and services available or paid for under this title or under another health insurance policy, and

“(III) for policies sold or issued on or after the end of the 90-day period beginning on the date of enactment of the Health Insurance Portability and Accountability Act of 1996 discloses such coordination or exclusion in the policy’s outline of coverage.

For purposes of this clause, the terms ‘coordinates’ and ‘coordination’ mean, with respect to a policy in relation to health benefits under this title or under another health insurance policy, 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 or under another health insurance policy.

“(vi)(I) An individual entitled to benefits under part A or enrolled under part B of this title who is applying for a health insurance policy (other than a policy described in subclause (III)) shall be furnished a disclosure statement described in clause (vii) for the type of policy being applied for. Such statement shall be

furnished as a part of (or together with) the application for such policy.

“(II) Whoever issues or sells a health insurance policy (other than a policy described in subclause (III)) to an individual described in subclause (I) and fails to furnish the appropriate disclosure statement as required under such subclause shall be fined under title 18, United States Code, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed \$25,000 (or \$15,000 in the case of a person other than the issuer of the policy) for each such violation.

“(III) A policy described in this subclause (to which subclauses (I) and (II) do not apply) is a Medicare supplemental policy or a health insurance policy identified under 60 Federal Register 30880 (June 12, 1995) as a policy not required to have a disclosure statement.

“(IV) Any reference in this section to the revised NAIC model regulation (referred to in subsection (m)(1)(A)) is deemed a reference to such regulation as revised by section 171(m)(2) of the Social Security Act Amendments of 1994 (Public Law 103-432) and as modified by substituting, for the disclosure required under section 16D(2), disclosure under subclause (I) of an appropriate disclosure statement under clause (vii).

“(vii) The disclosure statement described in this clause for a type of policy is the statement specified under subparagraph (D) of this paragraph (as in effect before the date of the enactment of the Health Insurance Portability and Accountability Act of 1996) for that type of policy, as revised as follows:

“(I) In each statement, amend the second line to read as follows:

‘THIS IS NOT MEDICARE SUPPLEMENT INSURANCE’.

“(II) In each statement, strike the third line and insert the following: **‘Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.’**

“(III) In each statement not described in subclause (V), strike the boldface matter that begins **‘This insurance’** and all that follows up to the next paragraph that begins **‘Medicare’**.

“(IV) In each statement not described in subclause (V), insert before the boxed matter (that states **‘Before You Buy This Insurance’**) the following: **‘This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.’**

“(V) In a statement relating to policies providing both nursing home and non-institutional coverage, to policies providing nursing home benefits only, or policies providing home care benefits only, amend the sentence that begins **‘Federal law’** to read as follows: **‘Federal law requires us to inform you that in certain situations this insurance may pay for some care also covered by Medicare.’**

“(viii)(I) Subject to subclause (II), nothing in this subparagraph shall restrict or preclude a State’s ability to regulate health insur-

ance policies, including any health insurance policy that is described in clause (iv), (v), or (vi)(III).

“(II) A State may not declare or specify, in statute, regulation, or otherwise, that a health insurance policy (other than a Medicare supplemental policy) or rider to an insurance contract which is not a health insurance policy, that is described in clause (iv), (v), or (vi)(III) and that is sold, issued, or renewed to an individual entitled to benefits under part A or enrolled under part B ‘duplicates’ health benefits under this title or under a Medicare supplemental policy.”

(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).

(c) TRANSITIONAL PROVISION.—

(1) NO PENALTIES.—Subject to paragraph (3), no criminal or civil money penalty may be imposed under section 1882(d)(3)(A) of the Social Security Act for any act or omission that occurred during the transition period (as defined in paragraph (4)) and that relates to any health insurance policy that is described in clause (iv) or (v) of such section (as amended by subsection (a)).

(2) LIMITATION ON LEGAL ACTION.—Subject to paragraph (3), no legal action shall be brought or continued in any Federal or State court insofar as such action—

(A) includes a cause of action which arose, or which is based on or evidenced by any act or omission which occurred, during the transition period; and

(B) relates to the application of section 1882(d)(3)(A) of the Social Security Act to any act or omission with respect to the sale, issuance, or renewal of any health insurance policy that is described in clause (iv) or (v) of such section (as amended by subsection (a)).

(3) DISCLOSURE CONDITION.—In the case of a policy described in clause (iv) of section 1882(d)(3)(A) of the Social Security Act that is sold or issued on or after the effective date of statements under section 171(d)(3)(C) of the Social Security Act Amendments of 1994 and before the end of the 30-day period beginning on the date of the enactment of this Act, paragraphs (1) and (2) shall only apply if disclosure was made in accordance with section 1882(d)(3)(C)(ii) of the Social Security Act (as in effect before the date of the enactment of this Act).

(4) TRANSITION PERIOD.—In this subsection, the term “transition period” means the period beginning on November 5, 1991, and ending on the date of the enactment of this Act.

(d) EFFECTIVE DATE.—(1) Except as provided in this subsection, the amendment made by subsection (a) shall be effective as if included in the enactment of section 4354 of the Omnibus Budget Reconciliation Act of 1990.

42 USC 1395ss
note.

42 USC 1395ss
note.

(2)(A) Clause (vi) of section 1882(d)(3)(A) of the Social Security Act, as added by subsection (a), shall only apply to individuals applying for—

(i) a health insurance policy described in section 1882(d)(3)(A)(iv) of such Act (as added by subsection (a)), after the date of the enactment of this Act, or

(ii) another health insurance policy after the end of the 30-day period beginning on the date of the enactment of this Act.

(B) A seller or issuer of a health insurance policy may substitute, for the disclosure statement described in clause (vii) of such section, the statement specified under section 1882(d)(3)(D) of the Social Security Act (as in effect before the date of the enactment of this Act), without the revision specified in such clause.

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.—The amount allowable as a deduction under subsection (a) to an individual for the taxable year shall not exceed the sum of the monthly limitations for months during such taxable year that the individual is an eligible individual.

“(2) MONTHLY LIMITATION.—The monthly limitation for any month is the amount equal to $\frac{1}{12}$ of—

“(A) in the case of an individual who has self-only coverage under the high deductible health plan as of the first day of such month, 65 percent of the annual deductible under such coverage, and

“(B) in the case of an individual who has family coverage under the high deductible health plan as of the

first day of such month, 75 percent of the annual deductible under such coverage.

“(3) SPECIAL RULE FOR MARRIED INDIVIDUALS.—In the case of individuals who are married to each other, if either spouse has family coverage—

“(A) both spouses shall be treated as having only such family coverage (and if such spouses each have family coverage under different plans, as having the family coverage with the lowest annual deductible), and

“(B) the limitation under paragraph (1) (after the application of subparagraph (A) of this paragraph) shall be divided equally between them unless they agree on a different division.

“(4) DEDUCTION NOT TO EXCEED COMPENSATION.—

“(A) EMPLOYEES.—The deduction allowed under subsection (a) for contributions as an eligible individual described in subclause (I) of subsection (c)(1)(A)(iii) shall not exceed such individual’s wages, salaries, tips, and other employee compensation which are attributable to such individual’s employment by the employer referred to in such subclause.

“(B) SELF-EMPLOYED INDIVIDUALS.—The deduction allowed under subsection (a) for contributions as an eligible individual described in subclause (II) of subsection (c)(1)(A)(iii) shall not exceed such individual’s earned income (as defined in section 401(c)(1)) derived by the taxpayer from the trade or business with respect to which the high deductible health plan is established.

“(C) COMMUNITY PROPERTY LAWS NOT TO APPLY.—The limitations under this paragraph shall be determined without regard to community property laws.

“(5) 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 contributed to any medical savings account of such individual for such year which is excludable from gross income under section 106(b), or

“(B) if such individual’s spouse is covered under the high deductible health plan covering such individual, any amount is contributed for such year to any medical savings account of such spouse which is so excludable.

“(6) 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 if—

“(i) such individual is covered under a high deductible health plan as of the 1st day of such month,

“(ii) such individual 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, and

“(iii)(I) the high deductible health plan covering
such individual is established and maintained by
the employer of such individual or of the spouse of
such individual and such employer is a small employer,
or

“(II) such individual is an employee (within the
meaning of section 401(c)(1)) or the spouse of such
an employee and the high deductible health plan cover-
ing such individual is not established or maintained
by any employer of such individual or spouse.

“(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 other-
wise) for accidents, disability, dental care, vision care,
or long-term care.

“(C) CONTINUED ELIGIBILITY OF EMPLOYEE AND SPOUSE
ESTABLISHING MEDICAL SAVINGS ACCOUNTS.—If, while an
employer is a small employer—

“(i) any amount is contributed to a medical savings
account of an individual who is an employee of such
employer or the spouse of such an employee, and

“(ii) such amount is excludable from gross income
under section 106(b) or allowable as a deduction under
this section,

such individual shall not cease to meet the requirement
of subparagraph (A)(iii)(I) by reason of such employer ceas-
ing to be a small employer so long as such employee contin-
ues to be an employee of such employer.

“(D) LIMITATIONS ON ELIGIBILITY.—

**“For limitations on number of taxpayers who are eligible to have
medical savings accounts, see subsection (i).**

“(2) HIGH DEDUCTIBLE HEALTH PLAN.—

“(A) IN GENERAL.—The term ‘high deductible health
plan’ means a health plan—

“(i) in the case of self-only coverage, which has
an annual deductible which is not less than \$1,500
and not more than \$2,250,

“(ii) in the case of family coverage, which has
an annual deductible which is not less than \$3,000
and not more than \$4,500, and

“(iii) the annual out-of-pocket expenses required
to be paid under the plan (other than for premiums)
for covered benefits does not exceed—

“(I) \$3,000 for self-only coverage, and

“(II) \$5,500 for family coverage.

“(B) SPECIAL RULES.—

“(i) EXCLUSION OF CERTAIN PLANS.—Such term does
not include a health plan if substantially all of its
coverage is coverage described in paragraph (1)(B).

“(ii) **SAFE HARBOR FOR ABSENCE OF PREVENTIVE CARE DEDUCTIBLE.**—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.

“(4) **SMALL EMPLOYER.**—

“(A) **IN GENERAL.**—The term ‘small employer’ means, with respect to any calendar year, any employer if such employer employed an average of 50 or fewer employees on business days during either of the 2 preceding calendar years. For purposes of the preceding sentence, a preceding calendar year may be taken into account only if the employer was in existence throughout such year.

“(B) **EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.**—In the case of an employer which was not in existence throughout the 1st preceding calendar year, the determination under subparagraph (A) shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

“(C) **CERTAIN GROWING EMPLOYERS RETAIN TREATMENT AS SMALL EMPLOYER.**—The term ‘small employer’ includes, with respect to any calendar year, any employer if—

“(i) such employer met the requirement of subparagraph (A) (determined without regard to subparagraph (B)) for any preceding calendar year after 1996,

“(ii) any amount was contributed to the medical savings account of any employee of such employer with respect to coverage of such employee under a high deductible health plan of such employer during such preceding calendar year and such amount was excludable from gross income under section 106(b) or allowable as a deduction under this section, and

“(iii) such employer employed an average of 200 or fewer employees on business days during each preceding calendar year after 1996.

“(D) **SPECIAL RULES.**—

“(i) **CONTROLLED GROUPS.**—For purposes of this paragraph, all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as 1 employer.

“(ii) PREDECESSORS.—Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.

“(5) FAMILY COVERAGE.—The term ‘family coverage’ means any coverage other than self-only coverage.

“(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 75 percent of the highest annual limit deductible permitted under subsection (c)(2)(A)(ii) for such calendar year.

“(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.

“(C) MEDICAL EXPENSES OF INDIVIDUALS WHO ARE NOT ELIGIBLE INDIVIDUALS.—Subparagraph (A) shall apply to an amount paid by an account holder for medical care of an individual who is not an eligible individual for the month in which the expense for such care is incurred only if no amount is contributed (other than a rollover contribution) to any medical savings account of such account holder for the taxable year which includes such month. This subparagraph shall not apply to any expense for coverage described in subclause (I) or (III) of subparagraph (B)(ii).

“(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. 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.—Any amount paid or distributed out of a medical savings account which is used exclusively to pay qualified medical expenses of any account holder shall not be includible in gross income.

“(2) INCLUSION OF AMOUNTS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—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 shall be included in the gross income of such holder.

“(3) EXCESS CONTRIBUTIONS RETURNED BEFORE DUE DATE OF RETURN.—

“(A) IN GENERAL.—If any excess contribution is contributed for a taxable year to any medical savings account of an individual, paragraph (2) shall not apply to distributions from the medical savings accounts of such individual (to the extent such distributions do not exceed the aggregate excess contributions to all such accounts of such individual for such year) if—

“(i) 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

“(ii) such distribution is accompanied by the amount of net income attributable to such excess contribution.

Any net income described in clause (ii) shall be included in the gross income of the individual for the taxable year in which it is received.

“(B) EXCESS CONTRIBUTION.—For purposes of subparagraph (A), the term ‘excess contribution’ means any contribution (other than a rollover contribution) which is neither excludable from gross income under section 106(b) nor deductible under this section.

“(4) ADDITIONAL TAX ON 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 15 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 MEDICARE ELIGIBILITY.—Subparagraph (A) shall not apply to any payment or distribution after the date on which the account holder attains the age specified in section 1811 of the Social Security Act.

“(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 such spouse is the account holder.

“(8) TREATMENT AFTER DEATH OF ACCOUNT HOLDER.—

“(A) TREATMENT IF DESIGNATED BENEFICIARY IS SPOUSE.—If the account holder's surviving spouse acquires such holder's interest in a medical savings account by reason of being the designated beneficiary of such account at the death of the account holder, such medical savings account shall be treated as if the spouse were the account holder.

“(B) OTHER CASES.—

“(i) IN GENERAL.—If, by reason of the death of the account holder, any person acquires the account holder's interest in a medical savings account in a case to which subparagraph (A) does not apply—

“(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.

“(ii) SPECIAL RULES.—

“(I) REDUCTION OF INCLUSION FOR PRE-DEATH EXPENSES.—The amount includible in gross income under clause (i) by any person (other than the estate) shall be reduced by the amount of qualified medical expenses which were incurred by the decedent before the date of the decedent's death and paid by such person within 1 year after such date.

“(II) DEDUCTION FOR ESTATE TAXES.—An appropriate deduction shall be allowed under section 691(c) to any person (other than the decedent or the decedent's spouse) with respect to amounts included in gross income under clause (i) by such person.

“(g) COST-OF-LIVING ADJUSTMENT.—In the case of any taxable year beginning in a calendar year after 1998, each dollar amount in subsection (c)(2) shall be increased by an amount equal to—

“(1) such dollar amount, multiplied by

“(2) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins by substituting ‘calendar year 1997’ for ‘calendar year 1992’ in subparagraph (B) thereof.

If any increase under the preceding sentence is not a multiple of \$50, such increase shall be rounded to the nearest multiple of \$50.

“(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 the Secretary.

“(i) LIMITATION ON NUMBER OF TAXPAYERS HAVING MEDICAL SAVINGS ACCOUNTS.—

“(1) IN GENERAL.—Except as provided in paragraph (5), no individual shall be treated as an eligible individual for any taxable year beginning after the cut-off year unless—

“(A) such individual was an active MSA participant for any taxable year ending on or before the close of the cut-off year, or

“(B) such individual first became an active MSA participant for a taxable year ending after the cut-off year by reason of coverage under a high deductible health plan of an MSA-participating employer.

“(2) CUT-OFF YEAR.—For purposes of paragraph (1), the term ‘cut-off year’ means the earlier of—

“(A) calendar year 2000, or

“(B) the first calendar year before 2000 for which the Secretary determines under subsection (j) that the numerical limitation for such year has been exceeded.

“(3) ACTIVE MSA PARTICIPANT.—For purposes of this subsection—

“(A) IN GENERAL.—The term ‘active MSA participant’ means, with respect to any taxable year, any individual who is the account holder of any medical savings account into which any contribution was made which was excludable from gross income under section 106(b), or allowable as a deduction under this section, for such taxable year.

“(B) SPECIAL RULE FOR CUT-OFF YEARS BEFORE 2000.—In the case of a cut-off year before 2000—

“(i) an individual shall not be treated as an eligible individual for any month of such year or an active MSA participant under paragraph (1)(A) unless such individual is, on or before the cut-off date, covered under a high deductible health plan, and

“(ii) an employer shall not be treated as an MSA-participating employer unless the employer, on or before the cut-off date, offered coverage under a high deductible health plan to any employee.

“(C) CUT-OFF DATE.—For purposes of subparagraph (B)—

“(i) IN GENERAL.—Except as otherwise provided in this subparagraph, the cut-off date is October 1 of the cut-off year.

“(ii) EMPLOYEES WITH ENROLLMENT PERIODS AFTER OCTOBER 1.—In the case of an individual described in subclause (I) of subsection (c)(1)(A)(iii), if the regularly scheduled enrollment period for health plans of the individual’s employer occurs during the last 3 months of the cut-off year, the cut-off date is December 31 of the cut-off year.

“(iii) SELF-EMPLOYED INDIVIDUALS.—In the case of an individual described in subclause (II) of subsection (c)(1)(A)(iii), the cut-off date is November 1 of the cut-off year.

“(iv) SPECIAL RULES FOR 1997.—If 1997 is a cut-off year by reason of subsection (j)(1)(A)—

“(I) each of the cut-off dates under clauses (i) and (iii) shall be 1 month earlier than the date determined without regard to this clause, and

“(II) clause (ii) shall be applied by substituting ‘4 months’ for ‘3 months’.

“(4) MSA-PARTICIPATING EMPLOYER.—For purposes of this subsection, the term ‘MSA-participating employer’ means any small employer if—

“(A) such employer made any contribution to the medical savings account of any employee during the cut-off year or any preceding calendar year which was excludable from gross income under section 106(b), or

“(B) at least 20 percent of the employees of such employer who are eligible individuals for any month of the cut-off year by reason of coverage under a high deductible health plan of such employer each made a contribution of at least \$100 to their medical savings accounts for any taxable year ending with or within the cut-off year which was allowable as a deduction under this section.

“(5) ADDITIONAL ELIGIBILITY AFTER CUT-OFF YEAR.—If the Secretary determines under subsection (j)(2)(A) that the numerical limit for the calendar year following a cut-off year described in paragraph (2)(B) has not been exceeded—

“(A) this subsection shall not apply to any otherwise eligible individual who is covered under a high deductible health plan during the first 6 months of the second calendar year following the cut-off year (and such individual shall be treated as an active MSA participant for purposes of this subsection if a contribution is made to any medical savings account with respect to such coverage), and

“(B) any employer who offers coverage under a high deductible health plan to any employee during such 6-month period shall be treated as an MSA-participating employer for purposes of this subsection if the requirements of paragraph (4) are met with respect to such coverage.

For purposes of this paragraph, subsection (j)(2)(A) shall be applied for 1998 by substituting ‘750,000’ for ‘600,000’.

“(j) DETERMINATION OF WHETHER NUMERICAL LIMITS ARE EXCEEDED.—

“(1) DETERMINATION OF WHETHER LIMIT EXCEEDED FOR 1997.—The numerical limitation for 1997 is exceeded if, based on the reports required under paragraph (4), the number of medical savings accounts established as of—

“(A) April 30, 1997, exceeds 375,000, or

“(B) June 30, 1997, exceeds 525,000.

“(2) DETERMINATION OF WHETHER LIMIT EXCEEDED FOR 1998 OR 1999.—

“(A) IN GENERAL.—The numerical limitation for 1998 or 1999 is exceeded if the sum of—

“(i) the number of MSA returns filed on or before April 15 of such calendar year for taxable years ending with or within the preceding calendar year, plus

“(ii) the Secretary’s estimate (determined on the basis of the returns described in clause (i)) of the number of MSA returns for such taxable years which will be filed after such date,

exceeds 600,000 (750,000 in the case of 1999). For purposes of the preceding sentence, the term ‘MSA return’ means any return on which any exclusion is claimed under section 106(b) or any deduction is claimed under this section.

“(B) ALTERNATIVE COMPUTATION OF LIMITATION.—The numerical limitation for 1998 or 1999 is also exceeded if the sum of—

“(i) 90 percent of the sum determined under subparagraph (A) for such calendar year, plus

“(ii) the product of 2.5 and the number of medical savings accounts established during the portion of such year preceding July 1 (based on the reports required under paragraph (4)) for taxable years beginning in such year,

exceeds 750,000.

“(3) PREVIOUSLY UNINSURED INDIVIDUALS NOT INCLUDED IN DETERMINATION.—

“(A) IN GENERAL.—The determination of whether any calendar year is a cut-off year shall be made by not counting the medical savings account of any previously uninsured individual.

“(B) PREVIOUSLY UNINSURED INDIVIDUAL.—For purposes of this subsection, the term ‘previously uninsured individual’ means, with respect to any medical savings account, any individual who had no health plan coverage (other than coverage referred to in subsection (c)(1)(B)) at any time during the 6-month period before the date such individual’s coverage under the high deductible health plan commences.

“(4) REPORTING BY MSA TRUSTEES.—

“(A) IN GENERAL.—Not later than August 1 of 1997, 1998, and 1999, each person who is the trustee of a medical savings account established before July 1 of such calendar year shall make a report to the Secretary (in such form and manner as the Secretary shall specify) which specifies—

“(i) the number of medical savings accounts established before such July 1 (for taxable years beginning in such calendar year) of which such person is the trustee,

“(ii) the name and TIN of the account holder of each such account, and

“(iii) the number of such accounts which are accounts of previously uninsured individuals.

“(B) ADDITIONAL REPORT FOR 1997.—Not later than June 1, 1997, each person who is the trustee of a medical savings account established before May 1, 1997, shall make an additional report described in subparagraph (A) but only with respect to accounts established before May 1, 1997.

“(C) PENALTY FOR FAILURE TO FILE REPORT.—The penalty provided in section 6693(a) shall apply to any report required by this paragraph, except that—

“(i) such section shall be applied by substituting ‘\$25’ for ‘\$50’, and

“(ii) the maximum penalty imposed on any trustee shall not exceed \$5,000.

“(D) AGGREGATION OF ACCOUNTS.—To the extent practicable, in determining the number of medical savings accounts on the basis of the reports under this paragraph, all medical savings accounts of an individual shall be treated as 1 account and all accounts of individuals who are married to each other shall be treated as 1 account.

“(5) DATE OF MAKING DETERMINATIONS.—Any determination under this subsection that a calendar year is a cut-off year shall be made by the Secretary and shall be published not later than October 1 of such year.”

(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, amounts contributed by such employee’s employer to any medical savings account of such employee shall be treated as employer-provided coverage for medical expenses under an accident or health plan to the extent such amounts do 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.

“(2) 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.

“(3) 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.

“(4) EMPLOYER MSA CONTRIBUTIONS REQUIRED TO BE SHOWN ON RETURN.—Every individual required to file a return under section 6012 for the taxable year shall include on such return the aggregate amount contributed by employers to the medical savings accounts of such individual or such individual’s spouse for such taxable year.

“(5) MSA CONTRIBUTIONS NOT PART OF COBRA COVERAGE.—Paragraph (1) shall not apply for purposes of section 4980B.

“(6) 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.

“(7) CROSS REFERENCE.—

“For penalty on failure by employer to make comparable contributions to the medical savings accounts of comparable employees, see section 4980E.”

(2) EXCLUSION FROM EMPLOYMENT TAXES.—

(A) 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).”

(B) 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).”

(C) 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).”

(3) EMPLOYER CONTRIBUTIONS REQUIRED TO BE SHOWN ON W-2.—Subsection (a) of section 6051 is amended by striking “and” at the end of paragraph (9), by striking the period at the end of paragraph (10) and inserting “, and”, and by inserting after paragraph (10) the following new paragraph:

“(11) the amount contributed to any medical savings account (as defined in section 220(d)) of such employee or such employee’s spouse.”

(4) PENALTY FOR FAILURE OF EMPLOYER TO MAKE COMPARABLE MSA CONTRIBUTIONS.—

(A) IN GENERAL.—Chapter 43 is amended by adding after section 4980D the following new section:

“SEC. 4980E. FAILURE OF EMPLOYER TO MAKE COMPARABLE MEDICAL SAVINGS ACCOUNT CONTRIBUTIONS.

“(a) GENERAL RULE.—In the case of an employer who makes a contribution to the medical savings account of any employee with respect to coverage under a high deductible health plan of the employer during a calendar year, there is hereby imposed a tax on the failure of such employer to meet the requirements of subsection (d) for such calendar year.

“(b) AMOUNT OF TAX.—The amount of the tax imposed by subsection (a) on any failure for any calendar year is the amount

equal to 35 percent of the aggregate amount contributed by the employer to medical savings accounts of employees for taxable years of such employees ending with or within such calendar year.

“(c) **WAIVER BY SECRETARY.**—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 the payment of such tax would be excessive relative to the failure involved.

“(d) **EMPLOYER REQUIRED TO MAKE COMPARABLE MSA CONTRIBUTIONS FOR ALL PARTICIPATING EMPLOYEES.**—

“(1) **IN GENERAL.**—An employer meets the requirements of this subsection for any calendar year if the employer makes available comparable contributions to the medical savings accounts of all comparable participating employees for each coverage period during such calendar year.

“(2) **COMPARABLE CONTRIBUTIONS.**—

“(A) **IN GENERAL.**—For purposes of paragraph (1), the term ‘comparable contributions’ means contributions—

“(i) which are the same amount, or

“(ii) which are the same percentage of the annual deductible limit under the high deductible health plan covering the employees.

“(B) **PART-YEAR EMPLOYEES.**—In the case of an employee who is employed by the employer for only a portion of the calendar year, a contribution to the medical savings account of such employee shall be treated as comparable if it is an amount which bears the same ratio to the comparable amount (determined without regard to this subparagraph) as such portion bears to the entire calendar year.

“(3) **COMPARABLE PARTICIPATING EMPLOYEES.**—For purposes of paragraph (1), the term ‘comparable participating employees’ means all employees—

“(A) who are eligible individuals covered under any high deductible health plan of the employer, and

“(B) who have the same category of coverage.

For purposes of subparagraph (B), the categories of coverage are self-only and family coverage.

“(4) **PART-TIME EMPLOYEES.**—

“(A) **IN GENERAL.**—Paragraph (3) shall be applied separately with respect to part-time employees and other employees.

“(B) **PART-TIME EMPLOYEE.**—For purposes of subparagraph (A), the term ‘part-time employee’ means any employee who is customarily employed for fewer than 30 hours per week.

“(e) **CONTROLLED GROUPS.**—For purposes of this section, all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as 1 employer.

“(f) **DEFINITIONS.**—Terms used in this section which are also used in section 220 have the respective meanings given such terms in section 220.”

(B) **CLERICAL AMENDMENT.**—The table of sections for chapter 43 is amended by adding after the item relating to section 4980D the following new item:

“Sec. 4980E. Failure of employer to make comparable medical savings account contributions.”

(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) **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 medical savings accounts (within the meaning of section 220(d)), the term ‘excess contributions’ means the sum of—

“(1) the aggregate amount contributed for the taxable year to the accounts (other than rollover contributions described in section 220(f)(5)) which is neither excludable from gross income under section 106(b) nor allowable as a deduction under section 220 for such year, and

“(2) the amount determined under this subsection for the preceding taxable year, reduced by the sum of—

“(A) the distributions out of the accounts which were included in gross income under section 220(f)(2), and

“(B) the excess (if any) of—

“(i) the maximum amount allowable as a deduction under section 220(b)(1) (determined without regard to section 106(b)) for the taxable year, over

“(ii) the amount contributed to the accounts for the taxable year.

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.”.

(f) **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.”

(g) **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).”

(h) **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)).”

(i) **CLERICAL AMENDMENT.**—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.”

26 USC 62 note.

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

26 USC 220 note.

(k) **MONITORING OF PARTICIPATION IN MEDICAL SAVINGS ACCOUNTS.**—The Secretary of the Treasury or his delegate shall—

(1) during 1997, 1998, 1999, and 2000, regularly evaluate the number of individuals who are maintaining medical savings accounts and the reduction in revenues to the United States by reason of such accounts, and

(2) provide such reports of such evaluations to Congress as such Secretary determines appropriate.

26 USC 220 note.

(l) **STUDY OF EFFECTS OF MEDICAL SAVINGS ACCOUNTS ON SMALL GROUP MARKET.**—The Comptroller General of the United States shall enter into a contract with an organization with expertise in health economics, health insurance markets, and actuarial

science to conduct a comprehensive study regarding the effects of medical savings accounts in the small group market on—

- (1) selection, including adverse selection,
- (2) health costs, including any impact on premiums of individuals with comprehensive coverage,
- (3) use of preventive care,
- (4) consumer choice,
- (5) the scope of coverage of high deductible plans purchased in conjunction with such accounts, and
- (6) other relevant items.

A report on the results of the study conducted under this subsection shall be submitted to the Congress no later than January 1, 1999. Reports.

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—
1997	40 percent
1998 through 2002	45 percent
2003	50 percent
2004	60 percent
2005	70 percent
2006 or thereafter	80 percent.”

(b) **EXCLUSION FOR AMOUNTS RECEIVED UNDER CERTAIN SELF-INSURED PLANS.**—Paragraph (3) of section 104(a) is amended by inserting “(or through an arrangement having the effect of accident or health insurance)” after “health insurance”.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to taxable years beginning after December 31, 1996. 26 USC 104 note.

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

(g).

“(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 under regulations prescribed 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.

A contract shall not be treated as a qualified long-term care insurance contract unless the determination of whether an individual is a chronically ill individual takes into account at least 5 of such activities.

“(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 of—

“(A) the periodic payments received for any period under all qualified long-term care insurance contracts which are treated as made for qualified long-term care services for an insured, and

“(B) the periodic payments received for such period which are treated under section 101(g) as paid by reason of the death of such insured,

exceeds the per diem limitation for such period, such excess shall be includible in gross income without regard to section 72. A payment shall not be taken into account under subparagraph (B) if the insured is a terminally ill individual (as defined in section 101(g)) at the time the payment is received.

“(2) PER DIEM LIMITATION.—For purposes of paragraph (1), the per diem limitation for any period is an amount equal to the excess (if any) of—

“(A) the greater of—

“(i) the dollar amount in effect for such period under paragraph (4), or

“(ii) the costs incurred for qualified long-term care services provided for the insured for such period, over

“(B) the aggregate payments received as reimbursements (through insurance or otherwise) for qualified long-term care services provided for the insured during such period.

“(3) AGGREGATION RULES.—For purposes of this subsection—

“(A) all persons receiving periodic payments described in paragraph (1) with respect to the same insured shall be treated as 1 person, and

“(B) the per diem limitation determined under paragraph (2) shall be allocated first to the insured and any remaining limitation shall be allocated among the other

such persons in such manner as the Secretary shall prescribe.

“(4) 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).

“(5) INFLATION ADJUSTMENT.—In the case of a calendar year after 1997, the dollar amount contained in paragraph (4) shall be increased at the same time and in the same manner as amounts are increased pursuant to section 213(d)(10).

“(6) PERIODIC PAYMENTS.—For purposes of this subsection, 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.

“(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 long-term care insurance coverage.

“(f) TREATMENT OF CERTAIN STATE-MAINTAINED PLANS.—

“(1) IN GENERAL.—If—

“(A) an individual receives coverage for qualified long-term care services under a State long-term care plan, and

“(B) the terms of such plan would satisfy the requirements of subsection (b) were such plan an insurance contract,

such plan shall be treated as a qualified long-term care insurance contract for purposes of this title.

“(2) STATE LONG-TERM CARE PLAN.—For purposes of paragraph (1), the term ‘State long-term care plan’ means any plan—

“(A) which is established and maintained by a State or an instrumentality of a State,

“(B) which provides coverage only for qualified long-term care services, and

“(C) under which such coverage is provided only to—

“(i) employees and former employees of a State (or any political subdivision or instrumentality of a State),

“(ii) the spouses of such employees, and

“(iii) individuals bearing a relationship to such employees or spouses which is described in any of paragraphs (1) through (8) of section 152(a).”

(b) RESERVE METHOD.—Clause (iii) of section 807(d)(3)(A) is amended by inserting “(other than a qualified long-term care insurance contract, as defined in section 7702B(b))” after “insurance contract”.

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

(1) CAFETERIA PLANS.—Section 125(f) is amended by adding at the end the following new sentence: “Such term shall not include any product which is advertised, marketed, or offered as long-term care insurance.”

(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.”

(d) CONTINUATION COVERAGE RULES NOT TO APPLY.—

(1) Paragraph (2) of section 4980B(g) is amended by adding at the end the following new sentence: “Such term shall not include any plan substantially all of the coverage under which is for qualified long-term care services (as defined in section 7702B(c)).”

(2) Paragraph (1) of section 607 of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new sentence: “Such term shall not include any plan substantially all of the coverage under which is for qualified long-term care services (as defined in section 7702B(c) of such Code).”

(3) Paragraph (1) of section 2208 of the Public Health Service Act is amended by adding at the end the following new sentence: "Such term shall not include any plan substantially all of the coverage under which is for qualified long-term care services (as defined in section 7702B(c) of such Code)."

42 USC 300bb-8.

(e) 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."

(f) EFFECTIVE DATES.—

26 USC 1702B
note.

(1) GENERAL EFFECTIVE DATE.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by this section shall apply to contracts issued after December 31, 1996.

(B) RESERVE METHOD.—The amendment made by subsection (b) shall apply to contracts issued after December 31, 1997.

(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 situated 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).

In the case of an individual who is covered on December 31, 1996, under a State long-term care plan (as defined in section 7702B(f)(2) of such Code), the terms of such plan on such date shall be treated for purposes of the preceding sentence as a contract issued on such date which met the long-term care insurance requirements of such State.

(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.

(5) APPLICATION OF PER DIEM LIMITATION TO EXISTING CONTRACTS.—The amount of per diem payments made under a contract issued on or before July 31, 1996, with respect to an insured which are excludable from gross income by reason of section 7702B of the Internal Revenue Code of 1986 (as added by this section) shall not be reduced under subsection (d)(2)(B) thereof by reason of reimbursements received under a contract issued on or before such date. The preceding sentence shall cease to apply as of the date (after July 31, 1996) such contract is exchanged or there is any contract modification which results in an increase in the amount of such per diem payments or the amount of such reimbursements.

26 USC 7702B
note.

(g) LONG-TERM CARE STUDY REQUEST.—The Chairman of the Committee on Ways and Means of the House of Representatives and the Chairman of the Committee on Finance of the Senate shall jointly request the National Association of Insurance Commissioners, in consultation with representatives of the insurance industry and consumer organizations, to formulate, develop, and conduct a study to determine the marketing and other effects of per diem limits on certain types of long-term care policies. If the National Association of Insurance Commissioners agrees to the study request, the National Association of Insurance Commissioners shall report the results of its study to such committees not later than 2 years after accepting the request.

Reports.

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) Paragraph (2) of section 162(l) is amended by adding at the end the following new subparagraph:

“(C) LONG-TERM CARE PREMIUMS.—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 section 213(d)(10)) shall be taken into account under paragraph (1).”

(C) 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)”.

26 USC 162 note.

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

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,

“(2) whether or not such benefits are paid in whole or in part on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate,

“(3) the name, address, and TIN of such individual, and

“(4) the name, address, and TIN of the chronically ill or terminally ill individual on account of whose condition such benefits are paid.

“(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 payment under a product which is advertised, marketed, or offered as long-term care insurance, and

“(2) any payment which is 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.

26 USC 6050Q
note.

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:

“(g) CONSUMER PROTECTION PROVISIONS.—

“(1) IN GENERAL.—The requirements of this subsection are met with respect to any contract if 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 contract if such contract 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 contract if such contract meets the requirements of section 4980C(d).

“(4) NONFORFEITURE REQUIREMENTS.—

“(A) IN GENERAL.—The requirements of this paragraph are met with respect to any level premium contract, if the issuer of such contract 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 contracts approved by the Secretary for the same contract 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) CROSS REFERENCE.—

“For coordination of the requirements of this subsection with State requirements, see section 4980C(f).”.

SEC. 326. REQUIREMENTS FOR ISSUERS OF QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.

(a) **IN GENERAL.**—Chapter 43 is amended by adding at the end the following new section:

“SEC. 4980C. REQUIREMENTS FOR ISSUERS OF QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.

“(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 insured for each day any requirement of subsection (c) or (d) is not met with respect to each qualified long-term care insurance contract.

“(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 qualified long-term care insurance contract, 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(g)(2)(B).

“(2) DELIVERY OF POLICY.—If an application for a qualified long-term care insurance contract (or for a certificate under such a contract for a group) is approved, the issuer shall deliver to the applicant (or policyholder or certificateholder) the contract (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 qualified long-term care insurance contract 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) QUALIFIED LONG-TERM CARE INSURANCE CONTRACT DEFINED.—For purposes of this section, the term ‘qualified long-term care insurance contract’ has the meaning given such term by section 7702B.

“(f) COORDINATION WITH STATE REQUIREMENTS.—If a State imposes any requirement which is more stringent than the analogous requirement imposed by this section or section 7702B(g), the requirement imposed by this section or section 7702B(g) shall be treated as met if the more stringent State requirement is met.”.

(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 qualified long-term care insurance contracts.”.

26 USC 4980C
note.

SEC. 327. 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(f) (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.

“(2) TREATMENT OF VIATICAL SETTLEMENTS.—

“(A) IN GENERAL.—If any portion of the death benefit under a life insurance contract on the life of an insured described in paragraph (1) is sold or assigned to a viatical settlement provider, the amount paid for the sale or assignment of such portion shall be treated as an amount paid under the life insurance contract by reason of the death of such insured.

“(B) VIATICAL SETTLEMENT PROVIDER.—

“(i) IN GENERAL.—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 (with respect to insureds described in the same subparagraph of paragraph (1) as the insured) 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 with respect to such insured, such person meets the requirements of clause (ii) or (iii), whichever applies to such insured.

“(ii) TERMINALLY ILL INSUREDS.—A person meets the requirements of this clause with respect to an insured who is a terminally ill individual if such person—

“(I) 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.

“(iii) CHRONICALLY ILL INSURED.—A person meets the requirements of this clause with respect to an insured who is a chronically ill individual if such person—

“(I) meets requirements similar to the requirements referred to in clause (ii)(I), and

“(II) meets the standards (if any) of the National Association of Insurance Commissioners for evaluating the reasonableness of amounts paid by such person in connection with such purchases or assignments with respect to chronically ill individuals.

“(3) SPECIAL RULES FOR CHRONICALLY ILL INSURED.—In the case of an insured who is a chronically ill individual—

“(A) IN GENERAL.—Paragraphs (1) and (2) shall not apply to any payment received for any period unless—

“(i) such payment is for costs incurred by the payee (not compensated for by insurance or otherwise) for qualified long-term care services provided for the insured for such period, and

“(ii) the terms of the contract giving rise to such payment satisfy—

“(I) the requirements of section 7702B(b)(1)(B), and

“(II) the requirements (if any) applicable under subparagraph (B).

For purposes of the preceding sentence, the rule of section 7702B(b)(2)(B) shall apply.

“(B) OTHER REQUIREMENTS.—The requirements applicable under this subparagraph are—

“(i) those requirements of section 7702B(g) and section 4980C which the Secretary specifies as applying to such a purchase, assignment, or other arrangement,

“(ii) standards adopted by the National Association of Insurance Commissioners which specifically apply to chronically ill individuals (and, if such standards are adopted, the analogous requirements specified under clause (i) shall cease to apply), and

“(iii) standards adopted by the State in which the policyholder resides (and if such standards are adopted, the analogous requirements specified under clause (i) and (subject to section 4980C(f)) standards under clause (ii), shall cease to apply).

“(C) PER DIEM PAYMENTS.—A payment shall not fail to be described in subparagraph (A) by reason of being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payment relates.

“(D) LIMITATION ON EXCLUSION FOR PERIODIC PAYMENTS.—

“For limitation on amount of periodic payments which are treated as described in paragraph (1), see section 7702B(d).”.

“(4) 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) CHRONICALLY ILL INDIVIDUAL.—The term ‘chronically ill individual’ has the meaning given such term by section 7702B(c)(2); except that such term shall not include a terminally ill individual.

“(C) QUALIFIED LONG-TERM CARE SERVICES.—The term ‘qualified long-term care services’ has the meaning given such term by section 7702B(c).

“(D) 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)).

“(5) 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.

26 USC 101 note.

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.—

26 USC 818 note.

(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—State Insurance 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—

“(I) are unable to acquire medical care coverage for such condition through insurance or from a health maintenance organization, or

“(II) 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.”

26 USC 501 note.

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

SEC. 342. EXEMPTION FROM INCOME TAX FOR STATE-SPONSORED WORKMEN'S COMPENSATION REINSURANCE ORGANIZATIONS.

(a) **IN GENERAL.**—Subsection (c) of section 501 (relating to list of exempt organizations), as amended by section 341, is amended by adding at the end the following new paragraph:

“(27) Any membership organization if—

“(A) such organization is established before June 1, 1996, by a State exclusively to reimburse its members for losses arising under workmen's compensation acts,

“(B) such State requires that the membership of such organization consist of—

“(i) all persons who issue insurance covering workmen's compensation losses in such State, and

“(ii) all persons and governmental entities who self-insure against such losses, and

“(C) such organization operates as a non-profit organization by—

“(i) returning surplus income to its members or workmen’s compensation policyholders on a periodic basis, and

“(ii) reducing initial premiums in anticipation of investment income.”

(b) **EFFECTIVE DATE.**—The amendment made by this section shall apply to taxable years ending after the date of the enactment of this Act. 26 USC 501 note.

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. 26 USC 833 note.

Subtitle G—IRA Distributions to the Unemployed

SEC. 361. DISTRIBUTIONS FROM CERTAIN PLANS MAY BE USED WITHOUT ADDITIONAL TAX TO PAY FINANCIALLY DEVASTATING MEDICAL EXPENSES.

(a) **IN GENERAL.**—Section 72(t)(3)(A) is amended by striking “(B),”.

(b) **DISTRIBUTIONS FOR PAYMENT OF HEALTH INSURANCE PREMIUMS OF CERTAIN UNEMPLOYED INDIVIDUALS.**—Paragraph (2) of section 72(t) is amended by adding at the end the following new subparagraph:

“(D) **DISTRIBUTIONS TO UNEMPLOYED INDIVIDUALS FOR HEALTH INSURANCE PREMIUMS.**—

“(i) **IN GENERAL.**—Distributions from an individual retirement plan to an individual after separation from employment—

“(I) if such individual has received unemployment compensation for 12 consecutive weeks under any Federal or State unemployment compensation law by reason of such separation,

“(II) if such distributions are made during any taxable year during which such unemployment compensation is paid or the succeeding taxable year, and

“(III) to the extent such distributions do not exceed the amount paid during the taxable year for insurance described in section 213(d)(1)(D) with respect to the individual and the individual’s spouse and dependents (as defined in section 152).

“(ii) DISTRIBUTIONS AFTER REEMPLOYMENT.—Clause (i) shall not apply to any distribution made after the individual has been employed for at least 60 days after the separation from employment to which clause (i) applies.

“(iii) SELF-EMPLOYED INDIVIDUALS.—To the extent provided in regulations, a self-employed individual shall be treated as meeting the requirements of clause (i)(I) if, under Federal or State law, the individual would have received unemployment compensation but for the fact the individual was self-employed.”

(c) CONFORMING AMENDMENT.—Subparagraph (B) of section 72(t)(2) is amended by striking “or (C)” and inserting “, (C), or (D)”.

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

26 USC 72 note.

Subtitle H—Organ and Tissue Donation Information Included With Income Tax Refund Payments

26 USC 6042
note.

SEC. 371. ORGAN AND TISSUE DONATION INFORMATION INCLUDED WITH INCOME TAX REFUND PAYMENTS.

(a) IN GENERAL.—The Secretary of the Treasury shall, to the extent practicable, include with the mailing of any payment of a refund of individual income tax made during the period beginning on February 1, 1997, and ending on June 30, 1997, a copy of the document described in subsection (b).

(b) TEXT OF DOCUMENT.—The Secretary of the Treasury shall, after consultation with the Secretary of Health and Human Services and organizations promoting organ and tissue (including eye) donation, prepare a document suitable for inclusion with individual income tax refund payments which—

- (1) encourages organ and tissue donation;
- (2) includes a detachable organ and tissue donor card; and

(3) urges recipients to—

- (A) sign the organ and tissue donor card;
- (B) discuss organ and tissue donation with family members and tell family members about the recipient’s desire to be an organ and tissue donor if the occasion arises; and
- (C) encourage family members to request or authorize organ and tissue donation if the occasion arises.

TITLE IV—APPLICATION AND ENFORCEMENT OF GROUP HEALTH PLAN REQUIREMENTS

Subtitle A—Application and Enforcement of Group Health Plan Requirements

SEC. 401. GROUP HEALTH PLAN PORTABILITY, ACCESS, AND RENEWABILITY REQUIREMENTS.

(a) IN GENERAL.—The Internal Revenue Code of 1986 is amended by adding at the end the following new subtitle:

“Subtitle K—Group Health Plan Portability, Access, and Renewability Requirements

“Chapter 100. Group health plan portability, access, and renewability requirements.

“CHAPTER 100—GROUP HEALTH PLAN PORTABILITY, ACCESS, AND RENEWABILITY REQUIREMENTS

“Sec. 9801. Increased portability through limitation on preexisting condition exclusions.

“Sec. 9802. Prohibiting discrimination against individual participants and beneficiaries based on health status.

“Sec. 9803. Guaranteed renewability in multiemployer plans and certain multiple employer welfare arrangements.

“Sec. 9804. General exceptions.

“Sec. 9805. Definitions.

“Sec. 9806. Regulations.

“SEC. 9801. INCREASED PORTABILITY THROUGH LIMITATION ON PREEXISTING CONDITION EXCLUSIONS.

“(a) LIMITATION ON PREEXISTING CONDITION EXCLUSION PERIOD; CREDITING FOR PERIODS OF PREVIOUS COVERAGE.—Subject to subsection (d), a group health plan may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if—

“(1) such exclusion relates to a condition (whether physical or mental), 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 enrollment date;

“(2) such exclusion extends for a period of not more than 12 months (or 18 months in the case of a late enrollee) after the enrollment date; and

“(3) the period of any such preexisting condition exclusion is reduced by the length of the aggregate of the periods of creditable coverage (if any) applicable to the participant or beneficiary as of the enrollment date.

“(b) DEFINITIONS.—For purposes of this section—

“(1) PREEXISTING CONDITION EXCLUSION.—

“(A) IN GENERAL.—The term ‘preexisting condition exclusion’ means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on

the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

“(B) TREATMENT OF GENETIC INFORMATION.—For purposes of this section, genetic information shall not be treated as a condition described in subsection (a)(1) in the absence of a diagnosis of the condition related to such information.

“(2) ENROLLMENT DATE.—The term ‘enrollment date’ means, with respect to an individual covered under a group health plan, the date of enrollment of the individual in the plan or, if earlier, the first day of the waiting period for such enrollment.

“(3) LATE ENROLLEE.—The term ‘late enrollee’ means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during—

“(A) the first period in which the individual is eligible to enroll under the plan, or

“(B) a special enrollment period under subsection (f).

“(4) 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 period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

“(c) RULES RELATING TO CREDITING PREVIOUS COVERAGE.—

“(1) CREDITABLE COVERAGE DEFINED.—For purposes of this part, the term ‘creditable coverage’ means, with respect to an individual, coverage of the individual under any of the following:

“(A) A group health plan.

“(B) Health insurance coverage.

“(C) Part A or part B of title XVIII of the Social Security Act.

“(D) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928.

“(E) Chapter 55 of title 10, United States Code.

“(F) A medical care program of the Indian Health Service or of a tribal organization.

“(G) A State health benefits risk pool.

“(H) A health plan offered under chapter 89 of title 5, United States Code.

“(I) A public health plan (as defined in regulations).

“(J) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

Such term does not include coverage consisting solely of coverage of excepted benefits (as defined in section 9805(c)).

“(2) NOT COUNTING PERIODS BEFORE SIGNIFICANT BREAKS IN COVERAGE.—

“(A) IN GENERAL.—A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

“(B) WAITING PERIOD NOT TREATED AS A BREAK IN COVERAGE.—For purposes of subparagraph (A) and subsection (d)(4), any period that an individual is in a waiting period for any coverage under a group health plan or is in an affiliation period shall not be taken into account in determining the continuous period under subparagraph (A).

“(C) AFFILIATION PERIOD.—

“(i) IN GENERAL.—For purposes of this section, the term ‘affiliation 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. During such an affiliation period, the organization is not required to provide health care services or benefits and no premium shall be charged to the participant or beneficiary.

“(ii) BEGINNING.—Such period shall begin on the enrollment date.

“(iii) RUNS CONCURRENTLY WITH WAITING PERIODS.—Any such affiliation period shall run concurrently with any waiting period under the plan.

“(3) METHOD OF CREDITING COVERAGE.—

“(A) STANDARD METHOD.—Except as otherwise provided under subparagraph (B), for purposes of applying subsection (a)(3), a group health plan shall count a period of creditable coverage without regard to the specific benefits for which coverage is offered during the period.

“(B) ELECTION OF ALTERNATIVE METHOD.—A group health plan may elect to apply subsection (a)(3) based on coverage of any benefits within each of several classes or categories of benefits specified in regulations rather than as provided under subparagraph (A). Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election a group health plan shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category.

“(C) PLAN NOTICE.—In the case of an election with respect to a group health plan under subparagraph (B), the plan shall—

“(i) prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made such election, and

“(ii) include in such statements a description of the effect of this election.

“(4) ESTABLISHMENT OF PERIOD.—Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection (e) or in such other manner as may be specified in regulations.

“(d) EXCEPTIONS.—

“(1) EXCLUSION NOT APPLICABLE TO CERTAIN NEWBORNS.—Subject to paragraph (4), a group health plan may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage.

“(2) EXCLUSION NOT APPLICABLE TO CERTAIN ADOPTED CHILDREN.—Subject to paragraph (4), a group health plan may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption.

“(3) EXCLUSION NOT APPLICABLE TO PREGNANCY.—For purposes of this section, a group health plan may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

“(4) LOSS IF BREAK IN COVERAGE.—Paragraphs (1) and (2) shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

“(e) CERTIFICATIONS AND DISCLOSURE OF COVERAGE.—

“(1) REQUIREMENT FOR CERTIFICATION OF PERIOD OF CREDITABLE COVERAGE.—

“(A) IN GENERAL.—A group health plan shall provide the certification described in subparagraph (B)—

“(i) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision,

“(ii) in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision, and

“(iii) on the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in clause (i) or (ii), whichever is later.

The certification under clause (i) may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

“(B) CERTIFICATION.—The certification described in this subparagraph is a written certification of—

“(i) the period of creditable coverage of the individual under such plan and the coverage under such COBRA continuation provision, and

“(ii) the waiting period (if any) (and affiliation period, if applicable) imposed with respect to the individual for any coverage under such plan.

“(C) ISSUER COMPLIANCE.—To the extent that medical care under a group health plan consists of health insurance coverage offered in connection with the plan, the plan is deemed to have satisfied the certification requirement under this paragraph if the issuer provides for such certification in accordance with this paragraph.

“(2) DISCLOSURE OF INFORMATION ON PREVIOUS BENEFITS.—

“(A) IN GENERAL.—In the case of an election described in subsection (c)(3)(B) by a group health plan, if the plan enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under paragraph (1)—

“(i) upon request of such plan, the entity which issued the certification provided by the individual shall promptly disclose to such requesting plan information on coverage of classes and categories of health benefits available under such entity’s plan, and

“(ii) such entity may charge the requesting plan or issuer for the reasonable cost of disclosing such information.

“(3) REGULATIONS.—The Secretary shall establish rules to prevent an entity’s failure to provide information under paragraph (1) or (2) with respect to previous coverage of an individual from adversely affecting any subsequent coverage of the individual under another group health plan or health insurance coverage.

“(f) SPECIAL ENROLLMENT PERIODS.—

“(1) INDIVIDUALS LOSING OTHER COVERAGE.—A group health plan shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

“(A) 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.

“(B) 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, but only if the plan sponsor (or the health insurance issuer offering health insurance coverage in connection with the plan) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time.

“(C) The employee’s or dependent’s coverage described in subparagraph (A)—

“(i) was under a COBRA continuation provision and the coverage under such provision was exhausted; or

“(ii) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated.

“(D) Under the terms of the plan, the employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in subparagraph (C)(i) or termination of coverage or employer contribution described in subparagraph (C)(ii).

“(2) FOR DEPENDENT BENEFICIARIES.—

“(A) IN GENERAL.—If—

“(i) a group health plan makes coverage available with respect to a dependent of an individual,

“(ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming

a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period), and

“(iii) a person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption,

the group health plan shall provide for a dependent special enrollment period described in subparagraph (B) during which the person (or, if not otherwise enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

“(B) DEPENDENT SPECIAL ENROLLMENT PERIOD.—The dependent special enrollment period under this subparagraph shall be a period of not less than 30 days and shall begin on the later of—

“(i) the date dependent coverage is made available, or

“(ii) the date of the marriage, birth, or adoption or placement for adoption (as the case may be) described in subparagraph (A)(iii).

“(C) NO WAITING PERIOD.—If an individual seeks coverage of a dependent during the first 30 days of such a dependent special enrollment period, the coverage of the dependent shall become effective—

“(i) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

“(ii) in the case of a dependent’s birth, as of the date of such birth; or

“(iii) in the case of a dependent’s adoption or placement for adoption, the date of such adoption or placement for adoption.

“SEC. 9802. PROHIBITING DISCRIMINATION AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES BASED ON HEALTH STATUS.

“(a) IN ELIGIBILITY TO ENROLL.—

“(1) IN GENERAL.—Subject to paragraph (2), a group health plan may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any of the following factors in relation to the individual or a dependent of the individual:

“(A) Health status.

“(B) Medical condition (including both physical and mental illnesses).

“(C) Claims experience.

“(D) Receipt of health care.

“(E) Medical history.

“(F) Genetic information.

“(G) Evidence of insurability (including conditions arising out of acts of domestic violence).

“(H) Disability.

“(2) NO APPLICATION TO BENEFITS OR EXCLUSIONS.—To the extent consistent with section 9801, paragraph (1) shall not be construed—

“(A) to require a group health plan to provide particular benefits (or benefits with respect to a specific procedure, treatment, or service) other than those provided under the terms of such plan; or

“(B) to prevent such a plan from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

“(3) CONSTRUCTION.—For purposes of paragraph (1), rules for eligibility to enroll under a plan include rules defining any applicable waiting periods for such enrollment.

“(b) IN PREMIUM CONTRIBUTIONS.—

“(1) IN GENERAL.—A group health plan may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any factor described in subsection (a)(1) in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

“(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed—

“(A) to restrict the amount that an employer may be charged for coverage under a group health plan; or

“(B) to prevent a group health plan from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

“SEC. 9803. GUARANTEED RENEWABILITY IN MULTIEMPLOYER PLANS AND CERTAIN MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.

“(a) IN GENERAL.—A group health plan which is a multiemployer plan (as defined in section 414(f)) or which is a multiple employer welfare arrangement may not deny an employer continued access to the same or different coverage under such plan, 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 provisions;

“(4) because the plan is ceasing to offer any coverage in a geographic area;

“(5) in the case of a plan that offers benefits through a network plan, because there is no longer any individual enrolled through the employer who lives, resides, or works in the service area of the network plan and the plan applies this paragraph uniformly without regard to the claims experience of employers or a factor described in section 9802(a)(1) in relation to such individuals or their dependents; or

“(6) 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.

“(b) **MULTIPLE EMPLOYER WELFARE ARRANGEMENT.**—For purposes of subsection (a), the term ‘multiple employer welfare arrangement’ has the meaning given such term by section 3(40) of the Employee Retirement Income Security Act of 1974, as in effect on the date of the enactment of this section.

“**SEC. 9804. GENERAL EXCEPTIONS.**

“(a) **EXCEPTION FOR CERTAIN PLANS.**—The requirements of this chapter shall not apply to—

“(1) any governmental plan, and

“(2) any group health plan for any plan year if, on the first day of such plan year, such plan has less than 2 participants who are current employees.

“(b) **EXCEPTION FOR CERTAIN BENEFITS.**—The requirements of this chapter shall not apply to any group health plan in relation to its provision of excepted benefits described in section 9805(c)(1).

“(c) **EXCEPTION FOR CERTAIN BENEFITS IF CERTAIN CONDITIONS MET.**—

“(1) **LIMITED, EXCEPTED BENEFITS.**—The requirements of this chapter shall not apply to any group health plan in relation to its provision of excepted benefits described in section 9805(c)(2) if the benefits—

“(A) are provided under a separate policy, certificate, or contract of insurance; or

“(B) are otherwise not an integral part of the plan.

“(2) **NONCOORDINATED, EXCEPTED BENEFITS.**—The requirements of this chapter shall not apply to any group health plan in relation to its provision of excepted benefits described in section 9805(c)(3) if all of the following conditions are met:

“(A) The benefits are provided under a separate policy, certificate, or contract of insurance.

“(B) There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor.

“(C) Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor.

“(3) **SUPPLEMENTAL EXCEPTED BENEFITS.**—The requirements of this chapter shall not apply to any group health plan in relation to its provision of excepted benefits described in section 9805(c)(4) if the benefits are provided under a separate policy, certificate, or contract of insurance.

“**SEC. 9805. DEFINITIONS.**

“(a) **GROUP HEALTH PLAN.**—For purposes of this chapter, the term ‘group health plan’ has the meaning given to such term by section 5000(b)(1).

“(b) **DEFINITIONS RELATING TO HEALTH INSURANCE.**—For purposes of this chapter—

“(1) **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 contract offered by a health insurance issuer.

“(B) NO APPLICATION TO CERTAIN EXCEPTED BENEFITS.—In applying subparagraph (A), excepted benefits described in subsection (c)(1) shall not be treated as benefits consisting of medical care.

“(2) HEALTH INSURANCE ISSUER.—The term ‘health insurance issuer’ means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) 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) of the Employee Retirement Income Security Act of 1974, as in effect on the date of the enactment of this section). Such term does not include a group health plan.

“(3) HEALTH MAINTENANCE ORGANIZATION.—The term ‘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.

“(c) EXCEPTED BENEFITS.—For purposes of this chapter, the term ‘excepted benefits’ means benefits under one or more (or any combination thereof) of the following:

“(1) BENEFITS NOT SUBJECT TO REQUIREMENTS.—

“(A) Coverage only for accident, or disability income insurance, or any combination thereof.

“(B) Coverage issued as a supplement to liability insurance.

“(C) Liability insurance, including general liability insurance and automobile liability insurance.

“(D) Workers’ compensation or similar insurance.

“(E) Automobile medical payment insurance.

“(F) Credit-only insurance.

“(G) Coverage for on-site medical clinics.

“(H) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

“(2) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED SEPARATELY.—

“(A) Limited scope dental or vision benefits.

“(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

“(C) Such other similar, limited benefits as are specified in regulations.

“(3) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS INDEPENDENT, NONCOORDINATED BENEFITS.—

“(A) Coverage only for a specified disease or illness.

“(B) Hospital indemnity or other fixed indemnity insurance.

“(4) **BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS SEPARATE INSURANCE POLICY.**—Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan.

“(d) **OTHER DEFINITIONS.**—For purposes of this chapter—

“(1) **COBRA CONTINUATION PROVISION.**—The term ‘COBRA continuation provision’ means any of the following:

“(A) Section 4980B, other than subsection (f)(1) thereof 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 of such Act.

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

“(2) **GOVERNMENTAL PLAN.**—The term ‘governmental plan’ has the meaning given such term by section 414(d).

“(3) **MEDICAL CARE.**—The term ‘medical care’ has the meaning given such term by section 213(d) determined without regard to—

“(A) paragraph (1)(C) thereof, and

“(B) so much of paragraph (1)(D) thereof as relates to qualified long-term care insurance.

“(4) **NETWORK PLAN.**—The term ‘network plan’ means health insurance coverage of a health insurance issuer 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 issuer.

“(5) **PLACED FOR ADOPTION DEFINED.**—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.

“SEC. 9806. REGULATIONS.

“The Secretary, consistent with section 104 of the Health Care Portability and Accountability Act of 1996, may promulgate such regulations as may be necessary or appropriate to carry out the provisions of this chapter. The Secretary may promulgate any interim final rules as the Secretary determines are appropriate to carry out this chapter.”.

(b) **CLERICAL AMENDMENT.**—The table of subtitles of such Code is amended by adding at the end the following new item:

“Subtitle K. Group health plan portability, access, and renewability requirements.”.

(c) **EFFECTIVE DATE.**—

(1) **IN GENERAL.**—The amendments made by this section shall apply to plan years beginning after June 30, 1997.

(2) **DETERMINATION OF CREDITABLE COVERAGE.**—

(A) **PERIOD OF COVERAGE.**—

(i) **IN GENERAL.**—Subject to clause (ii), no period before July 1, 1996, shall be taken into account under chapter 100 of the Internal Revenue Code of 1986 (as added by this section) in determining creditable coverage.

(ii) SPECIAL RULE FOR CERTAIN PERIODS.—The Secretary of the Treasury, consistent with section 104, shall provide for a process whereby individuals who need to establish creditable coverage for periods before July 1, 1996, and who would have such coverage credited but for clause (i) may be given credit for creditable coverage for such periods through the presentation of documents or other means.

(B) CERTIFICATIONS, ETC.—

(i) IN GENERAL.—Subject to clauses (ii) and (iii), subsection (e) of section 9801 of the Internal Revenue Code of 1986 (as added by this section) shall apply to events occurring after June 30, 1996.

(ii) NO CERTIFICATION REQUIRED TO BE PROVIDED BEFORE JUNE 1, 1997.—In no case is a certification required to be provided under such subsection before June 1, 1997.

(iii) CERTIFICATION ONLY ON WRITTEN REQUEST FOR EVENTS OCCURRING BEFORE OCTOBER 1, 1996.—In the case of an event occurring after June 30, 1996, and before October 1, 1996, a certification is not required to be provided under such subsection unless an individual (with respect to whom the certification is otherwise required to be made) requests such certification in writing.

(C) TRANSITIONAL RULE.—In the case of an individual who seeks to establish creditable coverage for any period for which certification is not required because it relates to an event occurring before June 30, 1996—

(i) the individual may present other credible evidence of such coverage in order to establish the period of creditable coverage; and

(ii) a group health plan and a health insurance issuer shall not be subject to any penalty or enforcement action with respect to the plan's or issuer's crediting (or not crediting) such coverage if the plan or issuer has sought to comply in good faith with the applicable requirements under the amendments made by this section.

(3) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—Except as provided in paragraph (2), in the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the later of—

(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(B) July 1, 1997.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

(4) **TIMELY REGULATIONS.**—The Secretary of the Treasury, consistent with section 104, shall first issue by not later than April 1, 1997, such regulations as may be necessary to carry out the amendments made by this section.

(5) **LIMITATION ON ACTIONS.**—No enforcement action shall be taken, pursuant to the amendments made by this section, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before January 1, 1998, or, if later, the date of issuance of regulations referred to in paragraph (4), if the plan or issuer has sought to comply in good faith with such requirements.

SEC. 402. PENALTY ON FAILURE TO MEET CERTAIN GROUP HEALTH PLAN REQUIREMENTS.

(a) **IN GENERAL.**—Chapter 43 of the Internal Revenue Code of 1986 (relating to qualified pension, etc., plans) is amended by adding after section 4980C the following new section:

“SEC. 4980D. FAILURE TO MEET CERTAIN GROUP HEALTH PLAN REQUIREMENTS.

“(a) **GENERAL RULE.**—There is hereby imposed a tax on any failure of a group health plan to meet the requirements of chapter 100 (relating to group health plan portability, access, and renewability requirements).

“(b) **AMOUNT OF TAX.**—

“(1) **IN GENERAL.**—The amount of the tax imposed by subsection (a) on any failure shall be \$100 for each day in the noncompliance period with respect to each individual to whom such failure relates.

“(2) **NONCOMPLIANCE PERIOD.**—For purposes of this section, the term ‘noncompliance period’ means, with respect to any failure, the period—

“(A) beginning on the date such failure first occurs, and

“(B) ending on the date such failure is corrected.

“(3) **MINIMUM TAX FOR NONCOMPLIANCE PERIOD WHERE FAILURE DISCOVERED AFTER NOTICE OF EXAMINATION.**—Notwithstanding paragraphs (1) and (2) of subsection (c)—

“(A) **IN GENERAL.**—In the case of 1 or more failures with respect to an individual—

“(i) which are not corrected before the date a notice of examination of income tax liability is sent to the employer, and

“(ii) which occurred or continued during the period under examination,

the amount of tax imposed by subsection (a) by reason of such failures with respect to such individual shall not be less than the lesser of \$2,500 or the amount of tax which would be imposed by subsection (a) without regard to such paragraphs.

“(B) **HIGHER MINIMUM TAX WHERE VIOLATIONS ARE MORE THAN DE MINIMIS.**—To the extent violations for which any person is liable under subsection (e) for any year are more than de minimis, subparagraph (A) shall be applied by substituting ‘\$15,000’ for ‘\$2,500’ with respect to such person.

“(C) EXCEPTION FOR CHURCH PLANS.—This paragraph shall not apply to any failure under a church plan (as defined in section 414(e)).

“(c) LIMITATIONS ON AMOUNT OF TAX.—

“(1) TAX NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No tax shall be imposed by subsection (a) on any failure during any period for which it is established to the satisfaction of the Secretary that the person otherwise liable for such tax did not know, and exercising reasonable diligence would not have known, that such failure existed.

“(2) TAX NOT TO APPLY TO FAILURES CORRECTED WITHIN CERTAIN PERIODS.—No tax shall be imposed by subsection (a) on any failure if—

“(A) such failure was due to reasonable cause and not to willful neglect, and

“(B)(i) in the case of a plan other than a church plan (as defined in section 414(e)), such failure is corrected during the 30-day period beginning on the first date the person otherwise liable for such tax knew, or exercising reasonable diligence would have known, that such failure existed, and

“(ii) in the case of a church plan (as so defined), such failure is corrected before the close of the correction period (determined under the rules of section 414(e)(4)(C)).

“(3) OVERALL LIMITATION FOR UNINTENTIONAL FAILURES.—In the case of failures which are due to reasonable cause and not to willful neglect—

“(A) SINGLE EMPLOYER PLANS.—

“(i) IN GENERAL.—In the case of failures with respect to plans other than specified multiple employer health plans, the tax imposed by subsection (a) for failures during the taxable year of the employer shall not exceed the amount equal to the lesser of—

“(I) 10 percent of the aggregate amount paid or incurred by the employer (or predecessor employer) during the preceding taxable year for group health plans, or

“(II) \$500,000.

“(ii) TAXABLE YEARS IN THE CASE OF CERTAIN CONTROLLED GROUPS.—For purposes of this subparagraph, if not all persons who are treated as a single employer for purposes of this section have the same taxable year, the taxable years taken into account shall be determined under principles similar to the principles of section 1561.

“(B) SPECIFIED MULTIPLE EMPLOYER HEALTH PLANS.—

“(i) IN GENERAL.—In the case of failures with respect to a specified multiple employer health plan, the tax imposed by subsection (a) for failures during the taxable year of the trust forming part of such plan shall not exceed the amount equal to the lesser of—

“(I) 10 percent of the amount paid or incurred by such trust during such taxable year to provide medical care (as defined in section 9805(d)(3))

directly or through insurance, reimbursement, or otherwise, or

“(II) \$500,000.

For purposes of the preceding sentence, all plans of which the same trust forms a part shall be treated as one plan.

“(ii) SPECIAL RULE FOR EMPLOYERS REQUIRED TO PAY TAX.—If an employer is assessed a tax imposed by subsection (a) by reason of a failure with respect to a specified multiple employer health plan, the limit shall be determined under subparagraph (A) (and not under this subparagraph) and as if such plan were not a specified multiple employer health plan.

“(4) WAIVER BY SECRETARY.—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 the payment of such tax would be excessive relative to the failure involved.

“(d) TAX NOT TO APPLY TO CERTAIN INSURED SMALL EMPLOYER PLANS.—

“(1) IN GENERAL.—In the case of a group health plan of a small employer which provides health insurance coverage solely through a contract with a health insurance issuer, no tax shall be imposed by this section on the employer on any failure which is solely because of the health insurance coverage offered by such issuer.

“(2) SMALL EMPLOYER.—

“(A) IN GENERAL.—For purposes of paragraph (1), the term ‘small employer’ means, with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year. For purposes of the preceding sentence, all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as one employer.

“(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

“(C) PREDECESSORS.—Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.

“(3) HEALTH INSURANCE COVERAGE; HEALTH INSURANCE ISSUER.—For purposes of paragraph (1), the terms ‘health insurance coverage’ and ‘health insurance issuer’ have the respective meanings given such terms by section 9805.

“(e) LIABILITY FOR TAX.—The following shall be liable for the tax imposed by subsection (a) on a failure:

“(1) Except as otherwise provided in this subsection, the employer.

“(2) In the case of a multiemployer plan, the plan.

“(3) In the case of a failure under section 9803 (relating to guaranteed renewability) with respect to a plan described in subsection (f)(2)(B), the plan.

“(f) DEFINITIONS.—For purposes of this section—

“(1) GROUP HEALTH PLAN.—The term ‘group health plan’ has the meaning given such term by section 9805(a).

“(2) SPECIFIED MULTIPLE EMPLOYER HEALTH PLAN.—The term ‘specified multiple employer health plan’ means a group health plan which is—

“(A) any multiemployer plan, or

“(B) any multiple employer welfare arrangement (as defined in section 3(40) of the Employee Retirement Income Security Act of 1974, as in effect on the date of the enactment of this section).

“(3) CORRECTION.—A failure of a group health plan shall be treated as corrected if—

“(A) such failure is retroactively undone to the extent possible, and

“(B) the person to whom the failure relates is placed in a financial position which is as good as such person would have been in had such failure not occurred.”

(b) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code is amended by adding after the item relating to section 4980C the following new item:

“Sec. 4980D. Failure to meet certain group health plan requirements.”

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to failures under chapter 100 of the Internal Revenue Code of 1986 (as added by section 401 of this Act).

26 USC 4980D
note.

Subtitle B—Clarification of Certain Continuation Coverage Requirements

SEC. 421. 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 striking “an individual” and inserting “a qualified beneficiary”;

(II) by striking “at the time of a qualifying event described in section 2203(2)” and inserting “at any time during the first 60 days of continuation coverage under this title”;

(III) by striking “with respect to such event.”; and

(IV) by inserting “(with respect to all qualified beneficiaries)” after “29 months”;

(B) in subparagraph (D)(i), by inserting before “, or” the following: “(other than such an exclusion or limitation which does not apply to (or is satisfied by) such beneficiary by reason of chapter 100 of the Internal Revenue Code

of 1986, part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, or title XXVII of this Act); 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 first 60 days of continuation coverage under this title”.

(2) 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 first 60 days of continuation coverage under this title”.

(3) 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 continuation 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 striking “an individual” and inserting “a qualified beneficiary”;

(ii) by striking “at the time of a qualifying event described in section 603(2)” and inserting “at any time during the first 60 days of continuation coverage under this part”;

(iii) by striking “with respect to such event”; and

(iv) by inserting “(with respect to all qualified beneficiaries)” after “29 months”;

(B) in subparagraph (D)(i), by inserting before “, or” the following: “(other than such an exclusion or limitation which does not apply to (or is satisfied by) such beneficiary by reason of chapter 100 of the Internal Revenue Code of 1986, part 7 of this subtitle, or title XXVII of the Public Health Service Act)”; 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 first 60 days of continuation coverage under this part”.

(2) NOTICES.—Section 606(a)(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1166(a)(3)) is amended by striking “at the time of a qualifying event described in section 603(2)” and inserting “at any time during the first 60 days of continuation coverage under this part”.

(3) 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 continuation 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)—

(i) by striking “at the time of a qualifying event described in paragraph (3)(B)” and inserting “at any time during the first 60 days of continuation coverage under this section”;

(ii) by striking “with respect to such event”; and

(iii) by inserting “(with respect to all qualified beneficiaries)” after “29 months”;

(B) in clause (iv)(I), by inserting before “, or” the following: “(other than such an exclusion or limitation which does not apply to (or is satisfied by) such beneficiary by reason of chapter 100 of this title, part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, or title XXVII of the Public Health Service Act)”; 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 first 60 days of continuation coverage under this section”.

(2) 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 first 60 days of continuation coverage under this section”.

(3) 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 continuation coverage under this section.”

(d) EFFECTIVE DATE.—The amendments made by this section shall become effective on January 1, 1997, regardless of whether the qualifying event occurred before, on, or after such date.

26 USC 4980B
note.

(e) NOTIFICATION OF CHANGES.—Not later than November 1, 1996, 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.

26 USC 4980B
note.

TITLE V—REVENUE OFFSETS

SEC. 500. 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—Company-Owned Life Insurance

SEC. 501. DENIAL OF DEDUCTION FOR INTEREST ON LOANS WITH RESPECT TO COMPANY-OWNED LIFE INSURANCE.

(a) IN GENERAL.—Paragraph (4) of section 264(a) is amended—
 (1) by inserting “, or any endowment or annuity contracts owned by the taxpayer covering any individual,” after “the life of any individual”, and
 (2) by striking all that follows “carried on by the taxpayer” and inserting a period.

(b) EXCEPTION FOR CONTRACTS RELATING TO KEY PERSONS; PERMISSIBLE INTEREST RATES.—Section 264 is amended—

(1) by striking “Any” in subsection (a)(4) and inserting “Except as provided in subsection (d), any”, and

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

“(d) SPECIAL RULES FOR APPLICATION OF SUBSECTION (a)(4).—

“(1) EXCEPTION FOR KEY PERSONS.—Subsection (a)(4) shall not apply to any interest paid or accrued on any indebtedness with respect to policies or contracts covering an individual who is a key person to the extent that the aggregate amount of such indebtedness with respect to policies and contracts covering such individual does not exceed \$50,000.

“(2) INTEREST RATE CAP ON KEY PERSONS AND PRE-1986 CONTRACTS.—

“(A) IN GENERAL.—No deduction shall be allowed by reason of paragraph (1) or the last sentence of subsection (a) with respect to interest paid or accrued for any month beginning after December 31, 1995, to the extent the amount of such interest exceeds the amount which would have been determined if the applicable rate of interest were used for such month.

“(B) APPLICABLE RATE OF INTEREST.—For purposes of subparagraph (A)—

“(i) IN GENERAL.—The applicable rate of interest for any month is the rate of interest described as Moody’s Corporate Bond Yield Average-Monthly Average Corporates as published by Moody’s Investors Service, Inc., or any successor thereto, for such month.

“(ii) PRE-1986 CONTRACTS.—In the case of indebtedness on a contract purchased on or before June 20, 1986—

“(I) which is a contract providing a fixed rate of interest, the applicable rate of interest for any month shall be the Moody’s rate described in clause (i) for the month in which the contract was purchased, or

“(II) which is a contract providing a variable rate of interest, the applicable rate of interest for any month in an applicable period shall be such Moody’s rate for the third month preceding the first month in such period.

For purposes of subclause (II), the taxpayer shall elect an applicable period for such contract on its return of tax imposed by this chapter for its first taxable year ending on or after October 13, 1995. Such

applicable period shall be for any number of months (not greater than 12) specified in the election and may not be changed by the taxpayer without the consent of the Secretary.

“(3) **KEY PERSON.**—For purposes of paragraph (1), the term ‘key person’ means an officer or 20-percent owner, except that the number of individuals who may be treated as key persons with respect to any taxpayer shall not exceed the greater of—

“(A) 5 individuals, or

“(B) the lesser of 5 percent of the total officers and employees of the taxpayer or 20 individuals.

“(4) **20-PERCENT OWNER.**—For purposes of this subsection, the term ‘20-percent owner’ means—

“(A) if the taxpayer is a corporation, any person who owns directly 20 percent or more of the outstanding stock of the corporation or stock possessing 20 percent or more of the total combined voting power of all stock of the corporation, or

“(B) if the taxpayer is not a corporation, any person who owns 20 percent or more of the capital or profits interest in the employer.

“(5) **AGGREGATION RULES.**—

“(A) **IN GENERAL.**—For purposes of paragraph (4)(A) and applying the \$50,000 limitation in paragraph (1)—

“(i) all members of a controlled group shall be treated as one taxpayer, and

“(ii) such limitation shall be allocated among the members of such group in such manner as the Secretary may prescribe.

“(B) **CONTROLLED GROUP.**—For purposes of this paragraph, all persons treated as a single employer under subsection (a) or (b) of section 52 or subsection (m) or (o) of section 414 shall be treated as members of a controlled group.”

(c) **EFFECTIVE DATES.**—

(1) **IN GENERAL.**—The amendments made by this section shall apply to interest paid or accrued after October 13, 1995.

(2) **TRANSITION RULE FOR EXISTING INDEBTEDNESS.**—

(A) **IN GENERAL.**—In the case of—

(i) indebtedness incurred before January 1, 1996, or

(ii) indebtedness incurred before January 1, 1997 with respect to any contract or policy entered into in 1994 or 1995,

the amendments made by this section shall not apply to qualified interest paid or accrued on such indebtedness after October 13, 1995, and before January 1, 1999.

(B) **QUALIFIED INTEREST.**—For purposes of subparagraph (A), the qualified interest with respect to any indebtedness for any month is the amount of interest (otherwise deductible) which would be paid or accrued for such month on such indebtedness if—

(i) in the case of any interest paid or accrued after December 31, 1995, indebtedness with respect to no more than 20,000 insured individuals were taken into account, and

(ii) the lesser of the following rates of interest were used for such month:

(I) The rate of interest specified under the terms of the indebtedness as in effect on October 13, 1995 (and without regard to modification of such terms after such date).

(II) The applicable percentage of the rate of interest described as Moody's Corporate Bond Yield Average-Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto, for such month.

For purposes of clause (i), all persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 or subsection (m) or (o) of section 414 of such Code shall be treated as 1 person. Subclause (II) of clause (ii) shall not apply to any month before January 1, 1996.

(C) **APPLICABLE PERCENTAGE.**—For purposes of subparagraph (B), the applicable percentage is as follows:

For calendar year:	The percentage is:
1996	100 percent
1997	90 percent
1998	80 percent.

(3) **SPECIAL RULE FOR GRANDFATHERED CONTRACTS.**—This section shall not apply to any contract purchased on or before June 20, 1986, except that section 264(d)(2) of the Internal Revenue Code of 1986 shall apply to interest paid or accrued after October 13, 1995.

26 USC 264 note.

(d) **SPREAD OF INCOME INCLUSION ON SURRENDER, ETC. OF CONTRACTS.**—

(1) **IN GENERAL.**—If any amount is received under any life insurance policy or endowment or annuity contract described in paragraph (4) of section 264(a) of the Internal Revenue Code of 1986—

(A) on the complete surrender, redemption, or maturity of such policy or contract during calendar year 1996, 1997, or 1998, or

(B) in full discharge during any such calendar year of the obligation under the policy or contract which is in the nature of a refund of the consideration paid for the policy or contract,

then (in lieu of any other inclusion in gross income) such amount shall be includible in gross income ratably over the 4-taxable year period beginning with the taxable year such amount would (but for this paragraph) be includible. The preceding sentence shall only apply to the extent the amount is includible in gross income for the taxable year in which the event described in subparagraph (A) or (B) occurs.

(2) **SPECIAL RULES FOR APPLYING SECTION 264.**—A contract shall not be treated as—

(A) failing to meet the requirement of section 264(c)(1) of the Internal Revenue Code of 1986, or

(B) a single premium contract under section 264(b)(1) of such Code,

solely by reason of an occurrence described in subparagraph (A) or (B) of paragraph (1) of this subsection or solely by

reason of no additional premiums being received under the contract by reason of a lapse occurring after October 13, 1995.

(3) SPECIAL RULE FOR DEFERRED ACQUISITION COSTS.—In the case of the occurrence of any event described in subparagraph (A) or (B) of paragraph (1) of this subsection with respect to any policy or contract—

(A) section 848 of the Internal Revenue Code of 1986 shall not apply to the unamortized balance (if any) of the specified policy acquisition expenses attributable to such policy or contract immediately before the insurance company's taxable year in which such event occurs, and

(B) there shall be allowed as a deduction to such company for such taxable year under chapter 1 of such Code an amount equal to such unamortized balance.

Subtitle B—Treatment of Individuals Who Lose United States Citizenship

SEC. 511. 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 one 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 one 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.

“(4) TREATMENT OF PROPERTY CONTRIBUTED TO CONTROLLED FOREIGN CORPORATIONS.—

“(A) IN GENERAL.—If—

“(i) an individual losing United States citizenship contributes property to any corporation which, at the time of the contribution, is described in subparagraph (B), and

“(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), during the 10-year period referred to in subsection (a), any income or gain on such property (or any other property which has a basis determined in whole or part by reference to such property) received or accrued by the corporation shall be treated as received or accrued directly by such individual and not by such corporation. The preceding sentence shall not apply to the extent the property has been treated under subparagraph (C) as having been sold by such corporation.

“(B) CORPORATION DESCRIBED.—A corporation is described in this subparagraph with respect to an individual if, were such individual a United States citizen—

“(i) such corporation would be a controlled foreign corporation (as defined in 957), and

“(ii) such individual would be a United States shareholder (as defined in section 951(b)) with respect to such corporation.

“(C) DISPOSITION OF STOCK IN CORPORATION.—If stock in the corporation referred to in subparagraph (A) (or any other stock which has a basis determined in whole or part by reference to such stock) is disposed of during the 10-year period referred to in subsection (a) and while the

property referred to in subparagraph (A) is held by such corporation, a pro rata share of such property (determined on the basis of the value of such stock) shall be treated as sold by the corporation immediately before such disposition.

“(D) ANTI-ABUSE RULES.—The Secretary shall prescribe such regulations as may be necessary to prevent the avoidance of the purposes of this paragraph, including where—

“(i) the property is sold to the corporation, and

“(ii) the property taken into account under subparagraph (A) is sold by the corporation.

“(E) INFORMATION REPORTING.—The Secretary shall require such information reporting as is necessary to carry out the purposes of this paragraph.”

(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 one 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, inherit-

ance, 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 one 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).”

26 USC 877 note.

(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) RULING REQUESTS.—In no event shall the 1-year period referred to in section 877(c)(1)(B) of such Code, as amended by this section, expire before the date which is 90 days after the date of the enactment of this Act.

(3) 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 512 shall apply to such individual except that 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.

(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. 512. 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. 513. 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).

Subtitle C—Repeal of Financial Institution Transition Rule to Interest Allocation Rules

SEC. 521. REPEAL OF FINANCIAL INSTITUTION TRANSITION RULE TO INTEREST ALLOCATION RULES.

(a) **IN GENERAL.**—Paragraph (5) of section 1215(c) of the Tax Reform Act of 1986 (Public Law 99-514, 100 Stat. 2548) is hereby repealed.

26 USC 864 note.

(b) **EFFECTIVE DATE.**—

26 USC 864 note.

(1) **IN GENERAL.**—The amendment made by this section shall apply to taxable years beginning after December 31, 1995.

(2) **SPECIAL RULE.**—In the case of the first taxable year beginning after December 31, 1995, the pre-effective date portion of the interest expense of the corporation referred to in such paragraph (5) of such section 1215(c) for such taxable year shall be allocated and apportioned without regard to such amendment. For purposes of the preceding sentence, the pre-effective date portion is the amount which bears the same ratio to the interest expense for such taxable year as the number of days during such taxable year before the date of the enactment of this Act bears to 366.

Approved August 21, 1996.

LEGISLATIVE HISTORY—H.R. 3103 (S. 1028) (S. 1698):

HOUSE REPORTS: Nos. 104-496, Pt. 1 (Comm. on Ways and Means) and 104-736 (Comm. of Conference).

SENATE REPORTS: No. 104-156 accompanying S. 1028 (Comm. on Labor and Human Resources).

CONGRESSIONAL RECORD, Vol. 142 (1996):

Mar. 28, considered and passed House.

Apr. 18, 23, considered and passed Senate, amended, in lieu of S. 1028.

Aug. 1, House agreed to conference report.

Aug. 2, Senate agreed to conference report.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 32 (1996):

Aug. 21, Presidential remarks and statement.