103d CONGRESS  
1ST SESSION  
H. R. 2610

To amend the Social Security Act and the Internal Revenue Code of 1986 to provide for a Mediplan that assures the provision of health insurance coverage to all residents, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JULY 1, 1993

Mr. STARK introduced the following bill; which was referred jointly to the Committees on Ways and Means and Energy and Commerce

SEPTEMBER 29, 1993

Additional sponsors: Mr. COYNE, Mr. SABO, and Mr. YATES

A BILL

To amend the Social Security Act and the Internal Revenue Code of 1986 to provide for a Mediplan that assures the provision of health insurance coverage to all residents, and for other purposes.

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

2 SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

3 (a) SHORT TITLE.—This Act may be cited as “Mediplan Health Care Act of 1993”.

4 (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 ELIGIBILITY AND BENEFITS

Sec. 101. Eligibility and benefits.

"TITLE XXI—MEDIPLAN HEALTH BENEFITS

"PART A—ELIGIBILITY

"Sec. 2101. Eligibility.
"Sec. 2102. Enrollment and Mediplan cards.

"PART B—BENEFITS

"Sec. 2121. Scope of benefits.
"Sec. 2122. Exclusions.

"PART C—PAYMENT FOR BENEFITS AND FINANCING

"Sec. 2141. Payments for benefits.
"Sec. 2142. Mediplan Trust Fund.

"PART D—ADMINISTRATIVE SIMPLIFICATION

"Sec. 2151. Requirement for entitlement verification system.
"Sec. 2152. Requirements for uniform claims and electronic claims data set.
"Sec. 2153. Electronic medical records and reporting.
"Sec. 2154. Uniform hospital cost reporting.
"Sec. 2155. Health service provider defined.

"PART E—GENERAL PROVISIONS

"Sec. 2161. Definitions relating to beneficiaries and income.
"Sec. 2162. Incorporation of certain medicare provisions and other provisions.
"Sec. 2163. State maintenance of effort payments.
"Sec. 2164. Modification of medicaid and other programs to avoid duplication of benefits.
"Sec. 2165. Maintenance of additional benefits for current beneficiaries under group health plans.

"PART F—REGULATION OF MEDIPLAN SUPPLEMENTAL POLICIES

"Sec. 2171. Standards and requirements for Mediplan supplemental policies.
"Sec. 2172. Establishment of standards.
"Sec. 2173. Requirements applicable to all Mediplan supplemental policies.
"Sec. 2174. Standards applicable only to insured Mediplan supplemental policies.
"Sec. 2175. Prohibition of duplication.
"Sec. 2176. Additional prohibitions.
"Sec. 2177. Information disclosure.
"Sec. 2178. Limitations on sales commissions.
"Sec. 2179. Definitions.

"PART G—STATE OPT OUT
TITLE I—HEALTH CARE
ELIGIBILITY AND BENEFITS

SEC. 101. ELIGIBILITY AND BENEFITS.

(a) IN GENERAL.—The Social Security Act is amended by adding at the end the following new title:

“TITLE XXI—MEDIPLAN HEALTH BENEFITS

“PART A—ELIGIBILITY

“SEC. 2101. ELIGIBILITY.

“(a) Universal Eligibility for Residents.—Except as provided in section 2163(a), each individual who is a resident of the United States is entitled to health insurance benefits under this title.

“(b) Special Eligibility Groups.—For purposes of this title, an individual described in subsection (a) may obtain special benefits under this title on the basis of one or more of the following special eligibility groups:
“(1) Children (as defined in section 2161(a)(1)).

“(2) Low-income individuals (as defined in section 2161(a)(2)).

“(3) Pregnant women (as defined in section 2161(a)(3)).

“(c) R e c i p r o c a l C o v e r a g e o f N o n r e s i d e n t s.— An individual who—

“(1) is not a resident of the United States,

“(2) is in the United States, and

“(3) is a national of a foreign state which provides health benefits to nationals of the United States who are nonresidents in that state,

is entitled to such health insurance benefits under this title, but only to the extent the Secretary determines that such benefits would be available to nationals of the United States similarly situated as a nonresident in the foreign state.

“S E C . 2 1 0 2 . E N R O L L M E N T A N D M E D I P L A N C A R D S .

“(a) E n r o l l m e n t.—The Secretary shall provide a mechanism for the enrollment of individuals entitled to benefits under this title and, in conjunction with such enrollment, the issuance of a Mediplan card which may be used for purposes of identification and processing of claims for benefits under this title. Mediplan cards shall
identify (as appropriate) if the individual is a child, a pregnant woman, or a low-income individual.

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(b) Enrollment at Birth.—The mechanism under subsection (a) shall include a process for the automatic enrollment of individuals at the time of birth in the United States.
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PART B—BENEFITS

SEC. 2121. SCOPE OF BENEFITS.

(a) In General.—Except as provided in the succeeding provisions of this part, the benefits provided to an individual described in section 2101(a) by the program established by this title shall consist of entitlement to the same benefits as are provided under title XVIII to individuals entitled to benefits under part A, and enrolled under part B, of title XVIII.

(b) Change in the Deductible and Limit on Cost-Sharing.—

“(1) In General.—Except as provided in the succeeding provisions of this part, the amount of expenses (other than expenses for benefits described in subsection (c)) with respect to which an individual is entitled to have payment made under this title for any year shall first be reduced by a deductible of $350, except that in no case shall the amount of the deductible for all the members of a family exceed
$500. Such deductible shall be instead of the deductible for inpatient hospital services under the first sentence of section 1813(a)(1) and the deductible under section 1833(b).

“(2) LIMIT ON OUT-OF-POCKET EXPENSES.— Whenever in a calendar year an individual’s expenses for deductibles, coinsurance, and copayments with respect to services covered under this title (including expenses for benefits described in subsection (c)) and furnished during the year equals $2,500, or $3,000 for all the members of a family, payment of benefits under this title for the individual (or for the members of such family, respectively) for services furnished during the remainder of the year shall be paid without the application of any coinsurance or copayments.

“(c) PRESCRIPTION DRUGS.—

“(1) IN GENERAL.— Subject to paragraph (2), benefits shall also be made available under this title for outpatient prescription drugs and biologicals (based on a formulary developed by the Secretary).

“(2) SEPARATE DEDUCTIBLE.— With respect to benefits under this subsection, instead of applying the cost-sharing described in subsection (b), except as provided in the succeeding provisions of this sec-
tion and subsection (b)(2), such benefits shall be subject to an annual individual deductible of $800 and coinsurance of 20 percent of the recognized payment amount under section 2141(g).

“(d) CHILDREN.—

“(1) NO DEDUCTIBLES OR COINSURANCE.—In the case of children (as defined in section 2161(a)(1)), there shall be no coinsurance, deductibles, or copayments applicable to covered benefits (including benefits described in paragraphs (2) and (3)).

“(2) ADDITIONAL PREVENTIVE BENEFITS.—

“(A) IN GENERAL.—Subject to the periodicity schedule established with respect to the services under subparagraph (B), for children benefits shall be available under this title for the following items and services:

“(i) Newborn and well-baby care, including normal newborn care and pediatrician services for high-risk deliveries.

“(ii) Well-child care, including routine office visits, routine immunizations (including the vaccine itself), routine laboratory tests, and preventive dental care.
“(B) Periodicity Schedule.—The Secretary, in consultation with the American Academy of Pediatrics and the American Dental Association, shall establish a schedule of periodicity which reflects the general, appropriate frequency with which services listed in subparagraph (A) should be provided to healthy children.

“(3) Other Additional Services for Children.—For children, benefits also shall be available under this title for the following:

“(A) Inpatient hospital services (without regard to the restrictions described in subsections (a)(1) and (b)(1) of section 1812 and the coinsurance described in section 1813(a)(1)).

“(B) Eyeglasses and hearing aids, and examinations therefor.

“(e) Pregnancy-Related Services.—

“(1) In general.—In the case of a pregnant woman (as defined in section 2161(a)(3)), benefits under this title shall include entitlement to have payment made for the following, without the application of deductibles, coinsurance, or copayments, subject to the periodicity schedule established with respect
to the services under paragraph (2) and prior authorization of certain services under paragraph (3):

"(A) Prenatal care, including care for all complications of pregnancy.

"(B) Inpatient labor and delivery services.

"(C) Postnatal care.

"(D) Postnatal family planning services.

"(2) Periodicity Schedule.—The Secretary, in consultation with the American College of Obstetrics and Gynecology, shall establish a schedule of periodicity which reflects the general, appropriate frequency with which services listed in paragraph (1) should be provided to pregnant women without complications of pregnancy.

"(3) Prior Authorization Required for Certain Services.—

"(A) In General.—Except in the case of items and services specified under subparagraph (B), benefits are not available with respect to an item or service under paragraph (1) unless the provision of the item or service has been approved by a utilization and quality control peer review organization before the provision of the item or service.
“(B) Exception for Routine or Common Items and Services.—Subparagraph (A) shall not apply to items and services which the Secretary has specified on a list as being either—

“(i) related to normal pregnancy, or

“(ii) related to a highly prevalent complication of pregnancy,

or in the case of emergency services.

“(4) Multiple Bases for Eligibility.—In the case of a pregnant woman who is also a child or a low-income individual, the benefits under this subsection shall be in addition or supplementation to the benefits otherwise available to the individual.

“(f) Lower-Income Individuals.—

“(1) Limitations on Deductibles and Coinurance.—

“(A) None for Low-Income Individuals.—In the case of a low-income individual, there shall be no coinsurance, deductibles, or copayments under this title.

“(B) Phase-In for Other Lower-Income Individuals.—In the case of an individual whose applicable modified gross income (as defined in section 2161(b)(1)) exceeds the pov-
property level (as defined in section 2161(b)(2)) but does not exceed twice the poverty level, the co-insurance, deductibles, and copayments applicable under this title shall bear the same ratio to the coinsurance, deductibles, and copayments otherwise applicable as—

"(i) the excess of the applicable modified gross income over the poverty level, bears to

"(ii) the poverty level.

If the ratio determined under the preceding sentence is not a multiple of 25 percentage points, such ratio shall be rounded to the nearest 25 percentage points.

"(2) ADDITIONAL BENEFITS FOR LOW-INCOME INDIVIDUALS.—In the case of low-income individuals (as defined in section 2161(a)(2)), benefits under this title shall also include entitlement to have payment made for the following, without the application of deductibles, coinsurance, or copayments:

"(A) Inpatient hospital services (without regard to the restrictions described in subsections (a)(1) and (b)(1) of section 1812 and the coinsurance described in section 1813(a)(1)).
“(B) Eyeglasses and hearing aids and examinations therefor.

**SEC. 2122. EXCLUSIONS.**

“(a) In General.—Except as provided in this section, section 1862 shall apply to expenses incurred for items and services provided under this title the same manner as such section applies to items and services provided under title XVIII.

“(b) Benefits Exception.—

“(1) Childrens' Services.—In applying section 1862(a) with respect to services described in section 2121(d)(2)(A) (relating to well-child services), payment shall not be denied under paragraph (1), (7), or (12) of such section 1862(a) if the services are provided in accordance with the periodicity schedule described in section 2121(d)(2)(B).

“(2) Services for Pregnant Women.—In applying section 1862(a) with respect to services described in section 2121(e)(1) (other than subparagraph (A) thereof), payment shall not be denied under paragraph (1) or (7) of such section 1862(a) if the services are provided in accordance with the periodicity schedule described in section 2121(e)(2).

“(3) Treatment of Eyeglasses and Hearing Aids for Children and Low-Income Individuals.
UALS.—Payment shall not be denied under this title under section 1862(a)(7) with respect to eyeglasses and hearing aids and examinations therefor in the case of children and low-income individuals.

“(c) COORDINATION OF PAYMENTS.—

“(1) PRIMARY TO GROUP HEALTH PLANS.—

Section 1862(b)(1) (relating to requirements of group health plans) shall not apply under this title.

“(2) SECONDARY TO MEDICARE.—Payment shall not be made under this title with respect to benefits to the extent that payment for such benefits may be made under title XVIII.

“PART C—PAYMENT FOR BENEFITS AND FINANCING

“SEC. 2141. PAYMENTS FOR BENEFITS.

“(a) IN GENERAL.—Except as otherwise provided in this section and in section 2121—

“(1) payment of benefits under this title with respect to benefits shall be made in an amount consistent with subsection (h) and on the same basis as payment is made with respect to such benefits under title XVIII, and

“(2) the provisions of sections 1814, 1833, 1834, 1842, 1848, and 1886 shall apply to payment of benefits under this title in the same manner as they apply to benefits under title XVIII.
“(b) No Cost-Sharing for Certain Services.— No deductibles, coinsurance, copayments, or other cost-sharing shall be imposed with respect to—

“(1) well-child care services described in section 2121(d)(1),

“(2) items and services for which an individual is entitled under this title as a pregnant woman, and

“(3) items and services for qualified low-income individuals.

For provision limiting the deductibles, coinsurance, and copayments under this title in any year, see section 2121(b)(2).

“(c) No Extra Billing Permitted.— Payment under this title may only be made on an assignment-related basis (as defined in section 1842(i)(1)). If an entity knowingly and willfully presents or causes to be presented a claim or bills an individual enrolled under this title for charges for services other than on an assignment-related basis, the Secretary may apply sanctions against such entity in accordance with section 1842(j)(2).

“(d) Adjustment of Payments.—

“(1) Establishment of New DRGs and Weights.— In making payment under this title with respect to inpatient hospital services, the Secretary shall establish such additional diagnosis-related
groups (and weighting factors with respect to discharges within such groups) and make such adjustments in the diagnosis-related groups and weighting factors with respect to discharges within such groups otherwise established under section 1886(d)(4) as may be necessary—

“(A) to reflect the types of discharges occurring under this title which are not occurring under title XVIII, and

“(B) to provide for a weighting factor, for cesarean section deliveries, which is 95 percent of the weighting factor that otherwise would be established.

“(2) P AYMENT FOR OBSTETRICAL SERVICES.—

“(A) G L O B A L F E E .— I n making payment under this title with respect to the group of obstetrical services typical of treatment throughout a course of pregnancy, the Secretary shall establish, as a schedule under section 1848, a global fee with respect to such group of services.

“(B) B O N U S F O R E A R L Y P R E S E N T A T I O N .— T he fee schedule amount with respect to obstetrical services under this title shall be increased by 5 percent in the case of services
furnished to women who have presented for pre-natal care during the first trimester.

“(C) Disincentive for Cesarean Sections.—The fee schedule amount otherwise established with respect to a cesarean section shall be 95 percent of the fee schedule amount otherwise established.

“(e) Conditions of and Limitations on Payments.—The provisions of sections 1814 and 1835 shall apply to payment for services under this title in the same manner as they apply to payment for services under parts A and B, respectively, of title XVIII.

“(f) Use of Trust Fund.—In carrying out this section, any reference in title XVIII to a trust fund shall be treated as a reference to the Mediplan Trust Fund established under section 2142.

“(g) Payment for Outpatient Prescription Drugs and Biologicals.—The Secretary, taking into account the payment methodology that was described in the amendments made by section 202 of the Medicare Catastrophic Coverage Act of 1988 (as in effect before its repeal), shall establish a prospective payment methodology for the payment for outpatient prescription drugs and biologicals under this title. Such methodology shall be established in a manner so as to meet the assurance de-
scribed in subsection (h) with respect to the class of services that includes outpatient prescription drugs and biologicals.

"(h) COMPUTATION OF APPROPRIATE REFERENCE RATES OR CONVERSION FACTORS TO STAY WITHIN BUDGET.—In computing the amount of payment with respect to services (within a class of services) for which a standardized amount, conversion factor, or other rate basis is established under title XVIII, such standardized amount, conversion factor, or other rate basis shall be established in such a manner as will assure that—

"(1) the aggregate Mediplan expenditures (as defined in section 201(d) of the Mediplan Health Care Act of 1993) for all the services within such class which are not attributable to services furnished to individuals who are enrolled in a staff or group model health maintenance organization (as defined in section 207(b)(2)(B) of such Act) with respect to health care services covered under the subscriber agreement, is equal to

"(2) the allocation to such class for the year under section 202 of such Act with respect to the national Mediplan expenditure budget, less the product of such allocation and the proportion of such allocation that the Secretary estimates is attributable
to services furnished to individuals who are enrolled in such a staff or group model health maintenance organization with respect to health care services covered under the subscriber agreement.

In computing the aggregate Mediplan expenditures under paragraph (1), there shall be taken into account the adjustment in medicare payment rates under section 205 of such Act.

"SEC. 2142. MEDIPLAN TRUST FUND."

"(a) Establishment.—(1) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the ‘Mediplan Trust Fund’ (in this section referred to as the ‘Trust Fund’). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1) and amounts appropriated under paragraph (2).

"(2) There are hereby appropriated to the Trust Fund amounts equivalent to 100 percent of the taxes imposed by sections 59B and 59C of the Internal Revenue Code of 1986. The amounts appropriated by the preceding sentence shall be transferred from time to time from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes, paid to or deposited into the Treasury; and proper adjustments shall
be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the taxes specified in such sentence.

“(b) Incorporation of Provisions.—

“(1) In general.—Subject to paragraph (2), the provisions of subsections (b) through (e) and (g) through (i) of section 1817 shall apply to the Trust Fund in the same manner as they apply to the Federal Hospital Insurance Trust Fund.

“(2) Exceptions.—In applying paragraph (1)—

“(A) the Board of Trustees and Managing Trustee of the Trust Fund shall be composed of the members of the Board of Trustees and the Managing Trustee, respectively, of the Federal Hospital Insurance Trust Fund; and

“(B) any reference in section 1817 to the Federal Hospital Insurance Trust Fund or to title XVIII (or part A thereof) is deemed a reference to the Trust Fund under this section and this title, respectively.

“PART D—ADMINISTRATIVE SIMPLIFICATION

“SEC. 2151. REQUIREMENT FOR ENTITLEMENT VERIFICATION SYSTEM.

“(a) In general.—
“(1) **Requirement.**—Each Mediplan supplemental plan (as defined in section 2166(d)) and the Secretary, with respect to the plan provided under this title, shall provide for an electronic system, that is certified by the Secretary as meeting the standards established under subsection (c), for the verification of an individual’s entitlement to benefits under such plan.

“(2) **Deadline for Application of Requirement.**—The deadline specified under this paragraph for the requirement under paragraph (1) is 6 months after the date the standards are established under subsection (c).

“(b) **Enforcement Through Civil Money Penalties.**—

“(1) **In General.**—In the case of a Mediplan supplemental plan that fails to provide for an electronic verification system that is certified by the Secretary as meeting the standards established under subsection (c), the plan is subject to a civil money penalty of not to exceed $100 for each day in which such failure persists. The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to a civil money penalty under this subsection in the same manner as
such provisions apply to a penalty or proceeding
under section 1128A(a) of such Act.

“(2) EFFECTIVE DATE.—No penalty may be
imposed under paragraph (1) for any failure occurring before the deadline specified in subsection (a)(2).

“(c) STANDARDS FOR ENTITLEMENT VERIFICATION SYSTEMS.—

“(1) IN GENERAL.—The Secretary shall establish standards consistent with this subsection respecting the requirements for certification of entitlement verification systems.

“(2) INFORMATION AVAILABLE.—Such standards shall require a system to provide information, with respect to individuals, concerning the following:

“(A) The specific benefits to which the individual is entitled under the plan.

“(B) Current status of the individual with respect to fulfillment of deductibles, copayments, and out-of-pocket limits on cost-sharing.

“(C) Restrictions on providers who may provide covered services, including utilization controls (such as preadmission certification).
“(3) Form of Inquiry.—Each verification system shall be capable of accepting inquiries under this subsection from health care providers in a variety of electronic and other forms, including—

“(A) through electronic transmission of information on the uniform health claims card (in a manner similar to that for verification of credit card purchases),

“(B) through the use of a touch-tone telephone line, and

“(C) through the use of a computer modem.

The system shall also provide, for an additional fee, for the acceptance of inquiries in a nonelectronic form.

“(4) Form of Response.—Each such system shall be capable of responding to such inquiries under this subsection in a variety of electronic and other forms, including—

“(A) through modem transmission of information,

“(B) through computer synthesized voice communication, and

“(C) through transmission of information to a facsimile (fax) machine.
The system shall also provide, for an additional fee, for the response to inquiries in a nonelectronic form.

“(5) Limitation on fees.—Neither the Secretary nor a Mediplan supplemental may impose a fee for the acceptance or response to an inquiry under this subsection except where the acceptance or response is in a nonelectronic form.

“(6) Public domain software to providers.—The Secretary shall provide for the development, and shall make available without charge to health service providers and Mediplan supplemental plans, such computer software as will enable—

“(A) such providers to make inquiries, and receive responses, electronically respecting the eligibility and benefits of an individual under plans, and

“(B) such plans to make inquiries, and receive responses, electronically respecting liability of other plans for the provision or payment of benefits.

“(7) Deadline.—The Secretary shall first establish the standards under this subsection (and shall develop and make available the software under paragraph (6)) by not later than 12 months after the date of the enactment of this title.
“(d) APPLICATION TO MEDICARE AND MEDICAID PROGRAMS.—

“(1) MEDICARE PROGRAM.—The Secretary shall provide, in regulations promulgated to carry out the medicare program, that there is established an entitlement verification system that meets the standards established under subsection (c), by not later than the deadline specified in subsection (a)(2).

“(2) STATE MEDICAID PLANS.—As a condition for the approval of a State plan under the medicaid program, effective for calendar quarters beginning on or after the deadline specified in subsection (a)(2), each such plan shall provide, in accordance with regulations of the Secretary, that there is established an entitlement verification system that meets the standards established under subsection (c).

“SEC. 2152. REQUIREMENTS FOR UNIFORM CLAIMS AND ELECTRONIC CLAIMS DATA SET.

“(a) REQUIREMENTS.—

“(1) SUBMISSION OF CLAIMS.—Each health service provider that furnishes services in the United States for which payment may be made under this title or under a Mediplan supplemental plan shall submit any claim for payment for such services only
in a form and manner consistent with standards established under subsection (c).

“(2) Acceptance of claims.—The Secretary and a Mediplan supplemental plan may not reject a claim for payment under this title or the plan on the basis of the form or manner in which the claim is submitted if the claim is submitted in accordance with the standards established under subsection (c).

“(3) Effective date.—This subsection shall apply to claims for services furnished on or after the date that is 6 months after the date standards are established under subsection (c).

“(b) Enforcement through civil money penalties.—

“(1) In general.—

“(A) Providers.—In the case of a health service provider that submits a claim in violation of subsection (a)(1), the provider is subject to a civil money penalty of not to exceed $100 (or, if greater, the amount of the claim) for each such violation.

“(B) Plans.—In the case of a Mediplan supplemental plan that rejects a claim in violation of subsection (a)(2), the plan is subject to a civil money penalty of not to exceed $100 (or,
if greater, the amount of the claim) for each such violation.

“(2) Process.—The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to a civil money penalty under paragraph (1) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

“(3) Sunset for penalty.—No civil money penalty may be imposed under this subsection for submission (or rejection) of any claim on or after the date that is 36 months after the effective date specified in subsection (a)(3).

“(c) Standards relating to uniform claims and electronic claims data set.—

“(1) Establishment of standards.—The Secretary shall establish standards that—

“(A) relate to the form and manner of submission of claims for benefits under this title and under a Mediplan supplemental plan, and

“(B) define the data elements to be contained in a uniform electronic claims data set to be used with respect to such claims.

“(2) Scope of information.—
“(A) IN GENERAL.—The standards under this subsection are intended to cover substantially most claims that are filed under this title and under Mediplan supplemental plans. Such information need not include all elements that may potentially be required to be reported under utilization review provisions of such plans.

“(B) ENSURING ACCOUNTABILITY FOR CLAIMS SUBMITTED ELECTRONICALLY.—In establishing such standards, the Secretary, in consultation with appropriate agencies, shall include such methods of ensuring provider responsibility and accountability for claims submitted electronically that are designed to control fraud and abuse in the submission of such claims.

“(C) COMPONENTS.—In establishing such standards the Secretary shall—

“(i) with respect to data elements, define data fields, formats, and medical nomenclature, and plan benefit and insurance information;
“(ii) develop a single, uniform coding system for diagnostic and procedure codes; and

“(iii) provide for standards for the uniform electronic transmission of such elements.

“(3) Coordination with standards for electronic medical records.—In establishing standards under this subsection, the Secretary shall assure that—

“(A) the development of such standards is coordinated with the development of the standards for electronic medical records under section 2153, and

“(B) the coding of data elements under the uniform electronic claims data set and the coding of the same elements in the uniform hospital clinical data set are consistent.

“(4) Use of task forces.—In adopting standards under this subsection—

“(A) the Secretary shall take into account the recommendations of current task forces, including at least the Workgroup on Electronic Data Interchange, National Uniform Billing Committee, the Uniform Claim Task Force, and
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the Computer-based Patient Record Institute, and

“(B) the Secretary shall provide that the electronic transmission standards are consist-
ent, to the extent practicable, with the applicable standards established by the Accredited
Standards Committee X-12 of the American National Standards Institute.

“(5) **Uniform, Unique Provider Identification Codes.**—In establishing standards under this
subsection—

“(A) the Secretary shall provide for a unique identifier code for each health service
provider that furnishes services for which a claim may be submitted under this title or
under a Mediplan supplemental plan, and

“(B) in the case of a provider that has a unique identifier issued for purposes of title
XVIII, the code provided under subparagraph (A) shall be the same as such unique identifier.

“(6) **Public Domain Software to Providers.**—The Secretary shall provide for the develop-
ment, and shall make available without charge to health service providers, such computer software as
will enable the providers to submit claims and to re-
ceive verification of claims status electronically.

“(7) Standards for paper claims.—The
standards shall provide for a uniform paper claims
form which is consistent with data elements required
for the submission of claims electronically.

“(8) Standards for claims for clinical
laboratory tests.—The standards shall provide
that claims for clinical laboratory tests for which
benefits are provided under this title or under a
Mediplan supplemental plan shall be submitted di-
rectly by the person or entity that performed (or su-
pervised the performance of) the tests to the plan in
a manner consistent with (and subject to such excep-
tions as are provided under) the requirement for di-
rect submission of such claims under title XVIII.

“(9) Deadline.—The Secretary shall first pro-
vide for the standards for the uniform claims under
this subsection (and shall develop and make avail-
able the software under paragraph (6)) by not later
than 1 year after the date of the enactment of this
title.

“(d) Use under this title and Medicare and
Medicaid Programs.—
“(1) Requirement for Providers.—In the case of a health service provider that submits a claim for services furnished under this title in violation of subsection (a)(1), no payment shall be made under this title for such services.

“(2) Requirements of Intermediaries and Carriers Under Medicare Program.—The Secretary shall provide, in regulations promulgated to carry out this title, that the claims process provided under this title conforms to the standards established under subsection (c).

“(3) Requirements of State Medicaid Plans.—As a condition for the approval of State plans under the medicaid program, effective as of the effective date specified in subsection (a)(3), each such plan shall provide, in accordance with regulations of the Secretary, that the claims process provided under the plan is modified to the extent required to conform to the standards established under subsection (c).

“SEC. 2153. ELECTRONIC MEDICAL RECORDS AND REPORTING.

“(a) Standards for Electronic Medical Records for Hospitals.—

“(1) Promulgation of standards.—
“(A) IN GENERAL.—Between July 1, 1994, and January 1, 1995, the Secretary shall promulgate standards described in paragraph (2) for hospitals concerning electronic medical records.

“(B) REVISION.—The Secretary may from time to time revise the standards promulgated under this paragraph.

“(2) CONTENTS OF STANDARDS.—The standards promulgated under paragraph (1) shall include at least the following:

“(A) A definition of a uniform hospital clinical data set, including a definition of the set of comprehensive data elements, for use by utilization and quality control peer review organizations.

“(B) Standards for an electronic patient care information system with data obtained at the point of care.

“(C) A specification of, and manner of presentation of, the individual data elements of the set and system under this paragraph.

“(D) Standards concerning the transmission of electronic medical data.
“(E) Standards relating to confidentiality of patient-specific information, which include the physical security of electronic data and the use of keys, passwords, encryption, and other means to ensure the protection of the confidentiality and privacy of electronic data.

“(3) Coordination with standards for uniform electronic claims data set.—In establishing standards under this subsection, the Secretary shall assure that—

“(A) the development of such standards is coordinated with the development of the standards for the uniform electronic claims data set under subsection (b), and

“(B) the coding of data elements under the uniform hospital clinical data set and the coding of the same elements under the uniform electronic claims data set are consistent.

“(4) Consultation.—In establishing standards under this subsection, the Secretary shall—

“(A) consult with the American National Standards Institute, hospitals, health benefit plans, and other interested parties, and

“(B) take into consideration, in developing standards under paragraph (2)(A), the data set
used by the utilization and quality control peer review program under part B of title XI.

“(b) REQUIREMENT FOR APPLICATION OF ELECTRONIC RECORDS STANDARDS TO HOSPITALS.—

“(1) AS CONDITION OF MEDICARE PARTICIPATION.—As of January 1, 1996, each hospital, as a requirement of each participation agreement under this title, shall, in accordance with the standards promulgated under subsection (a)(1)—

“(A) maintain clinical data included in the uniform hospital clinical data set under subsection (a)(2)(A) in electronic form on all inpatients,

“(B) upon request of the Secretary or of a utilization and quality control peer review organization (with which the Secretary has entered into a contract under part B of title XI), transmit electronically data requested from such data set, and

“(C) upon request of the Secretary, or of a fiscal intermediary or carrier, transmit electronically any data (with respect to a claim) from such data set.

“(2) APPLICATION OF PRESENTATION AND TRANSMISSION STANDARDS TO ELECTRONIC TRANS-
MISSION TO FEDERAL AGENCIES.—Effective January 1, 1996, if a hospital is required under a Federal program to transmit a data element that is subject to a standard, promulgated under subsection (a)(1), described in subparagraph (C) or (D) of subsection (a)(2), the head of the Federal agency responsible for such program (if not otherwise authorized) is authorized to require the provider to present and transmit the data element electronically in accordance with such a standard.

“(c) LIMITATION ON DATA REQUIREMENTS WHERE STANDARDS IN EFFECT.—

“(1) IN GENERAL.—On or after January 1, 1996, the Secretary under this title or under title XVIII (including any carrier or fiscal intermediary or nor any utilization and quality control peer review organization) and a Mediplan supplemental plan may not require, for the purpose of utilization review or as a condition of providing benefits or making payments under this title, title XVIII, or the plan, that a hospital—

“(A) provide any data element not in the uniform hospital clinical data set specified under the standards promulgated under subsection (a), or
“(B) transmit or present any such data element in a manner inconsistent with such standards applicable to such transmission or presentation.

“(2) Compliance.—The Secretary may impose a civil money penalty on any Mediplan supplemental plan that fails to comply with paragraph (1) in an amount not to exceed $100 for each such failure. The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

“(3) Application to Medicaid Program.—As a condition for the approval of State plans under the medicaid program and in accordance with regulations of the Secretary, effective as of January 1, 1996, each such plan may not require that a hospital, for the purpose of utilization review or as a condition of providing benefits or making payments under the plan—

“(A) provide any data element not in the uniform hospital clinical data set specified
under the standards promulgated under subsection (a), or

"(B) transmit or present any such data element in a manner inconsistent with such standards applicable to such transmission or presentation.

"(d) Preemption of State Quill Pen Laws.—

"(1) In General.— Any provision of State law that requires medical or health insurance records (including billing information) to be maintained in written, rather than electronic, form shall deemed to be satisfied if the records are maintained in an electronic form that meets standards established by the Secretary under paragraph (2).

"(2) Secretarial Authority.— Not later than 1 year after the date of the enactment of this title, the Secretary shall issue regulations to carry out paragraph (1). The regulations shall provide for an electronic substitute that is in the form of a unique identifier (assigned to each authorized individual) that serves the functional equivalent of a signature. The regulations may provide for such exceptions to paragraph (1) as the Secretary determines to be necessary to prevent fraud and abuse, to prevent the illegal distribution of controlled substances,
and in such other cases as the Secretary deems appropriate.

“(3) **EFFECTIVE DATE.**—Paragraph (1) shall take effect on the first day of the first month that begins more than 30 days after the date the Secretary issues the regulations referred to in paragraph (2).

“**SEC. 2154. UNIFORM HOSPITAL COST REPORTING.**

“Each hospital, as a requirement under a participation agreement under this title for each cost reporting period beginning during or after fiscal year 1993, shall provide for the reporting of information to the Secretary with respect to any hospital care provided in a uniform manner consistent with standards established by the Secretary to carry out section 4007(c) of the Omnibus Budget Reconciliation Act of 1987 and in an electronic form consistent with standards established by the Secretary.

“**SEC. 2155. HEALTH SERVICE PROVIDER DEFINED.**

“In this part, the term ‘health service provider’ includes a provider of services (as defined in section 1861(u)), physician, supplier, and other person furnishing health care services.
PART E—GENERAL PROVISIONS

SEC. 2161. DEFINITIONS RELATING TO BENEFICIARIES AND INCOME.

“(a) TERMS RELATING TO BENEFICIARIES.—In this title:

“(1) CHILD.—The term ‘child’ means an individual who throughout a month has not attained 23 years of age.

“(2) LOW-INCOME INDIVIDUAL.—The term ‘low-income individual’ means an individual whose applicable modified gross income (as defined in subsection (b)(1)) is less than 100 percent of the poverty level (as defined in subsection (b)(2)).

“(3) PREGNANT WOMAN.—The term ‘pregnant woman’ means a woman who has been certified by a physician (in a manner specified by the Secretary) as being pregnant, until the last day of the month in which the 60-day period (beginning on the date of termination of the pregnancy) ends.

“(b) TERMS RELATING TO INCOME.—In this title:

“(1) APPLICABLE MODIFIED GROSS INCOME.—

“(A) IN GENERAL.—Except as provided in this paragraph, the term ‘applicable modified gross income’ means, for a calendar year for an individual, the modified gross income (as de-
fined in section 59B(c) of the Internal Revenue Code of 1986) of the taxpayer (or the taxpayer for whom the individual may be claimed as a dependent) for the taxable year ending in the second previous calendar year.

"(B) Application of current year modified gross income.—

"(i) In general.—Subject to clause (ii), the Secretary shall establish a procedure under which an individual may file a declaration of estimated modified gross income for a taxable year ending in a calendar year, which modified gross income will apply under this subsection as the applicable modified gross income for the calendar year. Subject to clause (ii), such procedure shall be applicable regardless of whether or not the individual filed a tax return for the taxable year ending in the second previous calendar year.

"(ii) Limitation on application.—The Secretary may limit the application of clause (i), in the case of individuals who have filed tax returns for the taxable year ending in the second previous calendar
year, to individuals with respect to whom the applicable modified gross income will be reduced by at least 20 percent as a result of the application of such clause.

“(iii) Requirement for return.—Any individual who has filed a declaration under clause (i) for a calendar year is required to file an income tax return for the taxable year in the calendar year, regardless of whether any income tax is actually owed for the year. The failure of the individual to file such a return makes the individual liable for overpayments under this title under clause (iv) in the same manner as if this paragraph had not applied.

“(iv) Collection for overpayments.—If a declaration of estimated modified gross income is made applicable to a calendar year under clause (i) and the actual modified gross income for that taxable year exceeds such estimated modified gross income, the individual shall be liable to the United States for 110 percent of the amount of additional payments made under this title as a result of the use of
such estimated modified gross income instead of the actual modified gross income for that taxable year.

“(C) TRANSMITTAL OF INFORMATION.—By not later than October 1 of each year, the Secretary of the Treasury shall transmit to the Secretary such information relating to the applicable modified gross income of individuals for the taxable year ending in the previous year as may be necessary to apply this title in the succeeding calendar year.

“(2) POVERTY LEVEL.—The term ‘poverty level’ means, for an individual in a family, the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

“SEC. 2162. INCORPORATION OF CERTAIN MEDICARE PROVISIONS AND OTHER PROVISIONS.

“(a) USE OF CARRIERS AND INTERMEDIARIES.—The Secretary shall provide for the administration of this title through the use of fiscal intermediaries and carriers in the same manner as title XVIII is carried out through the use of such fiscal intermediaries and carriers, except
that no payment shall be made under this title except on
the basis of bills or charges that are submitted electroni-
cally in a manner specified by the Secretary.

"(b) DEFINITIONS.—Except as otherwise provided in
this title, the definitions contained in section 1861 shall
apply for purposes of this title in the same manner as they
apply for purposes of title XVIII.

"(c) CERTIFICATION, PROVIDER QUALIFICATION,
ETC.—The provisions of sections 1863 through 1875, sec-
tions 1877 through 1880, section 1883, section 1885, and
sections 1887 through 1892 shall apply to this title in the
same manner as they apply to title XVIII.

"(d) HEALTH MAINTENANCE ORGANIZATIONS AND
COMPETITIVE MEDICAL PLANS.—

"(1) IN GENERAL.—Except as provided in this
subsection, section 1876 shall apply to individuals
entitled to benefits under this title in the same man-
er as such section applies to individuals entitled to
benefits under part A, and enrolled under part B, of
title XVIII.

"(2) APPLICATION.—In applying section 1876
under this section—

"(A) the provisions of such section relating
only to individuals enrolled under part B of title
XVIII shall not apply;
“(B) any reference to a Trust Fund established under title XVIII and to benefits under such title is deemed a reference to the Mediplan Trust Fund and to benefits under this title;

“(C) the adjusted average per capita cost and the adjusted community rate shall be determined on the basis of benefits and payment rates under this title; and

“(D) subsection (f) shall not apply.

“(e) Title XI Provisions.—The following provisions shall apply to this title in the same manner as they apply to title XVIII:

“(1) Sections 1124, 1126, and 1128 through 1128B (relating to fraud and abuse).

“(2) Section 1134 (relating to nonprofit hospital philanthropy).

“(3) Section 1138 (relating to hospital protocols for organ procurement and standards for organ procurement agencies).

“(4) Section 1142 (relating to research on outcomes of health care services and procedures), except that any reference in such section to a Trust Fund is deemed a reference to the Mediplan Trust Fund.
“(5) Part B of title XI (relating to peer review of the utilization and quality of health care services).

“(f) Other Provisions.—The provisions of section 201(i) shall apply to this title and the Mediplan Trust Fund in the same manner as they apply to title XVIII and the Federal Hospital Insurance Trust Fund.

“SEC. 2163. STATE MAINTENANCE OF EFFORT PAYMENTS.

“(a) Condition of Coverage.—Notwithstanding any other provision of this title, no individual who is a resident of a State is eligible for benefits under this title for a month in a calendar year, unless the State provides (in a manner and at a time specified by the Secretary) for payment to the Mediplan Trust Fund of 1/12th of the amount specified in subsection (b) for the year.

“(b) Maintenance of Effort Amount.—The amount of payment specified in this subsection for a State for a year is equal to the amount of payment (net of Federal payments) made by a State under its State plan under title XIX for 1993 for medical assistance with respect to which benefits would have been payable under this title for low-income individuals if this title were in effect in that year, increased to the year involved by the compounded sum of the increase in the consumer price index for all urban consumers (U.S. City average, as published by the
SEC. 2164. MODIFICATION OF MEDICAID AND OTHER PROGRAMS TO AVOID DUPLICATION OF BENEFITS.

"Notwithstanding any other provision of law—

"(1) a State plan under title XIX shall not provide any medical assistance for benefits with respect to which any payments may be made under this title;

"(2) a health benefits plan under chapter 89 of title 5, United States Code, shall not provide benefits for which any payment may be made under this title; and

"(3) health benefits shall not be available under the Civilian Health and Medical Program of the Uniformed Services (as defined in section 1072(4) of title 10, United States Code) for services for which payment may be made under this title.

SEC. 2165. MAINTENANCE OF ADDITIONAL BENEFITS FOR CURRENT BENEFICIARIES UNDER GROUP HEALTH PLANS.

"(a) In General.—In the case of a group health plan (as defined in section 5000(b)(1) of the Internal Revenue Code of 1986) that, as of the date of the enactment
of this title, provides any health benefit to an employee
or former employee or a family member of an employee
or former employee that is additional to the benefits pro-
vided under this title, the group health plan must continue
to make available such an additional benefit to such an
individual notwithstanding the enactment of this title.

"(b) Limitation to Current Beneficiaries.—
Subsection (a) shall not apply to an individual who is not
entitled to benefits under the group health plan as of the
date of the enactment of this title.

"(c) Enforcement.—There is established a private
cause of action for damages (which shall be in an amount
triple the amount otherwise provided) in the case of a
group health plan that fails to continue to provide benefits
in accordance with subsection (a).

"Part F—Regulation of Mediplan Supplemental
Policies

"Sec. 2171. Standards and Requirements for
Mediplan Supplemental Policies.

"(a) Certification Required.—

"(1) In general.—No Mediplan supplemental
policy (as defined in section 2179(4)) may be issued
on or after the effective date specified in subsection
(d) (and no new contract may be offered under such
policy with respect to any individual or group begin-
ning on or after such effective date) unless the policy has been certified—

“(A) by the Secretary (in accordance with such procedures as the Secretary establishes),
or

“(B) by a State regulatory program (approved under subsection (b)),
as meeting the standards established under section 2172 by such effective date.

“(2) POLICY DISAPPROVED.— If the Secretary (or, in the case of a policy certified by a State regulatory program, the State) determines that a Mediplan supplemental policy does not meet the applicable standards of this title on or after such effective date, no coverage may be provided under the plan to individuals not enrolled as of the date of the determination and the policy may not be continued for policy years beginning after the date of such determination until the Secretary (or program) determines that such policy is in compliance with such standards.

“(b) STATE APPROVED PROGRAMS.—

“(1) IN GENERAL.— If the Secretary determines that a State has in effect an effective regulatory program for the application of the standards established
under section 2172 to Mediplan supplemental policies, the Secretary may approve such program for purposes of certification of Mediplan supplemental policies under this title.

“(2) ANNUAL REPORTS.—As a condition for the continued approval of such a regulatory program, the State shall report to the Secretary annually such information as the Secretary may require with respect to the performance of the program. Such information shall include a list of the Mediplan supplemental policies certified under the program, the compliance of such policies with the standards established under section 2172, and enforcement actions taken to ensure such compliance.

“(3) PERIODIC SECRETARIAL REVIEW OF STATE REGULATORY PROGRAMS.—The Secretary annually shall review State regulatory programs approved under paragraph (1) to determine if they continue to apply and enforce the standards. If the Secretary initially determines that a State regulatory program no longer is applying and enforcing such standards, the Secretary shall provide the State an opportunity to adopt such a plan of correction that would bring such program into compliance. If the Secretary makes a final determination that the State regu-
latory program, fails to apply and enforce such standards after such an opportunity, the Secretary shall disapprove such program and reassume respon-
sibility for certification of all Mediplan supplemental policies in that State.

“(4) GAO AUDITS.— The Comptroller General shall conduct periodic reviews on a sample of State regulatory programs approved under paragraph (1) to determine their compliance with the requirements of such paragraph. The Comptroller General shall report to the Secretary and Congress on the findings of such reviews.

“(c) EXCISE TAX SANCTIONS.— Nonqualified Mediplan supplemental policies are subject to an excise tax under section 5000A of the Internal Revenue Code of 1986.

“(d) EFFECTIVE DATE SPECIFIED.—

“(1) IN GENERAL.— Subject to paragraph (2), the effective date specified in this subsection for a State is the earlier of—

“(A) the date the State changes its statutes or regulations to establish a regulatory program that meets the requirements of this part, or
“(B) 1 year after the date the Secretary first publishes standards under section 2172.

“(2) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies as—

“(A) requiring State legislation (other than legislation appropriating funds) to establish a regulatory program that meets the requirements of this part, but

“(B) having a legislature which is not scheduled to meet in 1994 in a legislative session in which such legislation may be considered,

the effective date specified in this subsection is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1994. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

“SEC. 2172. ESTABLISHMENT OF STANDARDS.

“(a) ESTABLISHMENT OF STANDARDS.—The Secretary shall develop and publish, by not later than 9 months after the the date of the enactment of this title,
specifc standards to implement the requirements of this
title and to be applied under section 5000A of the Internal

"(b) More Stringent State Standards Per-
mittted.—In the case of insured Mediplan supplemental
policies (as defined in section 2174(c)(2)), a State may
implement standards that are more stringent than the
standards established under this section.

"(c) Application to ERISA.—The Secretary shall
consult with the Secretary of Labor concerning the appli-
cation of the requirements of this title to employee welfare
benefit plans under title I of the Employee Retirement In-

"Sec. 2173. Requirements Applicable to All
Mediplan SupPLEMENTAL POLICIES.

"(a) No Discrimination Based on Health Sta-
tus.—

"(1) Provision of services.—Except as pro-
vided under subsection (b), a Mediplan supplemental
policy may not deny, limit, or condition the coverage
under (or benefits of) the plan based on the health
status, claims experience, receipt of health care,
medical history, or lack of evidence of insurability,
of an individual.
“(2) **Premium Charges.**—A Mediplan supplemental policy may not vary premiums charged based on the health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability, of an individual.

“(b) **Treatment of Pre-existing Condition Exclusions for All Services.**—

“(1) **In General.**—Subject to the succeeding provisions of this subsection, a Mediplan supplemental policy may exclude coverage with respect to services related to treatment of a pre-existing condition, but the period of such exclusion may not exceed 6 months.

“(2) **Nonapplication to Newborns.**—The exclusion of coverage permitted under paragraph (1) shall not apply to services furnished to newborns.

“(3) **Credititing of Previous Coverage.**—

“(A) **In General.**—If an individual is in a period of continuous coverage (as defined in subparagraph (B)(i)) with respect to particular services as of the date of initial coverage under a plan, any period of exclusion of coverage with respect to a pre-existing condition for such services or type of services shall be reduced by 1
month for each month in the period of continuous coverage.

"(B) DEFINITIONS.—In this paragraph:

"(i) PERIOD OF CONTINUOUS COVERAGE.—The term ‘period of continuous coverage’ means, with respect to particular services, the period beginning on the date an individual is enrolled under a Mediplan supplemental policy or health benefit plan or program (including the medicare program, a State plan under title XIX, continuation coverage under section 4980B of the Internal Revenue Code of 1986, or a State general medical assistance program) which provides the same or substantially similar benefits with respect to such services and ends on the date the individual is not so enrolled for a continuous period of more than 3 months.

"(ii) PRE-EXISTING CONDITION.—The term ‘pre-existing condition’ means, with respect to coverage under a policy, a condition which has been diagnosed or treated during the 3-month period ending on the day before the first date of such coverage,
except that such term does not include a condition which was first diagnosed or treated during a period of continuous coverage.

“(C) Standards for similar benefits.—The Secretary shall establish such criteria for determining if benefits are substantially similar as may be necessary to carry out this subsection.

“(c) Simplification of Benefits.—

“(1) In general.—Each Mediplan supplemental policy shall only offer benefits consistent with the standards promulgated under paragraph (2).

“(2) Standards.—The Secretary shall promulgate standards providing for—

“(A) limitations on the groups or packages of benefits that may be offered under a Mediplan supplemental policy consistent with paragraphs (3) and (4) of this subsection,

“(B) uniform language and definitions to be used with respect to such benefits, and

“(C) uniform format to be used in the policy with respect to such benefits.

“(3) Basis.—The standards under paragraph (2) shall provide—
“(A) for such groups or packages of benefits as may be appropriate taking into account the considerations specified in paragraph (4) and the requirements of the succeeding subparagraphs,

“(B) for identification of a core group of basic benefits common to all policies, and

“(C) that, subject to paragraph (5), the total number of different benefit packages (counting the core group of basic benefits described in subparagraph (B) and each other combination of benefits that may be offered as a separate benefit package) that may be established in all the States and by all issuers shall not exceed 10.

“(4) INNOVATION.—With the approval of the Secretary, the issuer of a Mediplan supplemental policy may offer new or innovative benefits in addition to the benefits provided in a policy that otherwise complies with the standards. Any such new or innovative benefits may include benefits that are not otherwise available and are cost effective and shall be offered in a manner which is consistent with the goal of simplification of Mediplan supplemental policies.
"(5) Further Limitations.—

"(A) In General.—Except as provided in subparagraph (B), this subsection shall not be construed as preventing a State from restricting the groups of benefits that may be offered in Mediplan supplemental policies in the State.

"(B) Limitation.—A State with a regulatory program approved under section 2171(b)(1) may not restrict under subparagraph (A) the offering of a Mediplan supplemental policy consisting only of the core group of benefits described in paragraph (3)(B).

"(6) Construction.—This subsection shall not be construed as preventing an issuer of a Mediplan supplemental policy who otherwise meets the requirements of this section from providing, through an arrangement with a vendor, for discounts from that vendor to the policyholder or certificateholders for the purchase of items or services not covered under its Mediplan supplemental policies.

"(7) Making Basic Policy Available.—

"(A) In General.—Anyone who sells a Mediplan supplemental policy to an individual shall make available for sale to the individual a
Mediplan supplemental policy with only the core group of basic benefits (described in paragraph (3)(B)).

“(B) Outline of Coverage.—Anyone who sells a Mediplan supplemental policy to an individual shall provide the individual, before the sale of the policy, an outline of coverage which describes the benefits under the policy. Such outline shall be on a standard form approved by the Secretary consistent with the standards promulgated under this subsection.

“(8) Penalty.—Whoever sells or issues a Mediplan supplemental policy in violation of the requirements of this subsection is subject to a civil money penalty of not to exceed $25,000 (or $15,000 in the case of a seller who is not the issuer of the policy) for each such violation.

“(d) Minimum Loss Ratio Required.—

“(1) In General.—A Mediplan supplemental policy, a specific disease policy (as defined by the Secretary), or a hospital confinement indemnity policy (as defined by the Secretary) may not be issued or renewed (or otherwise provide coverage after the effective date specified in section 2171(d)) unless—
“(A) the policy can be expected for periods after the effective date of these provisions (as estimated for the entire period for which rates are computed to provide coverage, on the basis of incurred claims experience and earned premiums for such periods, and in accordance with a uniform methodology, including uniform reporting standards, developed by the Secretary) to return to policyholders in the form of aggregate benefits provided under the policy, at least 80 percent of the aggregate amount of premiums collected in the case of group policies or at least 70 percent in the case of individual policies; and

“(B) the issuer of the policy provides for the issuance of a proportional refund, or a credit against future premiums of a proportional amount, based on the premium paid and in accordance with paragraph (2), of the amount of premiums received necessary to assure that the ratio of aggregate benefits provided to the aggregate premiums collected (net of such refunds or credits) complies with the expectation required under subparagraph (A), treating poli-
cies of the same type as a single policy for each standard package.

For purposes of subparagraph (A) only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies. For the purpose of calculating the refund or credit required under paragraph (1)(B) for a policy issued before the effective date specified in section 2171(d), the refund or credit calculation shall be based on the aggregate benefits provided and premiums collected under all such policies issued by an insurer in a State (separated as to individual and group policies) and shall be based only on aggregate benefits provided and premiums collected under such policies after such date.

“(2) Application.—Paragraph (1)(B) shall be applied with respect to each type of policy by standard package. Paragraph (1)(B) shall not apply to a policy until 12 months following issue. In the case of a policy issued before the effective date specified in section 2171(d), paragraph (1)(B) shall not apply until 1 year after such date.

“(3) Timing of refund or credit.—
“(A) In general.— A refund or credit required under paragraph (1)(B) shall be made to each policyholder insured under the applicable policy as of the last day of the year involved.

“(B) Interest.— Such a refund shall include interest from the end of the calendar year involved until the date of the refund or credit at a rate as specified by the Secretary for this purpose from time to time which is not less than the average rate of interest for 13-week Treasury notes.

“(C) Deadline.— For purposes of this paragraph and paragraph (1)(B), refunds or credit against premiums due shall be made, with respect to a calendar year, not later than the third quarter of the succeeding calendar year.

“(4) No preemption.— The provisions of this subsection do not preempt a State from requiring a higher percentage than that specified in paragraph (1)(A).

“(5) Audits.— The Comptroller General shall periodically, not less often than every 3 years, perform audits with respect to the compliance of Mediplan supplemental policies and dread disease
policies with the loss ratio requirements of this subsection and shall report the results of such audits to any State involved and to the Secretary.

“(6) SANCTIONS.—

“(A) IN GENERAL.—A person who fails to provide refunds or credits as required in paragraph (1)(B) is subject to a civil money penalty of not to exceed $25,000 for each policy issued for which such failure occurred.

“(B) LIABILITY.—Each issuer of a policy subject to the requirements of paragraph (1)(B) shall be liable to the policyholder or, in the case of a group policy, to the certificateholder for credits required under such paragraph.

“(e) GUARANTEED RENEWABILITY.—

“(1) IN GENERAL.—Each Mediplan supplemental policy shall be guaranteed renewable and—

“(A) the issuer may not cancel or nonrenew the policy solely on the ground of health status of the individual, and

“(B) the issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.
"(2) Right of conversion upon termination of group policy.—If the Mediplan supplemental policy is terminated by the group policyholder and is not replaced as provided under paragraph (4), the issuer shall offer certificateholders an individual Mediplan supplemental policy which (at the option of the certificateholder)—

"(A) provides for continuation of the benefits contained in the group policy, or

"(B) provides for such benefits as otherwise meets the requirements of this part.

"(3) Right of conversion upon termination of membership in a group.—If an individual is a certificateholder in a group Mediplan supplemental policy and the individual terminates membership in the group, the issuer shall—

"(A) offer the certificateholder the conversion opportunity described in paragraph (2), or

"(B) at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

"(4) Replacement.—If a group Mediplan supplemental policy is replaced by another group Mediplan supplemental policy purchased by the same policyholder, the succeeding issuer shall offer cov-
verage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

“(5) SUSPENSION OF POLICY FOR CERTAIN LOW-INCOME INDIVIDUALS.—

“(A) IN GENERAL.— Each Mediplan supplemental policy shall provide that benefits and premiums under the policy shall be suspended at the request of the policyholder for the period (not to exceed 24 months) in which the policyholder is determined to be entitled for benefits under this title as a low-income individual, but only if the policyholder notifies the issuer of such policy within 90 days after the date the individual becomes so entitled. If such suspension occurs and if the policyholder or certificateholder loses such entitlement, such policy shall be automatically reinstated (effective as of the date of termination of such entitlement) under the following terms, if the policyholder provides notice of such loss of entitlement within 90 days after the date of such loss:
(i) There is no waiting period with respect to treatment of pre-existing conditions.

(ii) Coverage is substantially equivalent to coverage in effect before the date of the termination.

(iii) The classification of premiums are on terms which are at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage never terminated.

(B) Penalty.—Any person who issues a Mediplan supplemental policy and fails to comply with the requirements of subparagraph (A) is subject to a civil money penalty of not to exceed $25,000 for each such violation.

‘‘SEC. 2174. STANDARDS APPLICABLE ONLY TO INSURED MEDIPLAN SUPPLEMENTAL POLICIES.

‘‘(a) Open Enrollment.—

‘‘(1) In general.—Subject to the succeeding provisions of this subsection, a carrier that offers an insured Mediplan supplemental policy (as defined in subsection (c)) to individuals residing (or to groups
located) in a State must offer the same policy to any other resident of (or group located in) the State. Such requirement shall apply on a continuous, year-round basis.

"(2) Restrictions of enrollment in the case of certain association coverage.—In the case of an insured Mediplan supplemental policy offered through an association which is composed exclusively of employers (which may include self-employed individuals) and which has been formed for purposes other than obtaining health insurance, the carrier is not required to offer the policy to individuals or employers who are not employees of such employers or self-employed members of the association, or their dependents.

"(3) Treatment of health maintenance organizations.—

"(A) Geographic limitations.—A health maintenance organization may deny enrollment with respect to an individual if the individual is residing outside the service area of the organization, but only if such denial is applied uniformly without regard to health status or insurability.
“(B) SIZE LIMITS.—A health maintenance organization may apply to the Secretary to cease enrolling new employer groups or individuals in its insured Mediplan supplemental policy (or in a geographic area served by the policy) if—

“(i) it ceases to enroll any new employer groups or individuals, and

“(ii) it can demonstrate that its financial or administrative capacity to serve previously enrolled groups and individuals (and additional individuals who will be expected to enroll because of affiliation with such previously enrolled groups) will be impaired if it is required to enroll new employer groups or individuals.

“(b) NOTICES AND RENEWAL PERIODS.—

“(1) NOTICE AND SPECIFICATION OF RATES AND ADMINISTRATIVE CHANGES.—

“(A) NOTICE.—The carrier of an insured Mediplan supplemental policy shall provide for notice, at least 30 days before the date of expiration of the policy, of the terms for renewal of the policy. Except with respect to rates and administrative changes, the terms of renewal (in-
including benefits) shall be the same as the terms of issuance.

``(B) Renewal rates same as issuance rates.—The carrier may change the terms for such renewal, but the premium rates charged with respect to such renewal shall be the same as that for a new issue.

``(2) Period of renewal.—The period of renewal of each insured Mediplan supplemental policy shall be for a period of not less than 12 months.

``(c) Definitions.—In this section (and section 2172):

``(1) Carrier.—The term ‘carrier’ means any person that offers a Mediplan supplemental policy, whether through insurance or otherwise, including a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization, and a multiple employer welfare arrangement (as defined in section 3(40) of the Employee Retirement Income Security Act of 1974).

``(2) Insured Mediplan supplemental policy.—The term ‘insured Mediplan supplemental policy’ means any Mediplan supplemental policy provided through insurance, and includes a prepaid hospital or medical service plan, a health maintenance
organization, and a multiple employer welfare ar-
angement (as defined in section 3(40) of the Em-

SEC. 2175. PROHIBITION OF DUPLICATION.

“(a) In General.—

(1) In general.—It is unlawful for a person
to sell or issue to an individual entitled to benefits
under this title—

“(A) a health insurance policy with knowl-
dge that the policy duplicates health benefits
to which the individual is otherwise entitled
under this title (including special benefits as a
low-income individual),

“(B) a Mediplan supplemental policy with
knowledge that the individual is entitled to ben-
defits under another Mediplan supplemental pol-
icy, or

“(C) a health insurance policy (other than
a Mediplan supplemental policy) with knowledge
that the policy duplicates health benefits to
which the individual is otherwise entitled, other
than benefits to which the individual is entitled
under a requirement of State or Federal law.

“(2) Exception.—Paragraph (1) shall not
apply with respect to—
“(A) the sale or issuance of a group policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or for members or former members (or combination thereof) of the labor organizations,

“(B) the sale or issuance of a policy described in paragraph (1)(A) (other than a Mediplan supplemental policy to an individual entitled to benefits as a low-income individual) under which all the benefits are fully payable directly to or on behalf of the individual without regard to other health benefit coverage of the individual but only if there is disclosed in a prominent manner as part of (or together with) the application the applicable statement (specified under subsection (d)) of the extent to which benefits payable under the policy duplicate benefits under this title, or

“(C) the sale or issuance of a policy described in paragraph (1)(C) under which all the benefits are fully payable directly to or on be-
half of the individual without regard to other health benefit coverage of the individual.

“(b) ADDITIONAL PROHIBITION.—Whoever violates subsection (a) 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 seller who is not the issuer of the policy) for each such prohibited act.

“(c) RULE.—A seller (who is not the issuer of a health insurance policy) shall not be considered to violate subsection (a) with respect to the sale of a Mediplan supplemental policy if the policy is sold in compliance with subsection (d).

“(d) DISCLOSURE.—

“(1) IN GENERAL.—It is unlawful for a person to issue or sell a Mediplan supplemental policy to an individual entitled to benefits under this title, whether directly, through the mail, or otherwise, unless—

“(A) the person obtains from the individual, as part of the application for the issuance or purchase and on a form described in subparagraph (B), a written statement (in a form specified by the Secretary) signed by the individual stating, to the best of the individual’s
knowledge, what health insurance policies the individual has, from what source, and whether the individual is a low-income individual, and "(B) the written statement is accompanied by a written acknowledgment (in a form specified by the Secretary), signed by the seller of the policy, of the request for and receipt of such statement.

"(2) Statement.—The statement required by paragraph (1) shall be made on a form that—

"(A) states in substance that an individual entitled to benefits under this title does not need more than one Mediplan supplemental policy,

"(B) states in substance that low-income individuals usually do not need a Mediplan supplemental policy and that benefits and premiums under any such policy shall be suspended upon request of the policyholder during the period (of not longer than 24 months) of entitlement to benefits under this title as a low-income individual and may be reinstated upon no longer being a low-income individual, and

"(C) states that counseling services may be available in the State to provide advice concern-
ing the purchase of Mediplan supplemental policies and may provide the telephone number for such services.

“(3) NEED FOR STATEMENT.—

“(A) IN GENERAL.—Except as provided in subparagraph (B), if the statement required by paragraph (2) is not obtained or indicates that the individual has another Mediplan supplemental policy or indicates that the individual is entitled to benefits under this title as a low-income individual, the sale of a Mediplan supplemental policy shall be considered to be a violation of subsection (a).

“(B) EXCEPTION.—Subparagraph (A) shall not apply in the case of an individual who has a Mediplan supplemental policy, if the individual indicates in writing, as part of the application for purchase, that the policy being purchased replaces such other policy and indicates an intent to terminate the policy being replaced when the new policy becomes effective and the issuer or seller certifies in writing that such policy will not, to the best of the issuer’s or seller’s knowledge, duplicate coverage (taking into account any such replacement).
“(C) Penalty.—Whoever issues or sells a Mediplan supplemental policy in violation of this paragraph 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 seller who is not the issuer of the policy) for each such violation.

“SEC. 2176. ADDITIONAL PROHIBITIONS.

“(a) In General.—Whoever knowingly and willfully makes or causes to be made or induces or seeks to induce the making of any false statement or representation of a material fact with respect to compliance of any policy with the standards and requirements set forth in section 2173 or in regulations promulgated pursuant to such section 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 $5,000 for each such prohibited act.

“(b) False Representation.—Whoever falsely assumes or pretends to be acting, or misrepresents in any way that he is acting, under the authority of or in association with, the program of health insurance established
under this title, or any Federal agency, for the purpose of selling or attempting to sell insurance, or in such pretended character demands, or obtains money, paper, documents, or anything of value, 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 $5,000 for each such prohibited act.

"(c) Application of Civil Money Penalty Procedures.—The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this part in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

"Sec. 2177. Information Disclosure.

"(a) In General.—The Secretary shall provide, to all individuals entitled to benefits under this title such information as will permit such individuals to evaluate the value of Mediplan supplemental policies to them and the relationship of any such policies to benefits provided under this title.

"(b) Information on Prohibitions.—The Secretary shall—

"(1) inform all individuals entitled to benefits under this title of—

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“(A) the actions and practices that are subject to sanctions under this part and

“(B) the manner in which they may report any such action or practice to an appropriate official of the Department of Health and Human Services (or to an appropriate State official), and

“(2) publish the toll-free number for individuals to report suspected violations of the provision of this part.

“(c) Counseling Numbers.—The Secretary shall provide individuals entitled to benefits under this title with a listing of the addresses and telephone numbers of State and Federal agencies and offices that provide information and assistance to individuals with respect to the selection of Mediplan supplemental policies.

“SEC. 2178. LIMITATIONS ON SALES COMMISSIONS.

“(a) In General.—It is unlawful for a person who provides for a commission or other compensation to an agent or other representatives with respect to the sale of a Mediplan supplemental policy (or certificate)—

“(1) to provide for a first year commission or other first year compensation that exceeds 200 percent of the commission or other compensation for
the selling or servicing of the policy or certificate in
a second or subsequent year, or

“(2) to provide for compensation with respect
to replacement of such a policy or certificate that is
greater than the compensation that would apply to
the renewal of the policy or certificate.

“(b) PEnalty.—Whoever violates subsection (a)
shall be fined under title 18, United States Code, or im-
prisoned 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 for each such
prohibited act.

“(c) Defined.—In this section, the term ‘com-
pensation’ includes pecuniary and nonpecuniary com-
pensation of any kind relating to the sale or renewal of
a policy or certificate and specifically includes bonuses,
gifts, prizes, awards, and finders’ fees.

SEC. 2179. DEFINITIONS.

“In this part:

“(1) GROup.—The term ‘group’ means 2 or
more employees of the same employer who normally
perform on a monthly basis at least 17½ hours of
service per week for that employer.

“(2) HEALTTh MAINTEnANCE ORGAnIZATION.—
The term ‘health maintenance organization’ has the
meaning given the term ‘eligible organization’ in section 1876(b).

“(3) Mediplan Supplemental Policy.—The term ‘Mediplan supplemental policy’ is a health insurance policy or other health benefit plan offered by a private entity to individuals who are entitled to have payment made under this title, which provides reimbursement for expenses incurred for services and items for which payment may be made under this title but which are not reimbursable by reason of the application of deductibles, coinsurance amounts, or other limitations imposed pursuant to this title; but does not include—

“(A) any such policy or plan of the trustees of a fund established by one or more employers or labor organizations (or combination thereof) if the policy or plan offers benefits as a direct service organization under section 1833, or

“(B) a policy or plan of a health maintenance organization which offers benefits under this title under section 2162(d).

For purposes of this title, the term ‘policy’ includes a certificate issued under such policy.
“(4) State.—The term ‘State’ means the 50 States and the District of Columbia.

PART G—STATE OPT OUT

SEC. 2181. ELECTION.

“(a) In General.—A State may elect, in accordance with this part, to have health care benefits made available to residents of the State under a State alternative health care program under this part instead of under the other provisions of this title. Such an election shall not be effective unless—

“(1) the State submits to the Secretary an application for election, in a form and manner specified by the Secretary, and

“(2) the Secretary determines that the proposed health care program meets the requirements specified in sections 2182 and 2183.

“(b) No Application of Election on Out-of-State Residents.—An election of a State under this part shall not affect the entitlement of individuals who are not residents of the State to receive benefits under this title for services furnished in the State on the same terms and conditions as though such an election had not been made.
SEC. 2182. REQUIREMENTS FOR STATE ALTERNATIVE HEALTH CARE PROGRAMS.

The requirements, with respect to a State alternative health care program are as follows:

(1) ELIGIBILITY.—Each individual who is a resident of the State (as determined by the Secretary) is entitled to benefits under the program.

(2) ENROLLMENT AND MEDIPLAN CARDS.—The program provides for enrollment of eligible individuals, and the issuance of Mediplan cards, in a manner consistent with section 2102.

(3) SCOPE OF BENEFITS.—

(A) IN GENERAL.—The scope of benefits under the program shall not be less than the scope of benefits specified in section 2121 (including additional services for children, pregnancy-related services and special provisions for lower-income individuals).

(B) EXCLUSIONS.—The exclusions from benefits shall be no more restrictive than the exclusions specified in section 2122. Pursuant to section 2122(b)(2), payments under the program shall be secondary to payments under the medicare program.

(C) OUT-OF-STATE BENEFITS.—The program shall provide for coverage of medically
necessary services furnished outside the State, except in such cases as the Secretary may specify. In specifying such cases, the Secretary shall take into account the requirements of health maintenance organization for coverage of services outside the organization’s service area. Any such out-of-State coverage shall be provided in a manner consistent with the provision of benefits under this title to individuals who are not residents of the State.

“(4) LIMITATION ON COST-SHARING.—The program does not impose cost-sharing in excess of the cost-sharing that would be permitted under section 2141.

“(5) ENTITLEMENT VERIFICATION SYSTEM.—The program provides for an entitlement verification system that meets the requirements of section 2151(c).

“(6) UNIFORM CLAIMS AND ELECTRONIC DATA SET.—The program provides for use of uniform claims and electronic data set in accordance with the standards established under section 2152(c).

“(7) ELECTRONIC MEDICAL RECORDS AND REPORTING; UNIFORM HOSPITAL COST REPORTING.—The program requires hospitals in the State to meet
the standards for electronic medical records and uniform hospital cost reporting in accordance with sections 2153 and 2154.

“(8) Reporting System.—The program provides for such reporting of information on the program as the Secretary may require in order to assure that the program meets the requirements of this section.

“(9) Maintenance of Effort Payments.—The State is providing for payment to the Mediplan Trust Fund in accordance with section 2163.

“(10) Use of Funds and Savings.—The State will comply with the requirements of section 2185(b).

“SEC. 2183. CONTROL OF AGGREGATE EXPENDITURES.

“(a) Assurances Required.—

“(1) In general.—A State election under this part may not be approved until the Secretary has been provided satisfactory assurances that under the program, during a 3-year period (the first such period beginning with the first month in which this section applies to that program in the State) the aggregate expenditures for required health care services under the program will not exceed the applicable total limit specified in paragraph (2).
“(2) Applicable total limit.—The applicable total limit specified in this paragraph is the total of the maximum amount of payments that would be payable in the State for the required health care services under this title if the State election were not in effect.

“(3) Special rule for expenditures for HMOs.—In determining aggregate expenditures for purposes of paragraph (1), the Secretary shall exclude expenditures for services of staff or group model health maintenance organizations if the State program provides that such organizations may negotiate directly with providers of services covered under the program with respect to the organization’s rate of payment for such services and, in determining the applicable limits under paragraph (2), the Secretary shall exclude payments for services of such organizations.

“(b) Annual determination by Secretary.—The Secretary shall annually determine whether a State program met the assurances required under subsection (a) for the most recent 3-year period for which the State election was in effect.

“(c) Treatment of States failing to control aggregate expenditures.—
“(1) IN GENERAL.—The Secretary shall terminate approval of a State election under this part or impose a sanction described in paragraph (2) on a State if the Secretary determines that, with respect to a State program under this part for a 3-year period the aggregate expenditures for required health care services under the program exceeded the applicable total limit specified in subsection (a)(2).

“(2) SANCTIONS.—The sanction described in this paragraph is a reduction in the aggregate amount otherwise payable to the State under section 2185 for the following year (or for the following 3-year period, if the Secretary determines that a reduction for such period is appropriate in the case of a State) in an amount equal to the amount by which the aggregate expenditures for the preceding 3-year period under the program exceeded the applicable total limit.

“(3) NOTICE.—The Secretary may not impose any sanction against a state under paragraph (2) unless the Secretary has provided the State with notice of the Secretary’s determination under paragraph (1) and intent to impose the sanction under paragraph (2).
"SEC. 2184. TERMINATION OF APPROVAL OF STATE ELECTION.

“(a) PROCESS REQUIREMENTS.—

“(1) NOTICE.—The Secretary may terminate the approval of a State’s election under this part only after the expiration of a 90-day period beginning on the date the Secretary informs the State of the Secretary’s intention to terminate such approval, unless, during such 90-day period, the State requests a hearing with the Secretary.

“(2) HEARING.—If the State requests a hearing during the 90-day period described in paragraph (1), the Secretary shall conduct a hearing during which the State may present evidence showing that the Secretary should not terminate the approval of the election. If the Secretary decides to reject such evidence, the Secretary shall terminate the approval of the State’s election beginning with the first day of the first month that begins after the Secretary’s decision.

“(3) JUDICIAL REVIEW PROHIBITED.—There shall be no administrative or judicial review of a decision by the Secretary to terminate the approval of a State election under this subsection.

“(b) EFFECT OF TERMINATION ON PAYMENT RATES APPLICABLE TO SERVICES IN STATE.—
‘‘(1) IN GENERAL.—If the Secretary terminates the approval of a State election under this section, the maximum payment rates applicable to required health services shall be the maximum payment rates otherwise applicable to the services subject to the adjustment described in paragraph (2).

‘‘(2) RECAPTURE OF EXCESS SPENDING.—The Secretary shall reduce the maximum payment rates applicable under this title to required health services by such factor as the Secretary determines necessary to decrease the amount of aggregate expenditures that would otherwise be made for services provided in the State by the amount by which the aggregate expenditures for the preceding 3-year period under the program exceeded the applicable total limit specified in section 2183(a)(2).

‘SEC. 2185. PAYMENTS TO STATES.

‘‘(a) IN GENERAL.—In the case of a State with a State alternative health care program approved under this part, the Secretary shall provide for payment to the State, on a monthly basis, of such amounts as the Secretary determines to be equivalent to the payments that would have been made under this title with respect to residents in the State if the program had not been so approved. Such payments shall not include any amount attributable to
amounts paid under the medicare program under title XVIII for residents of the State.

“(b) USE OF FUNDS AND SAVINGS.—

“(1) USE OF FUNDS.—A State alternative health care program may only use funds provided under subsection (a) for payment of covered benefits, for the administration of the program under this part, and, if applicable, for the expansion of benefits or reduction of cost-sharing under paragraph (2).

“(2) APPLICATION OF SAVINGS.—In the case of a State for which the aggregate expenditures (described in section 2183) for required health services are less than the applicable total limit specified in section 2183(a)(2), the State shall provide for such increase in the scope of benefits (which may include a reduction in cost-sharing) as will assure the expenditure of funds consistent with paragraph (1).

“SEC. 2186. NO IMPACT ON MEDICARE BENEFITS.

“Nothing in this part shall be construed as affecting the entitlement of individuals to medicare benefits under title XVIII.”.

(b) EFFECTIVE DATE FOR BENEFITS.—Title XXI of the Social Security Act shall apply to items and services furnished on or after January 1, 1995.
(c) **Excise Tax on Premiums Received on Mediplan Supplemental Policies Which Do Not Meet Certain Requirements.**—

(1) **In General.**—Chapter 47 of the Internal Revenue Code of 1986 (relating to taxes on group health plans) is amended by adding at the end thereof the following new section:

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"SEC. 5000A. FAILURE TO SATISFY CERTAIN STANDARDS FOR MEDIPLAN SUPPLEMENTAL POLICIES.

"(a) Imposition of Tax.—

"(1) General Rule.—There is hereby imposed a tax on any nonqualified Mediplan supplemental policy.

"(2) Nonqualified Mediplan Supplemental Policy Defined.—For purposes of this section, the term 'nonqualified Mediplan supplemental policy' means any Mediplan supplemental policy that—

"(A) is not certified under section 21711 of the Social Security Act, or

"(B) the Secretary of Health and Human Services determines is providing coverage in violation of section 2171(a) of such Act.

"(b) Amount of Tax.—
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“(1) IN GENERAL.—The amount of tax imposed by subsection (a) shall be equal to—

“(A) in the case of an insured Mediplan supplemental policy, 50 percent of the gross premiums received by the issuer which are attributable to the period during which the policy is a nonqualified Mediplan supplemental policy, and

“(B) in the case of a self-insured Mediplan supplemental policy, 50 percent of the expenditures under such policy during the period that the policy is a nonqualified Mediplan supplemental policy.

“(2) GROSS PREMIUMS.—For purposes of paragraph (1)(A), gross premiums shall include any consideration received with respect to any insured Mediplan supplemental policy.

“(3) CONTROLLED GROUPS.—For purposes of paragraph (1)—

“(A) CONTROLLED GROUP OF CORPORATIONS.—All corporations which are members of the same controlled group of corporations shall be treated as 1 person. For purposes of the preceding sentence, the term ‘controlled group of
corporations’ has the meaning given to such term by section 1563(a), except that—

“(i) ‘more than 50 percent’ shall be substituted for ‘at least 80 percent’ each place it appears in section 1563(a)(1), and

“(ii) the determination shall be made without regard to subsections (a)(4) and (e)(3)(C) of section 1563.

“(B) PARTNERSHIPS, PROPRIETORSHIPS, ETC., WHICH ARE UNDER COMMON CONTROL.—

Under regulations prescribed by the Secretary, all trades or business (whether or not incorporated) which are under common control shall be treated as 1 person. The regulations prescribed under this subparagraph shall be based on principles similar to the principles which apply in the case of subparagraph (A).

“(C) LIABILITY FOR TAX.—

“(1) INSURED POLICY.—In the case of an insured Mediplan supplemental policy, the issuer of the insurance or subscriber contract under which such policy is provided shall be liable for the tax imposed by this section.

“(2) SELF-INSURED POLICY.—In the case of a self-insured policy—
“(A) In General.—Except as provided in subparagraph (B), the employer maintaining such policy shall be liable for the tax imposed by this section.

“(B) Multiemployer Policies, etc.—In the case of a multiemployer policy or any other policy not maintained by an employer, the issuer of the policy shall be liable for the tax imposed by this section.

“(d) Incorporation of Definitions.—For purposes of this section, the terms ‘Mediplan supplemental policy’, ‘insured Mediplan supplemental policy’, and ‘self-insured Mediplan supplemental policy’ have the meanings given such terms in section 2175 of the Social Security Act.”.

(2) Nondeductibility of Tax.—Subsection (a) of section 275 of such Code (relating to nondeductibility of certain taxes) is amended by adding at the end thereof the following new paragraph:

“(7) Taxes imposed by section 5000A (failure to satisfy certain standards for Mediplan supplemental policies).”

(3) Clerical Amendments.—
(A) So much of chapter 47 of such Code as precedes subsection (a) of section 5000 is amended to read as follows:

"CHAPTER 47—TAXES RELATING TO HEALTH BENEFIT PLANS"

"Sec. 5000. Contributions to nonconforming large group health plans."
"Sec. 5000A. Failure to satisfy certain standards for Mediplan supplemental policies."

"SEC. 5000. CONTRIBUTIONS TO NONCONFORMING LARGE GROUP HEALTH PLANS."

(B) The table of chapters for subtitle D of such Code is amended by striking the item relating to chapter 47 and inserting the following new item:

"Chapter 47. Taxes relating to health benefit plans."

TITLE II—COST CONTAINMENT

SEC. 201. NATIONAL MEDIPLAN EXPENDITURE BUDGET.

(a) Establishment.—

(1) In general.—For each calendar year (beginning with 1995), there is established a national Mediplan expenditure budget (in the amount specified under paragraph (2)).

(2) Amount.—

(A) 1995.—The total amount of the national Mediplan expenditure budgets for 1995 is equal to the Mediplan budget baseline (deter-
mined under subsection (b) for 1994) multiplied
by the applicable adjustment factor (specified
under subsection (c)) for 1995.

(B) Subsequent years.—The total
amount of such budget for each year after 1995
is equal to the budget determined under this
paragraph for the previous year multiplied by
the applicable adjustment factor (specified
under subsection (c)) for the year involved.

(3) Publication.—The Secretary of Health
and Human Services shall publish in the Federal
Register and report to the Congress, by not later
than April 1 before each year, the amount of the na-
tional Mediplan expenditure budget for the year.

(b) Mediplan Budget Baseline.—The Secretary
shall compute a Mediplan budget baseline under this sub-
section for 1994 as follows:

(1) 1993 Actual Expenditures.—The Sec-
retary shall determine (on the basis of the best data
available) the amount of the aggregate Mediplan ex-
penditures (as defined in subsection (d)(1)) during
1993.

(2) Projection for 1994.—The Secretary
shall increase such amount by the Secretary's esti-
mate of the percentage increase in the aggregate

(c) APPLICABLE ADJUSTMENT FACTOR.—The applicable adjustment factor under this subsection for each year is 1 plus the sum (expressed as a fraction) of—

(1) the average annual percentage increase in the gross domestic product (in current dollars, as published by the Secretary of Commerce) during the 5-year period ending with the second previous year; plus

(2)(A) for 1995, 3.5 percentage points, (B) for 1996, 2.5 percentage points, (C) for 1997, 1.5 percentage points, (D) for 1998, 0.5 percentage point, and (E) for each year thereafter, 0 percentage points.

(d) AGGREGATE MEDIPLAN EXPENDITURES DEFINED.—In this Act, the term “aggregate Mediplan expenditures” means, with respect to health care services or a class of services, expenditures made under the medicare program or under Mediplan with respect to the provision of such services or class of services, and also includes receipts of providers with respect to amounts payable as deductibles, coinsurance, or other amounts for which the beneficiary is liable with respect to items and services cov-
Sec. 202. CLASSES OF HEALTH CARE SERVICES.

(a) Establishment of Classes.—

(1) In general.—

(A) Specified services.—In the case of items and services specified in a subparagraph under paragraph (2), all of the items and services described in that subparagraph shall be considered to be a “separate” class of health care services.

(B) Overlapping services.—Except as the Secretary may provide, items and services specified in a subparagraph of paragraph (2) shall be considered to be excluded from the subsequent subparagraphs of that paragraph.

(2) Specified health care services.—The items and services specified in this paragraph are as follows:

(A) Inpatient hospital services, other than mental health services.
(B) Outpatient hospital services and ambulatory facility services (including renal dialysis facility services), other than mental health services.

(C) Diagnostic testing services (including clinical laboratory services and x-ray services).

(D) Physicians’ services and other professional medical services, other than mental health services.

(E) Home health services and hospice care.

(F) Rehabilitation services, such as physical therapy, occupational and speech therapy.

(G) Durable medical equipment and supplies.

(H) Prescription drugs and biologicals and insulin.

(I) Nursing facility services, including skilled nursing facility services and intermediate care facility services, other than mental health services.

(J) Mental health services.

(K) Other covered services.

(b) Publication.—

(1) In general.—The Secretary shall publish—
(A) by not later than April 1, 1994, proposed regulations defining the health care services and establishing the classes of services under this section, and

(B) by not later than June 1, 1994, final regulations defining the health care services and establishing such classes.

(2) ITEMS INCLUDED IN REGULATIONS.—In such regulations, the Secretary shall define—

(A) the class or classes to be established under subsection (a)(1),

(B) the services to be included within each class, and

(C) the methods and sources of data for computing, for purposes of this title, aggregate Mediplan expenditures for services within the class.

(3) CHANGES.—

(A) NO CHANGES AUTHORIZED.—After the Secretary has established classes of services under paragraph (1)(B), the Secretary may not change such classes (or the services included in such classes), except in the case of services not previously classified. Any such services not pre-
vously classified shall be classified within one of the classes previously established.

(B) **Recommended Changes.**—If the Secretary determines that a change in the classification established under this section may be appropriate, the Secretary shall submit to the Congress a report proposing such change. The Secretary shall include in the report an explanation of—

(i) the rationale for such change, and

(ii) the impact of such change on the total aggregate Mediplan expenditures permitted for classes of services that would be affected by the change.

(4) **Commission Reports.**—

(A) **Initial Reports.**—With respect to the establishment of classes of services under this section, each applicable Commission (as defined in section 208(1))—

(i) by not later than March 1, 1994, shall report its recommendations to the Secretary and Congress concerning such classes, and

(ii) by not later than May 1, 1994, shall report to the Secretary and the Con-
gress its comments concerning the classification proposed by the Secretary under paragraph (1)(A).

(B) Periodic reports.—Each applicable Commission shall periodically report to Congress on changes in the system of classification under this section that should be made to promote the more efficient provision of medically appropriate health care services.

Sec. 203. Allocation of Health Budget by Class of Service.

(a) Allocation.—

(1) In general.—The Secretary shall allocate the national Mediplan expenditure budget under section 201 for a year among classes of services specified under section 202.

(2) Proportional allocation based on historical projected expenditures.—The percent of the budget allocated to each class for a year shall be equal to the quotient (expressed as a percentage) of—

(A) the historical projected Mediplan expenditures for the class for the year (as determined under subsection (b)(1)), divided by
(B) the sum of such historical projected Mediplan expenditures for all the classes for the year.

(3) PUBLICATION.—

(A) IN GENERAL.—The Secretary shall, in conjunction with the publication of budget under section 201(a)(3) for a year and by not later than April 1 before the year, publish in the Federal Register and report to the Congress the allocation of the budget among the classes of services under this subsection.

(B) EXCEPTION FOR 1995.—For 1995, the Secretary shall publish and report the allocation of the budget among the classes of services under this subsection not later than August 1, 1994.

(b) HISTORICAL PROJECTED EXPENDITURES.—

(1) DETERMINATION.—For purposes of subsection (a)—

(A) FOR 1994.—The historical projected Mediplan expenditures for a class of services for 1994 is equal to the portion of the amount of aggregate Mediplan expenditures during 1993 (as determined under section 201(b)(1)) which is attributable to the class of services, multi-
plied by the trend factor (described in paragraph (2)) for the class for 1994.

(B) Subsequent years.—The historical projected Mediplan expenditures for a class of services for a year after 1994 is equal to the amount of the allocation for the class under subsection (a)(2) for the preceding year multiplied by the trend factor (described in subparagraph (B)) for the class for the year involved.

(2) Trend factor.—In paragraph (1), the “trend factor”, for a class of services, is 1 plus the average annual rate of increase in aggregate Mediplan expenditures for the class of services during the 5-year period ending with 1993.

(3) Publication of trend factors.—The Secretary shall publish, by not later than August 1, 1994, the trend factors for the different classes of services.

(c) Review and changes in allocation.—

(1) In general.—

(A) No administrative authority to change.—Except as specifically provided by law enacted after the enactment of this Act, the Secretary has no authority to change the alloca-
tion or trend factors from the allocation and trend factors provided under this section.

(B) RECOMMENDED CHANGES.—If the Secretary determines that a change in the allocation of the budget among classes is appropriate, the Secretary shall submit to the Congress a report proposing such change. The Secretary shall include in the report an explanation of—

(i) the rationale for such change, and

(ii) the impact of such change on the total aggregate Mediplan expenditures permitted for classes of services that would be affected by the change.

(2) COMMISSION REVIEW.—Each applicable Commission shall annually review and report to Congress, in its report submitted under section 202(b)(4), on the effect of the trend factors used in the allocation of the budget among classes of services. Such report shall include such recommendations for appropriate adjustments in the trend factors as the applicable Commission considers appropriate to properly take into account at least—

(A) changes in health care technology,
(B) changes in the patterns and practices relating to health care delivery found to be appropriate,
(C) changes in the distribution of health care services, and
(D) the special health care needs of underserved rural and inner city populations.

SEC. 204. NATIONAL HEALTH EXPENDITURES REPORTING SYSTEM.

(a) In General.—The Secretary shall establish a national health expenditures reporting system (in this section referred to as the “system”) for purposes of—
(1) establishing the national health expenditures budget,
(2) allocating the health budgets among classes of services,
(3) determining payment rates, and
(4) monitoring expenditures in States which have elections in effect under part G.

(b) Information Reporting.—
(1) By Provider.—Under the system, providers of health care services shall report (beginning not later than January 1, 1995) such information relating to the provision of health care services (including the volume and receipts for such services) in
such form and manner (including the use of electronic transmission), by such classification, and at such periodic intervals, as the Secretary shall specify in regulation.

(2) **USE OF REPORTING MECHANISMS.**—To the maximum extent practicable and appropriate, reporting under such system shall be done through reporting mechanisms (such as uniform hospital reports provided under section 2255 of the Social Security Act) and using data bases otherwise in use.

(3) **USE OF SURVEYS.**—The Secretary may, where appropriate, provide for the collection of information under the system through surveys of a sample of health care providers or with respect to a sample of information with respect to such providers.

(4) **CONFIDENTIALITY.**—Information gathered pursuant to the authority provided under this section shall not be disclosed in a manner that identifies individual providers of services.

(5) **TRANSITION.**—Before January 1, 1995, for purposes of this title, the Secretary may use such other data collection and estimation techniques as may be appropriate for purposes described in subsection (a).
(c) Enforcement.—If a provider of health services is required, under the system under this section, to report information and refuses, after being requested by the Secretary, to provide the information required, or deliberately provides information that is false, the Secretary may impose a civil money penalty of not to exceed $10,000 for each such refusal or provision of false information. The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to civil money penalties under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(d) Inclusion of Health Maintenance Organizations.—In this section, the term “provider of health care services” includes health maintenance organizations.

SEC. 205. CONFORMING MEDICARE PAYMENT RATES TO MEDIPLAN HEALTH EXPENDITURE ALLOCATIONS; TRANSITION.

(a) In General.—Notwithstanding any other provision of law, the Secretary shall substitute for the payment rate or allowance (or, in the absence of such a rate, payment amount) otherwise applied under the medicare program (and any maximum charge limits or payment limits imposed under such program) for any health care service
in a class of services the amount specified by the Secretary under subsection (b) for the class for the year involved.

(b) Amount.—

(1) In General.—At the same time as the Secretary establishes payment rates under section 2141 of the Social Security Act, the Secretary shall compute and publish, for each class of services for each year, an amount under this subsection determined as follows:

(A) First Year.—During the first year in which benefits are available under title XXI of the Social Security Act, the amount shall be the sum of—

(i) 20 percent of the payment amount established under such title for the class of services, and

(ii) 80 percent of the amount established under title XVIII of such Act.

(B) Second Year.—During the second year in which benefits are available under title XXI of the Social Security Act, the amount shall be the sum of—

(i) 40 percent of the payment amount established under such title for the class of services, and
(ii) 60 percent of the amount established under title XVIII of such Act.

(C) Third Year.—During the third year in which benefits are available under title XXI of the Social Security Act, the amount shall be the sum of—

(i) 60 percent of the payment amount established under such title for the class of services, and

(ii) 40 percent of the amount established under title XVIII of such Act.

(D) Fourth Year.—During the fourth year in which benefits are available under title XXI of the Social Security Act, the amount shall be the sum of—

(i) 80 percent of the payment amount established under such title for the class of services, and

(ii) 20 percent of the amount established under title XVIII of such Act.

(E) Fifth and Subsequent Years.—During the fifth year in which benefits are available under title XXI of the Social Security Act, and any subsequent year the amount shall be the 100 percent of the payment amount es-
established under such title for the class of services.

(2) **Indirect Application to Health Maintenance Organizations.**—Nothing in this subsection shall be construed as affecting the payment of amounts to health maintenance organizations under the medicare program under a risk-sharing contract under section 1876 of the Social Security Act. However, adjustments in payment rates under paragraph (1) may affect the computation of the average adjusted per capita cost under such section.

(c) **Publications.**—In publishing payment rates under the medicare program, the Secretary shall take into account the adjustment in rates under this section.

**SEC. 206. Adjustments to Medicare Payments for Graduate Medical Education.**

(a) **Determination of Full-Time-Equivalent Residents During Initial Residency Period.**—

(1) **Emphasis on Primary Care.**—Paragraph (4)(C)(ii) of section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) is amended by striking “is 1.00,” and inserting the following: “is—

“(I) 1.1, in the case of a resident who is a primary care resident (as defined in paragraph (5)(H)),
“(II) 1.0, in the case of a resident who is not a primary care resident and who specializes in internal medicine or pediatrics,

“(III) .9, in the case of a resident who is not described in subclause (I) or (II) and who is in the initial 3 years of the residency period, or

“(IV) .8, in the case of a resident not described in subclause (I), (II), or (III),”.

(2) PRIMARY CARE RESIDENT DEFINED.—Paragraph (5) of such section is amended—

(A) by redesignating subparagraph (H) as subparagraph (I), and

(B) by inserting after subparagraph (G) the following new subparagraph:

“(H) PRIMARY CARE RESIDENT.—The term ‘primary care resident’ means (in accordance with criteria established by the Secretary) a resident being trained in a distinct program of family practice medicine, general practice, general internal medicine, or general pediatrics.”.
(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to cost reporting periods beginning on or after October 1, 1993.

SEC. 207. DEFINITIONS.

In this title:

(1) APPLICABLE COMMISSION.—The term “applicable Commission” means—

(A) with respect to services included in a class of services furnished by a hospital, other institutional provider, or home health provider, the Prospective Payment Assessment Commission, and

(B) with respect to other health care services, the Physician Payment Review Commission.

(2) CLASS OF SERVICES.—The term “class” means, with respect to health care services, a class established under section 202.

(3) HEALTH CARE SERVICES.—The term “health care services” means the items and services described in section 202(a)(2).

(4) HEALTH MAINTENANCE ORGANIZATION.—The term “health maintenance organization” means an eligible organization with a contract under section 1876 of the Social Security Act or a qualified
health maintenance organization (as defined in section 1310(d) of the Public Health Service Act).

(5) Medicare Program; Medicare Beneficiary.—(A) The term “medicare program” means the programs established under parts A and B of title XVIII of the Social Security Act.

(B) The term “medicare beneficiary” means an individual entitled to benefits under part A or B, or both, of the medicare program.

(6) Medicaid Program.—The term “medicaid program” means any State plan approved under title XIX of the Social Security Act and includes a State program operating under a waiver under section 1115 of such Act.

(7) National MediPlan Expenditure Budget.—The term “national MediPlan expenditure budget” means the budget established under section 201.

(8) Secretary.—The term “Secretary” means the Secretary of Health and Human Services.

(9) State.—The term “State” means the 50 States and the District of Columbia.

(10) United States.—The term “United States” means the 50 States and the District of Columbia.
TITLE III—FINANCING
PROVISIONS

SEC. 301. INCOME TAXES FOR MEDIPLAN HEALTH CARE.

(a) In General.—Subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end thereof the following new part:

“PART VIII—INCOME TAXES FOR MEDIPLAN HEALTH CARE

“Sec. 59B. Tax on individuals.
“Sec. 59C. Tax on gross receipts of health service providers from providing covered benefits.

“SEC. 59B. TAX ON INDIVIDUALS.

“(a) Imposition of Tax.—In the case of an individual, there is hereby imposed (in addition to other taxes) for each taxable year on the modified gross income of the taxpayer a tax equal to the Mediplan health care premium determined under subsection (b) for such year.

“(b) Mediplan Health Care Premium.—The Mediplan health care premium for the taxable year shall be equal the lesser of—

“(1) $1,500 ($3,000 in the case of a joint return), or

“(2) 12.5 percent of the excess (if any) of the modified gross income of the taxpayer over $8,000 ($16,000 in the case of a joint return).
For purposes of this section, the term ‘modified gross income’ means the adjusted gross income of the taxpayer for the taxable year determined—

(1) without regard to paragraphs (6), (7), and (11) of section 62(a) and without regard to sections 911, 931, and 933, and

(2) increased by—

(A) the amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax,

(B) the amount of social security benefits (as defined in section 86(d)) received during the taxable year which is not includible in gross income under section 86,

(C) the amount of qualified military benefits (as defined in section 134(b)) received during the taxable year, and

(D) the amounts described in paragraphs (7) and (8) of section 6051(a) which are not includible in gross income.

(d) Medicare Beneficiaries Exempt From Tax.—

(1) In general.—The tax imposed by this section shall not apply to any individual who is a
medicare-eligible individual for more than 6 full months beginning in the taxable year.

“(2) MEDICARE-ELIGIBLE INDIVIDUAL.—For purposes of this subsection, the term ‘medicare-eligible individual’ means, with respect to any month, any individual who is entitled to (or, on application without the payment of an additional premium, would be entitled to) benefits under part A of title XVIII of the Social Security Act.

“(3) SPECIAL RULES FOR JOINT RETURNS WHERE ONLY 1 SPOUSE IS MEDICARE-ELIGIBLE.—In the case of a joint return where only 1 spouse is a medicare-eligible individual, this section shall be applied—

“(A) as if such return were the return of an unmarried individual, and

“(B) by taking into account one-half of the modified gross income determined under the joint return.

“(e) COST-OF-LIVING ADJUSTMENT.—In the case of any taxable year beginning in a calendar year after 1995, the $8,000 and $16,000 amounts contained in this section 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 the taxable year begins, by substituting ‘calendar year 1993’ for ‘calendar year 1987’ in subparagraph (B) thereof.

“(f) Coordination With Other Provisions.—

“(1) Not treated as medical expense.— For purposes of section 213, the tax imposed by this section shall not be treated as an expense for medical care.

“(2) Not treated as tax for certain purposes.—The taxes imposed by this section shall not be treated as taxes imposed by this chapter for purposes of determining—

“(A) the amount of any credit allowable under this chapter, or

“(B) the amount of the minimum tax imposed by section 55.

“Sec. 59C. Tax on Gross Receipts of Health Service Providers From Providing Covered Benefits.

“(a) Tax imposed.—In addition to other taxes, there is hereby imposed a tax on every health service provider for the taxable year an amount equal to 10 percent
of the gross receipts of such provider for such taxable year attributable to covered benefits provided by such provider.

“(b) Health Service Provider.—For purposes of this section—

“(1) In General.—The term ‘health service provider’ means any person entitled to submit a claim under section 2152 of the Social Security Act for services provided by such person.

“(2) Person.—The term ‘person’ includes—

“(A) any entity exempt from tax under section 501(a), and

“(B) the United States, any State or political subdivision thereof, the District of Columbia, and any agency or instrumentality of the foregoing.

“(c) Covered Benefits.—The term ‘covered benefit’ means any benefit to which an individual is entitled by reason of section 2121 of the Social Security Act.

“(d) Not Treated as Tax for Certain Purposes.—The taxes imposed by this section shall not be treated as taxes imposed by this chapter for purposes of determining—

“(1) the amount of any credit allowable under this chapter, or
“(2) the amount of the minimum tax imposed by section 55.”

(b) Taxes Included in Estimated Tax.—

(1) Subparagraph (A) of section 6655(g)(1) of such Code is amended by striking “plus” at the end of clause (iii), by redesignating clause (iv) as clause (v), and by inserting after clause (iii) the following new clause:

“(iv) the tax imposed by section 59C, plus”.

(2) Section 6655 of such Code is amended by redesignating subsection (j) as subsection (k) and by inserting after subsection (i) the following new subsection:

“(j) Exempt Entities Treated as Corporations for Mediplan Tax.—Each entity referred to in section 59C(b)(2) shall be treated as a corporation for purposes of applying this section with respect to the tax imposed by section 59C.”

(c) Certain Information Included on W-2.—Subsection (a) of section 6051 of such Code is amended by striking “and” at the end of paragraph (8), by striking the period at the end of paragraph (9) and inserting “, and”, and by inserting after paragraph (9) the following new paragraph:
“(10) the total amount of qualified military benefits (as defined in section 134(b)).”

(d) CLERICAL AMENDMENT.—The table of parts for such subchapter A of chapter 1 of such Code is amended by adding at the end thereof the following new item:

“Part VIII. Income taxes for Mediplan health care.”

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

(f) SECTION 15 NOT TO APPLY.—Section 15 of the Internal Revenue Code of 1986 shall not apply to the taxes imposed by part VIII of subchapter A of chapter 1 of such Code.