## ENROLLED BILLS PRESENTED

The Secretary of the Senate reported that on today, January 30, 1995, she had presented to the President of the United States the following enrolled bill:

S. 273. An act to amend section 61h–6, of title 2, United States Code.

## PETITIONS AND MEMORIALS

The following petitions and memorials were laid before the Senate and were referred or ordered to lie on the table as indicated:

POM–26. A resolution adopted by the House of the Legislature of the State of Alabama; to the Committee on the Judiciary.

''HR 27

''Whereas, with each passing year, this nation becomes more deeply in debt as its expenditures grossly and repeatedly exceed available revenues; and

''Whereas, as the federal debt grows, the stability of our national and world economy weakens, and the burden placed on future generations of Americans become more onerous; and

''Whereas, conjunctively with a required balancing of the federal budget is a necessary prohibition against the imposition of unfunded federal mandates and other cost reallocation to the several states; and

''Whereas, believing that fiscal uncertainties at the federal level is the greatest threat that our nation faces, and cognizant that statutory budget balancing remedies have failed, we firmly believe that constitutional restraint is vital to bring the fiscal discipline needed to restore financial responsibility;'' Now therefore be it

''*Resolved by the House of Representatives of the Legislature of Alabama,* That the Legislature urges the United States Congress to adopt an amendment to the United States Constitution which both requires the balancing of the federal budget and prohibits transferring the costs and burdens of federal responsibilities and inclinations to the states by unfunded mandates or similar means.

''*Be it Further Resolved,* that certified copies of this resolution be transmitted to the President of the United States, the President of the United States Senate, the Majority Leader of the United States Senate, the Minority Leader of the United States Senate, the Speaker of the House of Representatives, the Minority Leader of the House of Representatives, and to every member of the State's Congressional Delegation.''

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POM–27. A resolution adopted by the Senate of the General Assembly of the Commonwealth of Kentucky; to the Committee on the Judiciary.

''SENATE RESOLUTION

''Whereas, for far too many years, Congress has recklessly and repeatedly enacted federal budgets in which government expenditures have grossly exceeded available revenues, resulting in unparalleled federal budgetary deficits that unjustly mortgage the future of our nation's children; and

''Whereas, Congress has taken far too little action on its own initiative to implement responsible budgetary controls through the reduction or elimination of the need for federal spending for certain governmental programs or the imposition of sufficient tax levies that would generate adequate revenue to fund necessary federal government programs; and

''Whereas, Congressional attempts to control the federal budget deficit over the last decade have resulted in shifting the planning, operational, and funding responsibilities for many federally-mandated programs to the states and their local governments, while at the same time reducing federal financial support for those programs; and

''Whereas, those short-sighted budget deficit control efforts have forced some states and local governments to reduce budget expenditures for their own necessary programs and to raise taxes to fund the additional financial burden imposed by Congress; and

''Whereas, approximately eighty percent of the nation's state legislatures are currently required to enact a balanced state budget, either by their state constitutions, state statutes, or legislative rules, proving that this is a task that can be accomplished by fiscally responsible elected officials; and

''Whereas, fiscal restraint imposed by an amendment to the Constitution of the United States of America is necessary to curtail federal spending to conform to available federal revenues; and

''Whereas, Article V of the Constitution of the United States of America provides that amendments to the Constitution may be proposed by the Congress for submission to the states for their ratification when two-thirds of both houses deem it necessary;

''Now, therefore, be it

''*Resolved by the Senate of the General Assembly of the Commonwealth of Kentucky:*

''Section 1. That the Congress of the United States is hereby requested and petitioned to adopt an amendment to the Constitution of the United States of America, for submission to the states for their ratification, requiring that each federal budget enacted by the Congress and signed by the President of the United States be in balance.

''Section 2. That, notwithstanding the submission of a balanced budget amendment to the states, each Congress convened prior to the amendment's ratification should make every reasonable effort on its own initiative to enact a balanced federal budget prior to being subject to the amendment's mandate that it do so.

''Section 3. That the Congress, in striving to enact a balanced federal budget and to reduce the federal budget deficit, must begin by addressing spending needs and revenue generation possibilities at the federal level and by funding only what the federal government itself can afford instead of unjustly shifting the financial responsibility for continuing federally-mandated programs and services onto the overburdened back of state and local governments.

''Section 4. That the Clerk of the Senate is directed to send copies of this resolution to the Clerk of the United States House of Representatives, the Secretary of the United States Senate, and the members of Congress elected from the Commonwealth of Kentucky.''

## INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second time by unanimous consent, and referred as indicated:

By Mr. CONRAD (for himself, Mr. DASCHLE, Mr. DORGAN, Mr. PELL, Mr. AKAKA, Mr. JEFFORDS, and Mr. GRAHAM):

S. 293. A bill to amend title 38, United States Code, to authorize the payment to States of per diem for veterans receiving adult day health care, and for other purposes; to the Committee on Veterans Affairs.

By Mr. COHEN:

S. 294. A bill to increase the availability and affordability of health care coverage for individuals and their families, to reduce paperwork and simplify the administration of health care claims, to increase access to care in rural and underserved areas, to improve quality and protect consumers from health care fraud and abuse, to promote preventive care, to make long-term care more affordable, and for other purposes; to the Committee on Finance.

By Mrs. KASSEBAUM (for herself, Mr. JEFFORDS, Mr. GREGG, and Mr. GORTON):

S. 295. A bill to permit labor management cooperative efforts that improve America's economic competitiveness to continue to thrive, and for other purposes; to the Committee on Labor and Human Resources.

By Mr. KENNEDY (for himself, Mr. AKAKA, Mr. BINGAMAN, Mrs. BOXER, Mr. BRADLEY, Mr. CAMPBELL, Mr. DODD, Mr. FEINGOLD, Mr. HARKIN, Mr. INOUYE, Mr. LAUTENBERG, Mr. LEAHY, Ms. MIKULSKI, Ms. MOSELEY-BRAUN, Mr. MOYNIHAN, Mrs. MURRAY, Mr. PACKWOOD, Mr. PELL, Mr. ROBB, Mr. SIMON, and Mr. WELLSTONE):

S. 296. A bill to amend section 1977A of the Revised Statutes to equalize the remedies available to all victims of intentional employment discrimination, and for other purposes; to the Committee on Labor and Human Resources.

By Mr. ROCKEFELLER (for himself, Mr. DASCHLE, Mr. GRAHAM, Mr. AKAKA, Mr. CAMPBELL, Mr. JEFFORDS, Mr. LEAHY, and Mr. BINGAMAN):

S. 297. A bill to amend the Internal Revenue Code of 1986 to clarify the exclusion from gross income for veterans' benefits; to the Committee on Finance.

## STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. CONRAD (for himself, Mr. DASCHLE, Mr. DORGAN, Mr. PELL, Mr. AKAKA, Mr. JEFFORDS, and Mr. GRAHAM):

S. 293. A bill to amend title 38, United States Code, to authorize the payment to States of per diem for veterans receiving adult day health care, and for other purposes; to the Committee on Veterans' Affairs.

### STATE VETERANS HOME ACT

Mr. CONRAD. Mr. President, today I rise to introduce the State Veterans Home Act of 1995. The bill extends discretionary authority to the Department of Veterans Affairs to provide a per diem payment for adult day health care for veterans. The bill also authorizes the use of funds from the Extended Care Facilities Grants Program, section 8131, to construct or renovate existing facilities to provide adult day care for veterans.

The legislation I am introducing today is similar to S. 852 introduced at the beginning of the 103d Congress. In the last Congress, S. 852 was reported to the Senate as section 205 of S. 1030—Veterans Health Programs Improvement Act of 1993—and passed by the Senate on May 25, 1994. Regrettably due to the legislative log-jam at the end of the 103d Congress, it was not incorporated into the veterans health benefits measure, H.R. 3313, that passed the House in the closing days of the 103d Congress.

I am very pleased that the bill I am introducing today is cosponsored by Senators DASCHLE, DORGAN, AKAKA, JEFFORDS, PELL, and GRAHAM.

This legislation received support in the 103d Congress from veterans and their families in North Dakota, and from all major national veterans organizations during a hearing by the Senate Committee on Veterans' Affairs on June 23, 1993. I am hoping the 104th Congress will act expeditiously to pass this important health care measure for veterans. I am enclosing a letter of support from the National Association of State Veterans Homes.

Currently, under section 1741, the Department of Veterans Affairs is required to pay a per diem to States for each veteran that is assisted through the State Home Facilities Program with hospital, nursing home, or domiciliary care. The per diem payment is $15.11 for domiciliary care, and $35.37 for nursing home and hospital care. Under section 8131, State home facilities, the Department of Veterans Affairs is also authorized to provide matching grant assistance for the construction, expansion, or remodeling of existing facilities for domiciliary, nursing home, or hospital care for veterans who are eligible to reside in State veterans facilities.

Under the legislation that I am introducing today, the State Veterans Home Program would be amended to authorize a per diem payment for veterans that are assisted by States who provide adult day care including health care as needed. States would also be authorized to apply for matching grant assistance to provide facilities for adult day care. In fiscal year 1995, Congress appropriated $47.3 million under the State Home Facilities Program for the construction or expansion of State extended care facilities for veterans.

Mr. President, I have discussed the proposed legislation to amend the State Veterans Home Program relating to adult day care health care with State veterans officials in North Dakota and representatives of the National Association of State Veterans Homes. The arguments in support of amending the State Veterans Home Program to authorize adult day health care are compelling.

The opportunity for adult day health care services for veterans during the daytime hours in a community setting would enable many veterans to remain at home with their families in a supportive environment as an alternative to nursing home placement.

I ask my colleagues, how many people do each of us know who are in this circumstance? If the family could get relief during the day for a veteran who is ill or who is starting to fail, and would have a chance to have a place to go during the day, the family could take care of that individual at night, thereby preventing nursing home placement.

For a veteran who may be in the early stages of Alzheimer's disease or require limited supervision in a post-operative period, the opportunity for adult day health care would meet the requirements of a growing number of our veterans population, and at less cost than nursing and residential home care. Equally important, adult day health care would provide respite for the primary care givers of veterans.

People have often said to me: Senator, if we just had a chance to have a break, if we just had a chance to be able to go to work and have our loved one be able to be at home with us in the evening, we would be able to take care of him. We would be able to save a lot of money for the Government. There is no sense putting all these people in nursing homes. Our family would love to be able to take care of our grandfather or our father. We would love to have him at home but we work during the day, both spouses work during the day. The kids are at school. Nobody is home.

If we had a chance to have that veteran in a setting where he could be cared for during the day we would take care of him at night and save lots of money—save money for the families, save money for the Government.

Mr. President, as the health care requirements of our veterans population change, and the demands on limited Department of Veterans Affairs resources increase, I believe it important that States have the flexibility to provide adult day health care services for veterans.

We have heard a lot in the last 24 hours about State flexibility. Why should they not have flexibility with respect to a program like this? They are asking for it. Why do we not give it to them?

The 71 State veterans homes across the country have a proven record of providing excellent domiciliary, nursing home, and hospital care. They also have the expertise in geriatrics, and specialized health care that is required to provide the adult day health care services.

I urge the Senate Committee on Veterans' Affairs to support these amendments to the State Veterans Home Program, and to report legislation to authorize adult day health care services for veterans as soon as possible.

I ask unanimous consent Mr. President, that the full text of my bill along with a letter in support of this initiative from the National Association of State Veterans Homes be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

S. 293

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

**SECTION 1. PAYMENT TO STATES OF PER DIEM FOR VETERANS RECEIVING ADULT DAY HEALTH CARE.**

(a) PAYMENT OF PER DIEM FOR VETERANS RECEIVING ADULT DAY CARE.—Section 1741 of title 38, United States Code, is amended—

(1) by inserting ''(1)'' after ''(a)'';

(2) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively; and

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

''(2) The Secretary may pay each State per diem at a rate determined by the Secretary for each veteran receiving adult day health care in a State home, if such veteran is eligible for such care under laws administered by the Secretary.''.

(b) ASSISTANCE TO STATES FOR CONSTRUCTION OF ADULT DAY CARE FACILITIES.—(1) Section 8131(3) of title 38, United States Code, is amended by inserting ''adult day health,'' before ''or hospital care''.

(2) Section 8132 of such title is amended by inserting ''adult day health,'' before ''or hospital care''.

(3) Section 8135(b) of such title is amended—

(A) in paragraph (2)(C), by inserting ''or adult day health care facilities'' after ''domiciliary beds''; and

(B) in paragraph (3)(A), by inserting ''or construction (other than new construction) of adult day health care buildings'' before the semicolon.

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NATIONAL ASSOCIATION OF
STATE VETERANS HOMES,
*Marquette, MI, December 16, 1994.*

Hon. KENT CONRAD,
*U.S. Senator, Hart Senate Office Building, Washington, DC.*

DEAR SENATOR CONRAD: This letter is in response to your recent inquiry regarding the National Association of State Veterans Homes (NASVH) position on re-introduction of proposed legislation to allow State Homes to develop an Adult Day Health Program.

As noted in Mr. Jack Dack's previous letter dated April 26, 1993, a 1993 survey had 38 State Homes respond positively out of 48 responses from 52 homes surveyed. We again recommend that Section 1741 be amended to authorize State Homes Adult Day Health Care. The section should be amended to provide for a per diem payment for Adult Day Health Care and additional construction grant monies to support expansion/remodeling to permit States to provide Adult Day Health Care.

This letter is offered as a reaffirmation of the NASVH commitment to providing this needed service to veterans pursuant to the aforementioned changes in Title 38 United States Code, Section 1741.

If you have any questions, please let me know.

Sincerely,

CLIFFORD A. KINNEY, II, MPA, NHA,
*Chairperson, NASVH, Legislative Committee.*

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NATIONAL ASSOCIATION OF
STATE VETERANS HOMES,
*Marshalltown, IA, April 26, 1993.*

Hon. KENT CONRAD,
*U.S. Senate, Hart Office Building, Washington, DC.*

DEAR SENATOR CONRAD. This is to express the views of the National Association of State Veterans Homes pertinent to proposed legislation to improve (3) the State Home Program.

(A) Title 38 United States Code, Section 1741, authorizes per diem to State Homes for domiciliary, nursing home care and hospital care. We endorse legislation to provide authority to the Secretary, Department of Veterans Affairs, to provide a per diem payment for adult day health care and construction grant support for expansion, remodeling or alteration of existing buildings to permit provision of adult day health care.

A survey conducted by the National Association of State Veterans Homes in 1984 overwhelmingly supported an adult day health

care initiative if an appropriate reimbursement system through the Veterans Administration could be developed for State Homes. Of the 48 responses from 52 Homes surveyed, 38 responded positively.

It is recommended that Section 1741 be amended to include authorization for State Home Adult Day Health Care.

Often times, family and loved ones are the primary caregivers for adult persons. Trying to maintain adults in the home can be very stressful and care can be difficult to provide both physically and psychologically. Resources can be extremely limited, especially in rural communities and families may not be aware of what resources are available. Adult ''day care'' has been one concept implemented to address dependent adult care.

The seventy-one State Veterans Homes in forty-one states being long-term care facilities employ clinicians with expertise in geriatrics and staff with years of experience in working with dependent, infirm, and/or handicapped individuals. The Homes have the potential to offer adult day health care in a safe, structured environment with trained, caring staff. There could be provisions for meals and nutritious snacks, medication dispensing, exercise programming and the offering of health assessment and patient/family teaching. There could be planned activities and social interactions for adult participation.

Such a program would be an ideal option for the elderly veterans who are: in need of social stimulation to combat depression; in need of supervision and/or personal care; post-operative in need of supervision or medication; victims of early Alzheimer's Disease.

Involvement in adult day health care would provide a peace of mind and respite for the working and non-working caregivers.

The provisions of these services during daytime hours in a congregate setting would enable veterans to be maintained at home in a supportive environment and be an alternative to a nursing home placement. Participation in an Adult Day Health Care Program could possibly prolong the ability of the veteran to stay in his home thereby lowering the demands on the Department of Veterans Affairs system.

Besides providing respite for the primary caregivers, veterans could be screened and referred for medical and/or community resources, including Department of Veteran's Affairs medical care facilities. Pre-assessment for admission could take place if the veteran desires to make application for permanent living in the State Home. Other advantages to the individuals and family members are networking with family members and professionals, participation in support groups, gaining knowledge about community resources and how to access the system.

The National Association of State Veterans Homes supports that provisions in United States Code 38, Section 1741, be amended to authorize State Home Adult Day Health Care; per diem payments to states for providing same; and to permit the Department of Veterans Affairs to provide grants for expansion, remodeling or alteration of existing buildings to permit provision of such care.

We in the State Home Program do not know the level of participation by the states at this time; however, it is anticipated there would be activity initially by five to ten Homes in this area. Since the Department of Veterans is unable to approve requests for construction grants totaling more than the amount specifically appropriated by the Congress for that fiscal year, any additional grant requests for construction for adult day health care over the specified funding allowed would probably require a waiting period. This waiting period would allow an opportunity for the Department of Veterans Affairs and State Home Program to bring the increased need for additional construction funds to the attention of the Veterans Affairs' Committees for consideration.

The State Home Program has a proven track record of being able to blend Federal, State and private resources to maximize the resources available for providing care for the veterans of this Nation. Because of this track record, it is always wise to look for opportunities to expand the relationship, so as to further enhance the efficient use of the Department of Veterans Affairs' resources in its provision of care for veterans. The establishment of a per diem for these services is an expansion of the already successful State Home Program with the Department of Veterans Affairs. With this per diem as a starting point, the State Home Program in partnership with the Department of Veterans Affairs has the potential to move towards an efficient, effective means of providing this necessary service for its constituents.

(B) Sharing: While the United States Congress has been generous in providing for its veterans, and the Department of Veterans Affairs has done a commendable job within the confines of the budgeted amounts in taking care of the Nation's veterans, the resources to do so are becoming more limited. We must continue to work closer together, share ideas, stretch and share resources and assist one another if we are going to fulfill our mutual obligation to provide the necessary health care services for the Nation's veterans. This sharing proposal is an initiative to formalize a closer-working relationship between the Department of Veterans Affairs Medical Centers in states where State Veterans Homes presently exist. It will strengthen the long and successful partnership between the Department of Veterans Affairs and State Homes which has long been recognized as a vital resource for the Department of Veterans Affairs in providing care for the chronically ill, elderly veterans.

Since many State Homes are located within a radius of one hundred miles of a Department of Veterans Affairs medical facility, it is felt that sharing of services would result in service, efficiency and economy in provision of care. The ability to have Department of Veterans Affairs clinics, such as Urology, Psychiatric Consultation, Physical Medicine/Rehabilitation Consultation, etc., located within a State Veterans Home, would enhance continuity of care for the benefit of the veterans in State Homes. Chronically ill, debilitated, infirm veterans would not have to experience traveling to and from the medical centers for some clinics if such a sharing was possible. Other areas of sharing could be in non-clinical services such as laundry, Life/Safety, Quality Assurance programming, housekeeping, etc.

It is felt that by permitting the Department of Veterans' Affairs and the State Home Program to expand, their sharing will result in greater efficiencies and enhance care for veterans. The National Association of State Veterans Homes supports enactment of the concept of sharing in this proposed legislation and believes it to be a benefit to veterans, the Department of Veterans Affairs and the State Home Program.

On behalf of the National Association of State Veterans Homes, thank you for the opportunity to support legislation to improve the State Veterans Home Program.

Sincerely,

JACK J. DACK,
*Chairperson, Legislative Committee.*

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By Mr. COHEN:

S. 294. A bill to increase the availability and affordability of health care coverage for individuals and their families, to reduce paperwork and simplify the administration of health care claims, to increase access to care in rural and underserved areas, to improve quality and protect consumers from health care fraud and abuse, to promote preventive care, to make long-term care more affordable, and for other purposes; to the Committee on Finance.

ACCESS TO AFFORDABLE HEALTH CARE ACT

Mr. COHEN. Mr. President, as the 104th Congress opened, it did so with a great deal of fanfare this month. Much of the discussion has been devoted to congressional reform, tax cuts, the balanced budget amendment, unfunded mandates, and welfare reform, but on one issue our colleagues have been notably silent.

I say that with one notable exception, my colleague from Illinois, who has just spoken rather eloquently on the whole subject of health care reform, which is what I would like to talk about this afternoon.

Health care reform was a dominant topic on everyone's mind during the last Congress. As I mentioned just a moment ago, today it is barely a whisper. I believe that this is a mistake. I think it is time for the Senate to put the issue back on the front burner of the public agenda.

Health care reform may not be a major clause in the House Republican's Contract With America, but rising health care costs and expanding gaps in coverage are still very much on the minds of the American people. In fact, postelection polls conducted for the Health Care Leadership Council and by the Washington Post and ABC News show that health care remains a top priority—as important even as cutting taxes, passing a balanced budget amendment, or enacting welfare reform.

Abraham Lincoln once observed that ''with public sentiment nothing can fail, and without it nothing can succeed.''

I think the American people wisely rejected the big-government approach advocated last year by the administration. More Government is clearly not the way to lower health care costs.

And when I say they rejected big government, this is a copy of the bill that in fact was being debated last year, some 1,443 pages long. The public did not understand it. They felt also that we were moving toward, if I can use that Tofflerian phrase, demasification of the centralized health care system. The fact is, they rejected it.

The fact is that Government spending on health care, with all of its bureaucratic endeavors and controls, has risen much faster than private health care spending. In fact, between 1970 and 1991 Medicare and Medicaid grew 427 percent, more than double the amount of 165 percent in the private sector. So we have seen a real disparity in terms of Government sponsored and funded

programs versus that of the private sector.

But the public rejection of the Clinton health care plan does not mean that American people do not want health care reform.

As my colleague from California, Senator DIANE FEINSTEIN, observed, the main reason the President's health care reform efforts collapsed was that the ''Democrats listened to the 15 percent of the public who had no coverage, while the Republicans listened to the 85 percent who did.'' What some Democrats in Washington derided as merely incremental was, to the American public, essential.

Susan Sontag wrote:

> Illness is the night-side of life, a more onerous citizenship. Everyone who is born holds dual citizenship, in the kingdom of the well and the kingdom of the sick. Although we all prefer to use only the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place.

As such, the flaws in our health care system are ones that will—sooner or later—touch every American family.

The American people want health care reform, but they want something they can understand and afford. They want a program that gives them some reassurance against their growing sense of financial insecurity against potential illness—a program that gives them some protection should they cross over into that kingdom of the sick.

When the American people say they want reform, they mean: ''If I lose my job or get sick, I want to keep my health insurance and I do not want it to cost so much.'' They want Congress to enact targeted reforms to contain health care costs and to ensure that they do not lose the health care coverage that they have.

Health care reform, I think, as my colleague from Illinois has pointed out, is pretty familiar to most of us now. We have spent over 4 years studying the problem, countless hours of staff researching the issue, debating the issue, drafting legislation, negotiating compromise. We have something, I think, very valuable to show for that effort.

Despite the partisan and sometimes bitter debate in the last Congress, there is broad-based, bipartisan agreement on some key steps that can and should be taken to contain health care costs and increase access for millions of Americans. In fact, I believe that action could have been taken on these changes 3 years ago if some had not insisted that there be comprehensive reform, or no reform at all.

Today I am introducing legislation outlining a blueprint for reform that is based on principles upon which I believe a bipartisan majority in Congress could agree. The plan takes significant strides toward the goal of universal coverage by bringing millions more Americans into the system. While some might characterize these reforms as incremental, they are by no means insignificant.

They would include insurance market reforms to make insurance portable and prohibit insurers from denying, canceling, or limiting coverage or otherwise discriminating against individuals on the basis of their health status.

They would include refundable tax credits for low-income families and full tax deductibility for the self-employed to make insurance coverage more affordable.

They would include voluntary purchasing cooperatives to give individuals and small businesses access to more affordable coverage; administrative reforms to reduce costs and paperwork and make the system more efficient.

They would include malpractice reforms to reduce the costly practice of defensive medicine; expanded access to care in rural areas; more affordable long-term care; and, finally, stronger efforts to combat fraud and abuse, which currently rob our system of as much as $100 billion every year.

Many of my colleagues have heard me take the floor time and time again to complain about health care fraud in this country. In fact, just last week I introduced separate legislation dealing with health care fraud, because we are losing $100 billion every year to health care fraud. It amounts to $275 million a day, $11.5 million every single hour.

We could have taken action last year. We did not take action last year. The said wait until health care reform comes. Health care reform did not come. So by the time this legislation or some variation of this legislation is finally adopted, we will lost another $100 billion to health care fraud and abuse.

Many of the principles involved in this legislation—and, by the way, Mr. President, this contains about 200 typewritten pages—could have been adopted more than 4½ years ago when I first introduced it. In fact, it could have been adopted when Senator Lloyd Bentsen passed his version of the bill back in 1992.

Although action on health care reform has been deferred in the past. It simply cannot be deferred any longer.

The new Republican-controlled Congress has both the obligation and the political opportunity to enact health care reform, but the window of opportunity will not be open long. We simply cannot afford to repeat past mistakes and allow the issue to become complicated or obfuscated by election-year politics.

I listened with great interest to my colleagues from Illinois outline some of the letters he has received from constituents and others pointing out it is not a Republican or Democratic issue, it is an American problem.

Last month, one of my constituents, Leslie Mansfield, of Bar Harbor, testified before the Maine Health Care Reform Commission about the importance of health care reform for her family. Since her son was diagnosed with juvenile diabetes 6 years ago, the family has faced mounting insurance and medical bills. Even though the rest of the family is healthy, in 3 short years they have seen their insurance premiums jump from $190 to $600 a month, and they fear that they will soon be either dropped by their insurer or priced out of the market entirely.

If the new Congress does not move quickly on health care reform, millions of Americans like Leslie Mansfield and her family will be worse off, not better off.

Health care costs, which last year topped $1 trillion, will continue to rise, placing an increasing strain on families, employers, and governments alike, and pricing millions more Americans out of the market. Insurers and businesses will be able to continue to cut costs by avoiding customers at greater risk. People with preexisting medical conditions like heart disease and diabetes will face even steeper premiums or could lose their coverage entirely. And we will continue to lose an estimated $275 million a day—that is $11.5 million every hour—to health care fraud.

Health care reform does not have to be an all-or-nothing proposition. That mistake was made both in 1992 and in 1994 and should not be repeated. By building upon our areas of agreement, we can take major steps to contain costs, expand choice and extend access to care to millions more Americans.

We have come a long way to reach this point in the health care debate and we should move forward. While to do nothing may not be a breach of the Contract With America, it most certainly would be a breach of trust with the American people.

I urge my colleagues to join me in cosponsoring the Access to Affordable Health Care Act and ask unanimous consent that a section-by-section summary as well as the full text of the bill be printed in the CONGRESSIONAL RECORD.

Mr. SIMON. Mr. President, will the Senator yield for 30 seconds? I want to commend the Senator for his statement.

Mr. COHEN. I yield to the Senator.

Mr. SIMON. I, obviously, have not read the bill. But if we recognize the problem and work together, we can do something for the American people in this session of Congress. I commend him for his leadership.

Mr. COHEN. Mr. President, I thank my friend for his comments. Let me conclude with a few observations.

There has been so much partisanship discussed in the House and the Senate on various other issues. There was a great deal of partisanship on the health care debate as well. I remember when Senator DOLE asked the committee to put together a task force headed up by JOHN CHAFEE to meet with our Democratic counterpart; we ran into a stonewall.

It was not open to negotiation. There was no compromise. It was all-or-nothing, comprehensive or nothing at all. As a result, we had nothing at all. One of the members of the Democratic task force came to me just a couple of days ago and said, ''You know, if we had done what you had suggested 2 years ago, it would have been a great step forward.'' We did not do it then. We ought to do it now.

Let Senators put aside the partisanship and reach across the aisle and do something the American people will support—Republican, Democrat, independent, it does not matter. We need the relief. We need the reform. We ought not to defer this any longer. I yield the floor.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

S. 294

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

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

(a) SHORT TITLE.—This Act may be cited as the ''Access to Affordable Health Care Act''.

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

## TITLE I—HEALTH INSURANCE MARKET REFORM

### Subtitle A—Insurance Market Standards

#### SEC. 1001. NONDISCRIMINATION BASED ON HEALTH STATUS.

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

(b) TREATMENT OF PREEXISTING CONDITION EXCLUSIONS FOR ALL SERVICES.—

(1) IN GENERAL.—A health plan may impose a limitation or exclusion of benefits relating to treatment of a condition based on the fact that the condition preexisted the effective date of the plan with respect to an individual only if—

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

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

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

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

(2) CREDITING OF PREVIOUS COVERAGE.—A health plan shall provide that if an individual under such plan is in a period of continuous coverage as of the date of enrollment under such plan, any period of exclusion of coverage with respect to a preexisting condition shall be reduced by 1 month for each month in the period of continuous coverage.

(3) DEFINITIONS.—For purposes of this subsection:

(A) PERIOD OF CONTINUOUS COVERAGE.—

(i) IN GENERAL.—The term ''period of continuous coverage'' means the period beginning on the date an individual is enrolled under a health plan or an equivalent health care program and ends on the date the individual is not so enrolled for a continuous period of more than 3 months.

(ii) EQUIVALENT HEALTH CARE PROGRAM.—The term ''equivalent health care program'' means—

(I) part A or part B of the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.),

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

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

(IV) the veterans health care program under chapter 17 of title 38, United States Code,

(V) the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), as defined in section 1073(4) of title 10, United States Code, and

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

(B) PREEXISTING CONDITION.—The term ''preexisting condition'' means, with respect to coverage under a health plan, a condition which was diagnosed, or which was treated, within the 3-month period ending on the day before the date of enrollment (without regard to any waiting period).

(c) LIMITATIONS PROHIBITED.—

(1) IN GENERAL.—A health plan may not impose a lifetime limitation on the provision of benefits under the plan.

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

#### SEC. 1002. GUARANTEED ISSUE AND RENEWAL

(a) SMALL GROUP MARKET.—Each health plan offering coverage in the small group market shall guarantee each individual purchaser and small employer (and each eligible employee of such small employer) applying for coverage in such market the opportunity to enroll in the plan.

(b) LARGE EMPLOYER MARKET.—Each health plan offering coverage in the large employer market shall guarantee any individual eligible for coverage under the plan the opportunity to enroll in such plan.

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

(d) RENEWAL OF POLICY.—

(1) SMALL GROUP MARKET.—A health plan issued to a small employer or an individual purchaser in the small group market shall be renewed at the option of the employer or individual, if such employer or individual purchaser remains eligible for coverage under the plan.

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

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

(1) the nonpayment of premiums;

(2) fraud on the part of the employer or individual relating to such plan; or

(3) the misrepresentation by the employer or individual of material facts relating to an application for coverage of a claim or benefit.

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

#### SEC. 1003. RATING LIMITATIONS.

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

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

(1) develop specific standards in the form of a model Act and model regulations that provide for the implementation of the rating limitations described in subsection (d); and

(2) report to the Secretary concerning such standards within 6 months after the date of enactment of this Act.

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

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

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

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

(B) shall include age (as specified in paragraph (3)), family type, and geography; and

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

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

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

(3) Uniform age categories and age adjustment factors that reflect the relative actuarial costs of benefit packages among enrollees. By the end of the 3-year period beginning on the effective date of this section, for individuals who have attained age 18 but not age 65, the highest age adjustment factor may not exceed 3 times the lowest age adjustment factor.

(e) DISCOUNTS.—Standards developed under this section shall permit health plans to provide premium discounts based on workplace health promoting activities.

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

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

(b) ROLE OF THE SECRETARY.—Not later than 9 months after the date of enactment of this Act, the Secretary, in consultation with the NAIC and other organizations with expertise in the areas of quality assurance (including the Joint Commission on Accreditation of Health Care Organizations, the National Committee for Quality Assurance, and peer review organizations), shall establish minimum guidelines specified in subsection (c) for the issuance by each State of delivery system quality standards. Such standards shall be the applicable health plan standards under this section.

(c) MINIMUM GUIDELINES.—The minimum guidelines specified in this subsection are as follows:

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

(A) quality management;

(B) credentialing;

(C) utilization management;

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

(E) practice guidelines and protocols.

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

(A) comparative standardized consumer information with respect to health plan premiums and quality measures, including health care report cards;

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

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

(D) grievance procedures.

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

**SEC. 1005. RISK ADJUSTMENT.**

Each health plan offering coverage in the small group market in a State shall participate in a risk adjustment program developed by such State under standards established by the Secretary.

**SEC. 1006. EFFECTIVE DATES.**

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

(b) RATING LIMITATIONS AND RISK ADJUSTMENTS.—The standards promulgated under sections 1003 and 1005 shall apply to plans that are issued or renewed after December 31, 1996.

### Subtitle B—Establishment and Application of Standards

**SEC. 1011. GENERAL RULES.**

(a) CONSTRUCTION.—

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

(2) PREEMPTION OF STATE LAW.—

(A) IN GENERAL.—No requirement of this title shall be construed as preempting any State law unless such State law directly conflicts with such requirement. The provision of additional consumer protections under State law as described in subparagraph (B) shall not be considered to directly conflict with any such requirement.

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

(i) laws that limit the exclusions or limitations for preexisting medical conditions to periods that are less than those provided for under section 1001;

(ii) laws that limit variations in premium rates beyond the variations permitted under section 1003; and

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

(C) LIMITED PREEMPTION OF STATE MANDATED BENEFITS.—No State law or regulation in effect in a State that requires health plans offered to small employers in the State to include specified items and services other than those described in section 1005(b)(2)(B) shall apply with respect to a health plan offered by an insurer to a small employer.

(b) REGULATIONS.—The Secretary, in consultation with NAIC, and the Secretary of Labor are each authorized to issue regulations as are necessary to implement this Act.

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

Nothing in this Act shall be construed as prohibiting States from enacting health care reform measures that exceed the measures established under this Act, including reforms that expand access to health care services, control health care costs, and enhance quality of care.

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

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

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

### Subtitle C—Definitions

**SEC. 1021. DEFINITIONS.**

(a) HEALTH PLAN.—For purposes of this title and title II, the term ''health plan'' means a plan that provides, or pays the cost of, health benefits. Such term does not include the following, or any combination thereof:

(1) Coverage only for accidental death, dismemberment, dental, or vision.

(2) Coverage providing wages or payments in lieu of wages for any period during which the employee is absent from work on account of sickness or injury.

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

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

(5) Worker's compensation or similar insurance.

(6) Automobile medical-payment insurance.

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

(8) Any plan or arrangement not described in any preceding subparagraph which provides for benefit payments, on a periodic basis, for a specified disease or illness or period of hospitalization without regard to the costs incurred or services rendered during the period to which the payments relate.

(9) Such other plan or arrangement as the Secretary determines is not a health plan.

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

(1) SMALL GROUP MARKET.—The term ''small group market'' means the market for health plans which is composed of small employers and individual purchasers.

(2) SMALL EMPLOYER.—The term ''small employer'' means, with respect to any calendar year, any employer if, on each of 20 days during the preceding calendar year (each day being in a different week), such employer (or any predecessor) employed less than 51 employees for some portion of the day.

(3) INDIVIDUAL PURCHASER.—The term ''individual purchaser'' means an individual who is not eligible to enroll in a health plan sponsored by a large or small employer.

(4) LARGE EMPLOYER MARKET.—The term ''large employer market'' means the market for health plans which is composed of large employers.

(5) LARGE EMPLOYER.—The term ''large employer''—

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

(B) includes a multiemployer plan as defined in section 3(37) of the Employment Retirement Income Security Act of 1974 (29 U.S.C. 1002(37)) and a plan which is maintained by a rural electric cooperative or a rural telephone cooperative association (within the meaning of section 3(40) of such Act (29 U.S.C. 1002(40)).

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

(1) NAIC.—The term ''NAIC'' means the National Association of Insurance Commissioners.

(2) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

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

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

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

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

(1) engaging in marketing and outreach efforts to inform individuals and small employers about the small group health insurance purchasing arrangement, which may include the payment of sales commissions;

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

(3) providing administrative functions, such as eligibility screening, claims administration, and customer service.

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

(1) whether the program will be operated directly by the State or through 1 or more State-sponsored private organizations and the details of such operation;

(2) program goals for reducing the cost of health insurance for, and increasing insurance coverage in, the small group market;

(3) the approaches proposed for enlisting participation by insurers and small employers, including any plans to use State funds to subsidize the cost of insurance for participating individuals and employers; and

(4) the methods proposed for evaluating the effectiveness of the program in reducing the number of uninsured in the State and on lowering the cost of health insurance for the small group market in the State.

(d) GRANT CRITERIA.—In awarding grants, the Secretary shall consider the potential impact of the State's proposal on the cost of health insurance for the small group market and on the number of uninsured, and the need for regional variation in the awarding of grants. To the extent the Secretary deems appropriate, grants shall be awarded to fund programs employing a variety of approaches for establishing small group health insurance purchasing arrangements.

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

(f) ANNUAL REPORT BY STATES.—States receiving grants under this section shall report to the Secretary annually on the numbers and rates of participation by eligible insurers and small employers, on the estimated impact of the program on reducing the number of uninsured, and on the cost of insurance available to the small group market in the State.

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

(h) SECRETARIAL REPORT.—The Secretary shall report to Congress by not later than January 1, 1997, on the number and amount of grants awarded under this section, and include with such report an evaluation of the impact of the grant program on the number of uninsured and cost of health insurance to small group markets in participating States.

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

### SEC. 3001. PERMANENT EXTENSION AND INCREASE OF DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

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

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

(1) by striking ''25 percent'' in paragraph (1) and inserting ''the applicable percentage'', and

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

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

| For taxable years beginning in: | The applicable percentage is: |
|---|---|
| 1994, 1995 and 1996 | 25 |
| 1997 | 50 |
| 1998 and 1999 | 75 |
| 2000 and thereafter | 100.'' |

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

### SEC. 3002. CREDIT FOR HEALTH INSURANCE EXPENSES.

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

**''SEC. 34A. HEALTH INSURANCE EXPENSES.**

''(a) ALLOWANCE OF CREDIT.—

''(1) IN GENERAL.—In the case of an eligible individual, there shall be allowed as a credit against the tax imposed by this subtitle for the taxable year an amount equal to the applicable percentage of the qualified health insurance expenses paid by such individual during the taxable year.

''(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the term 'applicable percentage' means 60 percent reduced (but not below zero) by 10 percentage points for each $1,000 (or fraction thereof) by which the taxpayer's adjusted gross income for the taxable year exceeds the applicable dollar amount.

''(3) APPLICABLE DOLLAR AMOUNT.—For purposes of this subsection, the term 'applicable dollar amount' means—

''(A) in the case of a taxpayer filing a joint return, $28,000,

''(B) in the case of any other taxpayer (other than a married individual filing a separate return), $18,000, and

''(C) in the case of a married individual filing a separate return, zero.

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

''(b) QUALIFIED HEALTH INSURANCE EXPENSES.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualified health insurance expenses' means amounts paid during the taxable year for insurance which constitutes medical care (within the meaning of section 213(d)(1)(C)). For purposes of the preceding sentence, the rules of section 213(d)(6) shall apply.

''(2) DOLLAR LIMIT ON QUALIFIED HEALTH INSURANCE EXPENSES.—The amount of the qualified health insurance expenses paid during any taxable year which may be taken into account under subsection (a)(1) shall not exceed $1,200 ($2,400 in the case of a taxpayer filing a joint return).

''(3) ELECTION NOT TO TAKE CREDIT.—A taxpayer may elect for any taxable year to have amounts described in paragraph (1) not treated as qualified health insurance expenses.

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

''(d) SPECIAL RULES.—For purposes of this section—

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

''(2) MEDICARE-ELIGIBLE INDIVIDUALS.—No expense shall be treated as a qualified health insurance expense if it is an amount paid for insurance for an individual for any period with respect to which such individual is entitled (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) SUBSIDIZED EXPENSES.—No expense shall be treated as a qualified health insurance expense to the extent—

''(A) such expense is paid, reimbursed, or subsidized (whether by being disregarded for purposes of another program or otherwise) by the Federal Government, a State or local government, or any agency or instrumentality thereof, and

''(B) the payment, reimbursement, or subsidy of such expense is not includible in the gross income of the recipient.

''(e) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the purposes of this section.''.

(b) ADVANCE PAYMENT OF CREDIT.—

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

**''SEC. 3507A. ADVANCE PAYMENT OF HEALTH INSURANCE EXPENSES CREDIT.**

''(a) GENERAL RULE.—Except as otherwise provided in this section, every employer making payment of wages with respect to whom a health insurance expenses eligibility certificate is in effect shall, at the time of paying such wages, make an additional payment equal to such employee's dependent care advance amount.

''(b) HEALTH INSURANCE EXPENSES ELIGIBILITY CERTIFICATE.—For purposes of this title, a health insurance expenses eligibility certificate is a statement furnished by an employee to the employer which—

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

''(2) certifies that the employee does not have a health insurance expenses eligibility certificate in effect for the calendar year with respect to the payment of wages by another employer,

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

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

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

''(c) HEALTH INSURANCE EXPENSES ADVANCE AMOUNT.—

''(1) IN GENERAL.—For purposes of this title, the term 'health insurance expenses advance amount' means, with respect to any payroll period, the amount determined—

''(A) on the basis of the employee's wages from the employer for such period,

''(B) on the basis of the employee's estimated qualified health insurance expenses included in the health insurance expenses eligibility certificate, and

''(C) in accordance with tables provided by the Secretary.

''(2) ADVANCE AMOUNT TABLES.—The tables referred to in paragraph (1)(C) shall be similar in form to the tables prescribed under section 3402(a) and, to the maximum extent feasible, shall be coordinated with such tables and the tables prescribed under section 3507(c).

''(d) OTHER RULES.—For purposes of this section, rules similar to the rules of subsections (d) and (e) of section 3507 shall apply.

''(e) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the purposes of this section.''.

(2) CONFORMING AMENDMENT.—The table of sections for chapter 25 of such Code is

amended by adding after the item relating to section 3507 the following new item:

''Sec. 3507A. Advance payment of health insurance expenses credit.''.

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

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

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

(2) MEDICAL, DENTAL, ETC., EXPENSES.—Subsection (e) of section 213 of such Code is amended by inserting ''or section 34A'' after ''section 21''.

(d) CLERICAL AMENDMENT.—The table of sections for subpart A of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 34 the following new item:

''Sec. 34A. Health insurance expenses.''.

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

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

### SEC. 4001. NONREFUNDABLE CREDIT FOR CERTAIN PRIMARY HEALTH SERVICES PROVIDERS.

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

**''SEC. 23. PRIMARY HEALTH SERVICES PROVIDERS.**

''(a) ALLOWANCE OF CREDIT.—There shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to the product of—

''(1) the number of months during such taxable year—

''(A) during which the taxpayer is a qualified primary health services provider, and

''(B) which are within the taxpayer's mandatory service period, and

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

''(b) QUALIFIED PRIMARY HEALTH SERVICES PROVIDER.—For purposes of this section, the term 'qualified primary health services provider' means, with respect to any month, any qualified practitioner who—

''(1) has in effect a certification by the Bureau as a provider of primary health services and such certification is, when issued, for a health professional shortage area in which the qualified practitioner is commencing the providing of primary health services,

''(2) is providing primary health services full time in the health professional shortage area identified in such certification, and

''(3) has not received a scholarship under the National Health Service Corps Scholarship Program or any loan repayments under the National Health Service Corps Loan Repayment Program.

For purposes of paragraph (2) and subsection (e)(3), a provider shall be treated as providing services in a health professional shortage area when such area ceases to be such an area if it was such an area when the provider commenced providing services in the area.

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

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

''(1) BUREAU.—The term 'Bureau' means the Bureau of Primary Health Care, Health Resources and Services Administration of the United States Public Health Service.

''(2) QUALIFIED PRACTITIONER.—The term 'qualified practitioner' means a physician, a physician assistant, a nurse practitioner, or a certified nurse-midwife.

''(3) PHYSICIAN.—The term 'physician' has the meaning given to such term by section 1861(r) of the Social Security Act.

''(4) PHYSICIAN ASSISTANT; NURSE PRACTITIONER.—The terms 'physician assistant' and 'nurse practitioner' have the meanings given to such terms by section 1861(aa)(5) of the Social Security Act.

''(5) CERTIFIED NURSE-MIDWIFE.—The term 'certified nurse-midwife' has the meaning given to such term by section 1861(gg)(2) of the Social Security Act.

''(6) PRIMARY HEALTH SERVICES.—The term 'primary health services' has the meaning given such term by section 330(b)(1) of the Public Health Service Act.

''(7) HEALTH PROFESSIONAL SHORTAGE AREA.—The term 'health professional shortage area' has the meaning given such term by section 332(a)(1)(A) of the Public Health Service Act.

''(e) RECAPTURE OF CREDIT.—

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

''(A) no credit shall be allowed under subsection (a) for such taxable year and any succeeding taxable year, and

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

''(i) the applicable percentage, and

''(ii) the aggregate unrecaptured credits allowed to such taxpayer under this section for all prior taxable years.

''(2) APPLICABLE RECAPTURE PERCENTAGE.—

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

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

''(B) TIMING.—For purposes of subparagraph (A), month 1 shall begin on the first day of the mandatory service period.

''(3) RECAPTURE EVENT DEFINED.—

''(A) IN GENERAL.—For purposes of this subsection, the term 'recapture event' means the failure of the taxpayer to be a qualified primary health services provider for any month during the taxpayer's mandatory service period.

''(B) SECRETARIAL WAIVER.—The Secretary, in consultation with the Secretary of Health and Human Services, may waive any recapture event caused by extraordinary circumstances.

''(4) NO CREDITS AGAINST TAX; MINIMUM TAX.—Any increase in tax under this subsection shall not be treated as a tax imposed by this chapter for purposes of determining the amount of any credit under subpart A, B, or D of this part or for purposes of section 55.''

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

''Sec. 23. Primary health services providers.''

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

### SEC. 4002. EXPENSING OF MEDICAL EQUIPMENT.

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

''(1) DOLLAR LIMITATION.—

''(A) GENERAL RULE.—The aggregate cost which may be taken into account under subsection (a) for any taxable year shall not exceed $17,500.

''(B) HEALTH CARE PROPERTY.—The aggregate cost which may be taken into account under subsection (a) shall be increased by the lesser of—

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

''(ii) $10,000.''

(b) DEFINITION.—Section 179(d) of such Code (relating to definitions) is amended by adding at the end the following new paragraph:

''(11) HEALTH CARE PROPERTY.—For purposes of this section, the term 'health care property' means section 179 property—

''(A) which is medical equipment used in the screening, monitoring, observation, diagnosis, or treatment of patients in a laboratory, medical, or hospital environment,

''(B) which is owned (directly or indirectly) and used by a physician (as defined in section 1861(r) of the Social Security Act) in the active conduct of such physician's full-time trade or business of providing primary health services (as defined in section 330(b)(1) of the Public Health Service Act) in a health professional shortage area (as defined in section 332(a)(1)(A) of the Public Health Service Act), and

''(C) substantially all the use of which is in such area.''

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

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

### SEC. 4003. EXPANDED SERVICES FOR MEDICALLY UNDERSERVED INDIVIDUALS.

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

**''SEC. 330B. EXPANDED SERVICES FOR MEDICALLY UNDERSERVED INDIVIDUALS.**

''(a) ESTABLISHMENT OF HEALTH SERVICES ACCESS PROGRAM.—From amounts appropriated under this section, the Secretary shall, acting through the Bureau of Health Care Delivery Assistance, award grants under this section to federally qualified health centers (hereinafter referred to in this section as 'FQHC's') and other entities and organizations submitting applications under this section (as described in subsection (c)) for the purpose of providing access to services for medically underserved populations (as defined in section 330(b)(3)) or in high impact areas (as defined in section 329(a)(5)) not currently being served by a FQHC.

''(b) ELIGIBILITY FOR GRANTS.—

''(1) IN GENERAL.—The Secretary shall award grants under this section to entities or organizations described in this paragraph and paragraph (2) which have submitted a proposal to the Secretary to expand such entities or organizations operations (including

expansions to new sites (as determined necessary by the Secretary)) to serve medically underserved populations or high impact areas not currently served by a FQHC and which—

''(A) have as of January 1, 1991, been certified by the Secretary as a FQHC under section 1905(l)(2)(B) of the Social Security Act; or

''(B) have submitted applications to the Secretary to qualify as FQHC's under such section 1905(l)(2)(B); or

''(C) have submitted a plan to the Secretary which provides that the entity will meet the requirements to qualify as a FQHC when operational.

''(2) NON FQHC ENTITIES.—

''(A) ELIGIBILITY.—The Secretary shall also make grants under this section to public or private nonprofit agencies, health care entities or organizations which meet the requirements necessary to qualify as a FQHC except, the requirement that such entity have a consumer majority governing board and which have submitted a proposal to the Secretary to provide those services provided by a FQHC as defined in section 1905(l)(2)(B) of the Social Security Act and which are designed to promote access to primary care services or to reduce reliance on hospital emergency rooms or other high cost providers of primary health care services, provided such proposal is developed by the entity or organizations (or such entities or organizations acting in a consortium in a community) with the review and approval of the Governor of the State in which such entity or organization is located.

''(B) LIMITATION.—The Secretary shall provide in making grants to entities or organizations described in this paragraph that no more than 10 percent of the funds provided for grants under this section shall be made available for grants to such entities or organizations.

''(c) APPLICATION REQUIREMENTS.—

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

''(2) REQUIREMENTS.—An application submitted under this section must provide—

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

''(ii) for a corresponding schedule of discounts to be applied to such fees or payments, based upon the patient's ability to pay (determined by using a sliding scale formula based on the income of the patient);

''(B) assurances that the entity or organization provides services to persons who are eligible for benefits under title XVIII of the Social Security Act, for medical assistance under title XIX of such Act or for assistance for medical expenses under any other public assistance program or private health insurance program; and

''(C) assurances that the entity or organization has made and will continue to make every reasonable effort to collect reimbursement for services—

''(i) from persons eligible for assistance under any of the programs described in subparagraph (B); and

''(ii) from patients not entitled to benefits under any such programs.

''(d) LIMITATIONS ON USE OF FUNDS.—

''(1) IN GENERAL.—From the amounts awarded to an entity or organization under this section, funds may be used for purposes of planning but may only be expended for the costs of—

''(A) assessing the needs of the populations or proposed areas to be served;

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

''(C) development of an implementation plan that addresses—

''(i) recruitment and training of personnel; and

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

''(2) RECRUITING, TRAINING AND COMPENSATION OF STAFF.—From the amounts awarded to an entity or organization under this section, funds may be used for the purposes of paying for the costs of recruiting, training and compensating staff (clinical and associated administrative personnel (to the extent such costs are not already reimbursed under title XIX of the Social Security Act or any other State or Federal program)) to the extent necessary to allow the entity to operate at new or expended existing sites.

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

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

''(B) acquiring, expanding, and modernizing of existing facilities;

''(C) purchasing essential (as determined by the Secretary) equipment; and

''(D) amortization of principal and payment of interest on loans obtained for purposes of site construction, acquisition, modernization, or expansion, as well as necessary equipment.

''(4) SERVICES.—From the amounts awarded to an entity or organization under this section, funds may be expanded for the payment of services but only for the costs of—

''(A) providing or arranging for the provision of all services through the entity necessary to qualify such entity as a FQHC under section 1905(l)(2)(B) of the Social Security Act;

''(B) providing or arranging for any other service that a FQHC may provide and be reimbursed for under title XIX of such Act; and

''(C) providing any unreimbursed costs of providing services as described in section 330(a) to patients.

''(e) PRIORITIES IN THE AWARDING OF GRANTS.—

''(1) CERTIFIED FQHC's.—The Secretary shall give priority in awarding grants under this section to entities which have, as of January 1, 1991, been certified as a FQHC under section 1905(l)(2)(B) of the Social Security Act and which have submitted a proposal to the Secretary to expand their operations (including expansion to new sites) to serve medically underserved populations for high impact areas not currently served by a FQHC. The Secretary shall give first priority in awarding grants under this section to those FQHCs or other entities which propose to serve populations with the highest degree of unmet need, and which can demonstrate the ability to expand their operations in the most efficient manner.

''(2) QUALIFIED FQHC's.—The Secretary shall give second priority in awarding grants to entities which have submitted applications to the Secretary which demonstrate that the entity will qualify as a FQHC under section 1905(l)(2)(B) of the Social Security Act before it provides or arranges for the provision of services supported by funds awarded under this section, and which are serving or proposing to serve medically underserved populations or high impact areas which are not currently served (or proposed to be served) by a FQHC.

''(3) EXPANDED SERVICES AND PROJECTS.—The Secretary shall give third priority in awarding grants in subsequent years to those FQHCs or other entities which have provided for expanded services and project and are able to demonstrate that such entity will incur significant unreimbursed costs in providing such expanded services.

''(f) RETURN OF FUNDS TO SECRETARY FOR COSTS REIMBURSED FROM OTHER SOURCES.—To the extent that an entity or organization receiving funds under this section is reimbursed from another source for the provision of services to an individual, and does not use such increased reimbursement to expand services furnished, areas served, to compensate for costs of unreimbursed services provided to patients, or to promote recruitment, training, or retention of personnel, such excess revenues shall be returned to the Secretary.

''(g) TERMINATION OF GRANTS.—

''(1) FAILURE TO MEET FQHC REQUIREMENTS.—

''(A) IN GENERAL.—With respect to any entity that is receiving funds awarded under this section and which subsequently fails to meet the requirements to qualify as a FQHC under section 1905(l)(2)(B) or is an entity that is not required to meet the requirements to qualify as a FQHC under section 1905(l)(2)(B) of the Social Security Act but fails to meet the requirements of this section, the Secretary shall terminate the award of funds under this section to such entity.

''(B) NOTICE.—Prior to any termination of funds under this section to an entity, the entities shall be entitled to 60 days prior notice of termination and, as provided by the Secretary in regulations, an opportunity to correct any deficiencies in order to allow the entity to continue to receive funds under this section.

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

''(A) sell any property (including equipment) acquired or constructed by the entity using funds made available under this section or transfer such property to another FQHC, provided, that the Secretary shall reimburse any costs which were incurred by the entity in acquiring or constructing such property (including equipment) which were not supported by grants under this section; and

''(B) recoup any funds provided to an entity terminated under this section.

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

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

**SEC. 4004. INCREASE IN NATIONAL HEALTH SERVICE CORPS AND AREA HEALTH EDUCATION CENTER FUNDING.**

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

(1) by striking ''1991, and'' and inserting ''1991,''; and

(2) by striking ''through 2000'' and inserting '', 1994, and 1995, and $20,000,000 for each of the fiscal years 1996 through 2000''.

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

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

(2) in subparagraph (C), by striking ''and 1995'' and inserting ''1995, and $20,000,000 for each of the fiscal years 1996 through 2000''.

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

(a) APPOINTMENT OF ASSISTANT SECRETARY.—

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

(A) by striking ''by a Director, who shall advise the Secretary'' and inserting ''by an Assistant Secretary for Rural Health (in this section referred to as the 'Assistant Secretary'), who shall report directly to the Secretary''; and

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

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

(B) Section 338J(a) of the Public Health Service Act (42 U.S.C. 254r(a)) is amended by striking ''Director of the Office of Rural Health Policy'' and inserting ''Assistant Secretary for Rural Health''.

(C) Section 464T(b) of the Public Health Service Act (42 U.S.C. 285p–2(b)) is amended in the matter preceding paragraph (1) by striking ''Director of the Office of Rural Health Policy'' and inserting ''Assistant Secretary for Rural Health''.

(D) Section 6213 of the Omnibus Budget Reconciliation Act of 1989 (42 U.S.C. 1395x note) is amended in subsection (e)(1) by striking ''Director of the Office of Rural Health Policy'' and inserting ''Assistant Secretary for Rural Health''.

(E) Section 403 of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (42 U.S.C. 300ff–11 note) is amended in the matter preceding paragraph (1) of subsection (a) by striking ''Director of the Office of Rural Health Policy'' and inserting ''Assistant Secretary for Rural Health''.

(3) AMENDMENT TO THE EXECUTIVE SCHEDULE.—Section 5315 of title 5, United States Code, is amended by striking ''Assistant Secretaries of Health and Human Services (5)'' and inserting ''Assistant Secretaries of Health and Human Services (6)''.

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

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

**SEC. 4006. STUDY ON TRANSITIONAL MEASURES TO ENSURE ACCESS.**

(a) IN GENERAL.—The Prospective Payment Assessment Commission shall conduct a study concerning the need for legislation or regulations to ensure that vulnerable populations have adequate access to health plans and health care providers and services.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, the Prospective Payment Assessment Commission shall prepare and submit to Congress a report concerning the findings and recommendations of the Commission based on the study conducted under subsection (a).

## TITLE V—QUALITY AND CONSUMER PROTECTION

### Subtitle A—Quality Improvement Foundations

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

(a) ESTABLISHMENT.—

(1) GRANT PROCESS.—The Secretary shall, through a competitive grantmaking process, award demonstration grants for the establishment and operation of quality improvement foundations. In awarding such grants the Secretary shall consider geographic diversity, regional economics of scale, population density, regional needs and other regional differences.

(2) ELIGIBLE APPLICANTS.—To be eligible to receive a grant for the establishment of a quality improvement foundation under paragraph (1), and applicant entity shall—

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

(B) have a board that includes health care providers, representatives from relevant institutions of higher education in the region, consumers, purchasers of health care, and other interested parties.

(b) DUTIES.—

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

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

(A) Collaboration with and technical assistance to providers and health plans in ongoing efforts to improve the quality of health care provided to individuals in the State.

(B) Population-based monitoring of practice patterns and patient outcomes,on an other than a case-by-case basis.

(C) Developing programs in lifetime learning for health professionals to improve the quality of health care by ensuring that health professionals remain informed about new knowledge, acquire new skills, and adopt new roles as technology and societal demands change.

(D) Disseminating information about successful quality improvement programs, practice guidelines, and research findings, including information on innovative staffing of health professionals.

(E) Assist in developing innovative patient education systems that enhance patient involvement in decisions relating to their health care, including an emphasis on shared decisionmaking between patients and health care providers.

(F) Issuing a report to the public regarding the foundation's activities for the previous year including areas of success during the previous year and areas for opportunities in improving health outcomes for the community, and the adoption of guidelines.

(c) RESTRICTIONS ON DISCLOSURE.—The restrictions on disclosure of information under section 1160 of the Social Security Act shall apply to quality improvement foundations under this section, except that—

(1) such foundations shall make data available to qualified organizations and individuals for research for public benefit under the terms set forth in section 5218;

(2) individuals and qualified organizations shall meet standards consistent with the Public Health Service Act and policies regarding the conduct of scientific research, including provisions related to confidentiality, privacy, protection of humans and shall pay reasonable costs for data; and

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

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

### Subtitle B—Administrative Simplification

#### PART 1—PURPOSE AND DEFINITIONS

**SEC. 5101. PURPOSE.**

It is the purpose of this subtitle to improve the efficiency and effectiveness of the health care system, including the medicare program under title XVIII of the Social Security Act and the medicaid program under title XIX of such Act, by encouraging the development of a health information network through the establishment of standards and requirements for the electronic transmission of certain health information.

**SEC. 5102. DEFINITIONS.**

For purposes of this subtitle:

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

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

(3) COORDINATION OF BENEFITS.—The term ''coordination of benefits'' means determining and coordinating the financial obligations of health plans when health care benefits are payable under two or more health plans.

(4) HEALTH CARE PROVIDER.—The term ''health care provider'' includes a provider of services (as defined in section 1861(u) of the Social Security Act), a provider of medical or other health services (as defined in section 1861(s) of the Social Security Act), and any other person furnishing health care services or supplies.

(5) HEALTH INFORMATION.—The term ''health information'' means any information, whether oral or recorded in any form or medium that—

(A) is created or received by a health care provider, health plan, health oversight agency (as defined in section 5202), health researcher, public health authority (as defined in section 5202), employer, life insurer, school or university, or certified health information network service; and

(B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

(6) HEALTH INFORMATION NETWORK.—The term ''health information network'' means the health information system that is formed through the application of the requirements and standards established under this subtitle.

(7) HEALTH INFORMATION PROTECTION ORGANIZATION.—The term ''health information protection organization'' means a private entity or an entity operated by a State that accesses standard data elements of health information through the health information network and—

(A) processes such information into nonidentifiable health information and discloses such information;

(B) if such information is protected health information (as defined in section 5202), discloses such information only in accordance with subtitle C; and

(C) may store such information

(8) HEALTH INFORMATION NETWORK SERVICE.—The term ''health information network service''—

(A) means a private entity or an entity operated by a State that enters into contracts to—

(i) process or facilitate the processing of nonstandard data elements of health information into standard data elements;

(ii) provide the means by which persons are connected to the health information network

for purposes of meeting the requirements of this subtitle, including the holding of standard data elements of health information;

(iii) provide authorized access to health information through the health information network; or

(iv) provide specific information processing services, such as automated coordination of benefits and claims transaction routing; and

(B) includes a health information protection organization.

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

(10) NON-IDENTIFIABLE HEALTH INFORMATION.—The term ''non-identifiable health information'' means health information that is not protected health information as defined in section 5202.

(11) PATIENT MEDICAL RECORD INFORMATION.—The term ''patient medical record information'' means health information derived from a clinical encounter that relates to the physical or mental condition of an individual.

(12) STANDARD.—The term ''standard'' when referring to an information transaction or to data elements of health information means the transaction or data elements meet any standard adopted by the Secretary under part 2 that applies to such information transaction or data elements.

## PART 2—STANDARDS FOR DATA ELEMENTS AND INFORMATION TRANSACTIONS

### SEC. 5111. GENERAL REQUIREMENTS ON SECRETARY.

(a) IN GENERAL.—The Secretary shall adopt standards and modifications to standards under this subtitle that are—

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

(2) in use and generally accepted or developed or modified by the standards setting organizations accredited by the American National Standard Institute (ANSI); and

(3) consistent with the objective of protecting the privacy of protected health information (as defined in section 5202).

(b) INITIAL STANDARDS.—The Secretary may develop an expedited process for the adoption of initial standards under this subtitle.

(c) FAILSAFE.—If the Secretary is unable to adopt standards or modified standards in accordance with subsection (a) that meet the requirements of this subtitle—

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

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

(d) ASSISTANCE TO THE SECRETARY.—In complying with the requirements of this subtitle, the Secretary shall rely on recommendations of the Health Information Advisory Committee established under section 5163 and shall consult with appropriate Federal agencies.

### SEC. 5112. STANDARDS FOR TRANSACTIONS AND DATA ELEMENTS.

(a) IN GENERAL.—The Secretary shall adopt standards for transactions and data elements to make uniform and able to be exchanged electronically health information that is—

(1) appropriate for the following financial and administrative transactions: claims (including coordination of benefits) or equivalent encounter information, claims attachments, enrollment and disenrollment, eligibility, payment and remittance advice, premium payments, first report of injury, claims status, and referral certification and authorization;

(2) related to other transactions determined appropriate by the Secretary consistent with the goals of improving the health care system and reducing administrative costs; and

(3) related to research inquiries by a health researcher with respect to information standardized under paragraph (1) or (2).

(b) UNIQUE HEALTH IDENTIFIERS.—The Secretary shall adopt standards providing for a standard unique health identifier for each individual, employer, health plan, and health care provider for use in the health care system.

(c) CODE SETS.—

(1) IN GENERAL.—The Secretary, in consultation with experts from the private sector and Federal agencies, shall—

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

(B) establish code sets for such data elements if no code sets for the data elements have been developed.

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

(d) ELECTRONIC SIGNATURE.—The Secretary, in coordination with the Secretary of Commerce, shall promulgate regulations specifying procedures for the electronic transmission and authentication of signatures, compliance with which will be deemed to satisfy Federal and State statutory requirements for written signatures with respect to information transactions required by this subtitle and written signatures on medical records and prescriptions.

(e) SPECIAL RULES—

(1) COORDINATION OF BENEFITS.—Any standards adopted under subsection (a) that relate to coordination of benefits shall provide that a claim for reimbursement for medical services furnished is tested by an algorithm specified by the Secretary against all records that are electronically available through the health information network relating to enrollment and eligibility for the individual who received such services to determine any primary and secondary obligors for payment.

(2) CLINICAL LABORATORY TESTS.—

(A) IN GENERAL.—Except as provided in subparagraph (B), any standards adopted under subsection (a) shall provide that claims for clinical laboratory tests for which benefits are payable by a plan sponsor shall be submitted directly by the person or entity that performed (or supervised the performance of) the tests to the sponsor in a manner consistent with (and subject to such exceptions as are provided under) the requirement for direct submission of such claims under the medicare program.

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

(i) to a physician with whom the physician who performed or supervised the test shares a practice; or

(ii) on a pre-paid, at-risk basis to the person or entity who performs or supervises the test.

### SEC. 5113. TIMETABLES FOR ADOPTION OF STANDARDS.

(a) INITIAL STANDARDS.—The Secretary shall adopt standards relating to the data elements and transactions for the information described in section 5112(a) not later than 9 months after the date of the enactment of this subtitle (except in the case of standards for claims attachments which shall be adopted not later than 24 months after the date of the enactment of this subtitle).

(b) ADDITIONS AND MODIFICATIONS TO STANDARDS.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary shall review the standards adopted under this subtitle and shall adopt additional or modified standards as determined appropriate, but no more frequently than once every 6 months. Any addition or modification to standards shall be completed in a manner which minimizes the disruption and cost of compliance.

(2) SPECIAL RULES.—

(A) FIRST 12-MONTH PERIOD.—Except with respect to additions and modifications to code sets under subparagraph (B), the Secretary shall not adopt any modifications to standards adopted under this subtitle during the 12-month period beginning on the date such standards are adopted unless the Secretary determines that a modification is necessary in order to permit compliance with requirements relating to the standards.

(B) ADDITIONS AND MODIFICATIONS TO CODE SETS.—

(i) IN GENERAL.—The Secretary shall ensure that procedures exist for the routine maintenance, testing, enhancement, and expansion of code sets.

(ii) ADDITIONAL RULES.—If a code set is modified under this subsection, the modified code set shall include instructions on how data elements that were encoded prior to the modification are to be converted or translated so as to preserve the value of the data elements. Any modification to a code set under this subsection shall be implemented in a manner that minimizes the disruption and cost of complying with such modification.

(c) EVALUATION OF STANDARDS.—The Secretary may establish a process to measure or verify the consistency of standards adopted or modified under this subtitle. Such process may include demonstration projects and analysis of the cost of implementing such standards and modifications.

## PART 3—REQUIREMENTS WITH RESPECT TO CERTAIN TRANSACTIONS AND INFORMATION

### SEC. 5121. REQUIREMENTS ON HEALTH PLANS.

(a) IN GENERAL.—If a person desires to conduct any of the transactions described in section 5112(a) with a health plan as a standard transaction, the health plan shall conduct such standard transaction in a timely manner and the information transmitted or received in connection with such transaction shall be in the form of standard data elements.

(b) SATISFACTION OF REQUIREMENTS.—A health plan may satisfy the requirement imposed on such plan under subsection (a) by directly transmitting standard data elements or submitting nonstandard data elements to a certified health information network service for processing into standard data elements and transmission.

### SEC. 5122. TIMETABLES FOR COMPLIANCE WITH REQUIREMENTS.

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

(b) COMPLIANCE WITH MODIFIED STANDARDS.—

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

(2) SPECIAL RULE.—In the case of modifications to standards that do not occur within

the 12-month period beginning on the date such standards are adopted, the time determined appropriate by the Secretary under paragraph (1) shall be no sooner than the last day of the 90-day period beginning on the date such modified standard is adopted and no later than the last day of the 12 month period beginning on the date such modified standard is adopted.

## PART 4—ACCESSING HEALTH INFORMATION

### SEC. 5131. ACCESS FOR AUTHORIZED PURPOSES.

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

(b) GOVERNMENT AGENCIES.—

(1) IN GENERAL.—Certified Health information protection organizations shall make available to a Federal or State agency pursuant to a Federal Acquisition Regulation (or an equivalent State system), any non-identifiable health information that is requested by such agency.

(2) CERTAIN INFORMATION AVAILABLE AT LOW COST.—If a health information protection organization described in paragraph (1) needs information from a health plan in order to comply with a request of a Federal or State agency that is necessary to comply with a requirement under this Act, such plan shall make such information available to such organization for a charge that does not exceed the reasonable cost of transmitting the information. An organization that receives information under the preceding sentence shall, upon request from any certified health information protection organization, make such information available to such an organization for a charge that does not exceed the reasonable cost of transmitting the information.

(c) FUNCTIONAL SEPARATION.—The standards adopted by the Secretary under subsection (a) shall ensure that any health information disclosed under such subsection shall not, after such disclosure, be used or released for an administrative, regulatory, or law enforcement purpose unless such disclosure was made for such purpose.

### SEC. 5132. RESPONDING TO ACCESS REQUESTS.

(a) IN GENERAL.—The Secretary shall adopt, and modify as appropriate, standards under which a health plan shall respond to requests for access to health information consistent with this subtitle and subtitle C.

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

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

(2) that a plan shall respond to a request in a timely manner taking into account the age and amount of the information being requested.

(c) LENGTH OF TIME INFORMATION SHOULD BE ACCESSIBLE.—The Secretary shall adopt standards with respect to the length of time any standard data elements for a type of health information should be accessible through the health information network.

### SEC. 5133. TIMETABLES FOR ADOPTION OF STANDARDS AND COMPLIANCE.

(a) INITIAL STANDARDS.—The Secretary shall adopt standards under this part not later than 9 months after the date of the enactment of this subtitle and such standards shall be effective upon adoption.

(b) MODIFICATIONS TO STANDARDS.—The provisions of paragraphs (1) and (2)(A) of section 5114(b) shall apply to modifications to standards under this part.

## PART 5—STANDARDS AND CERTIFICATION FOR HEALTH INFORMATION NETWORK

### SEC. 5141. STANDARDS AND CERTIFICATION FOR HEALTH INFORMATION NETWORK SERVICES.

(a) STANDARDS FOR OPERATION.—The Secretary shall establish standards with respect to the operation of health information network services ensuring that—

(1) such services have policies and security procedures that are consistent with the privacy requirements under subtitle C, including secure methods of access to and transmission of data; and

(2) such services, if they are part of a larger organization, have policies and procedures in place which isolate their activities with respect to processing information in a manner that prevents unauthorized access to such information by such larger organization.

(b) CERTIFICATION BY THE SECRETARY.—

(1) ESTABLISHMENT.—Not later than 12 months after the date of the enactment of this subtitle, the Secretary shall establish a certification procedure for health information network services which ensures that certified services are qualified to meet the requirements of this subtitle.

(2) AUDITS AND REPORTS.—The procedure established under paragraph (1) shall provide for audits and reports as the Secretary determines appropriate in order to monitor such entity's compliance with the requirements of this subtitle.

(c) LOSS OF CERTIFICATION.—

(1) MANDATORY TERMINATION.—If a health information network service violates a requirement imposed under subtitle C, its certification under this section shall be terminated unless the Secretary determines that appropriate corrective action has been taken.

(2) DISCRETIONARY TERMINATION.—If a health information network service violates a requirement or standard imposed under this subtitle and a penalty has been imposed under section 5151, the Secretary shall review the certification of such service and may terminate such certification.

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

### SEC. 5142. ENSURING AVAILABILITY OF INFORMATION.

The Secretary shall establish a procedure under which a health plan which does not have the ability to transmit standard data elements directly or does not have access to a certified health information network service shall be able to make health information available for disclosure as authorized by this subtitle.

## PART 6—PENALTIES

### SEC. 5151. GENERAL PENALTY FOR FAILURE TO COMPLY WITH REQUIREMENTS AND STANDARDS.

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

(b) LIMITATIONS.—

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

(2) FAILURES DUE TO REASONABLE CAUSE.—

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

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

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

(B) EXTENSION OF PERIOD.—

(i) NO PENALTY.—The period referred to in subparagraph (A)(ii) may be extended as determined appropriate by the Secretary based on the nature and extent of the failure to comply.

(ii) ASSISTANCE.—If the Secretary determines that a health plan failed to comply because such plan was unable to comply, the Secretary may provide technical assistance to such plan during the period described in clause (i). Such assistance shall be provided in any manner determined appropriate by the Secretary.

(3) REDUCTION.—In the case of a failure to comply which is due to reasonable cause and not to willful neglect, any penalty under subsection (a) that is not entirely waived under paragraph (2) may be waived to the extent that the payment of such penalty would be excessive relative to the compliance failure involved.

## PART 7—MISCELLANEOUS PROVISIONS

### SEC. 5161. EFFECT ON STATE LAW.

(a) IN GENERAL.—Except as provided in subsection (b), a provision, requirement, or standard under this subtitle shall supersede any contrary provision of State law, including—

(1) a provision of State law that requires medical or health plan records (including billing information) to be maintained or transmitted in written rather than electronic form, and

(2) a provision of State law which provides for requirements or standards that are more stringent than the requirements or standards under this subtitle;

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

(b) PUBLIC HEALTH REPORTING.—Nothing in this subtitle shall be construed to invalidate or limit the authority, power, or procedures established under any law providing for the reporting of disease or injury, child abuse, birth, or death, public health surveillance, or public health investigation or intervention.

### SEC. 5162. HEALTH INFORMATION CONTINUITY.

(a) HEALTH PLANS.—If a health plan takes any action that would threaten the continued availability of standard data elements of health information held by such plan, such data elements shall be transferred to a health plan in accordance with procedures established by the Secretary.

(b) HEALTH INFORMATION NETWORK SERVICES.—If a certified health information network service loses its certified status or takes any action that would threaten the

continued availability of the standard data elements of health information held by such service, such data elements shall be transferred to another such service, as designated by the Secretary.

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

(a) ESTABLISHMENT.—There is established a committee to be known as the Health Information Advisory Committee.

(b) DUTIES.—The committee shall—

(1) provide assistance to the Secretary in complying with the requirements imposed on the Secretary under this subtitle and subtitle C; and

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

(c) MEMBERSHIP.—

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

(2) EXPERTISE.—The membership of the committee shall consist of individuals who are of recognized standing and distinction in the areas of information systems, consumer health, or privacy, and who possess the demonstrated capacity to discharge the duties imposed on the committee.

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

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

There are authorized to be appropriated such sums as may be necessary to carry out the purposes of this subtitle.

## Subtitle C—Privacy of Health Information

### PART 1—DEFINITIONS

**SEC. 5201. DEFINITIONS.**

For purposes of this subtitle:

(1) PROTECTED HEALTH INFORMATION.—The term ''protected health information'' means any information, including demographic information collected from an individual, whether oral or recorded in any form or medium, that—

(A) is created or received by a health care provider, health plan, health oversight agency, health researcher, public health authority, employer, life insurer, school or university, or certified health information network service; and

(B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and—

(i) identifies an individual; or

(ii) with respect to which there is a reasonable basis to believe that the information can be used to identify an individual.

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

(3) HEALTH INFORMATION TRUSTEE.—The term ''health information trustee'' means—

(A) a health care provider, health plan, health oversight agency, certified health information network service, employer, life insurer, or school or university insofar as it creates, receives, maintains, uses, or transmits protected health information;

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

(C) any employee or agent of a person covered under subparagraphs (A) or (B).

(4) HEALTH OVERSIGHT AGENCY.—The term ''health oversight agency'' means a person who—

(A) performs or oversees the performance of an assessment, evaluation, determination, or investigation relating to the licensing, accreditation, or certification of health care providers; or

(B)(i) performs or oversees the performance of an assessment, evaluation, determination, investigation, or prosecution relating to the effectiveness of, compliance with, or applicability of legal, fiscal, medical, or scientific standards or aspects of performance related to the delivery of, or payment for health care, health services, equipment, or research or relating to health care fraud or fraudulent claims regarding health care, health services or equipment, or related activities and items; and

(ii) is a public agency, acting on behalf of a public agency, acting pursuant to a requirement of a public agency, or carrying out activities under a Federal or State law governing the assessment, evaluation, determination, investigation, or prosecution described in clause (i).

(5) PUBLIC HEALTH AUTHORITY.—The term ''public health authority'' means an authority or instrumentality of the United States, a State, or a political subdivision of a State that is (A) responsible for public health matters; and (B) engaged in such activities as injury reporting, public health surveillance, and public health investigation or intervention.

(6) INDIVIDUAL REPRESENTATIVE.—The term ''individual representative'' means any individual legally empowered to make decisions concerning the provision of health care to an individual (where the individual lacks the legal capacity under State law to make such decisions) or the administrator or executor of the estate of a deceased individual.

(7) PERSON.—The term ''person'' includes an authority of the United States, a State, or a political subdivision of a State.

### PART 2—AUTHORIZED DISCLOSURES

#### Subpart A—General Provisions

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

(a) GENERAL RULE.—A health information trustee may disclose protected health information only for a purpose that is authorized under this subtitle.

(b) DISCLOSURE WITHIN A TRUSTEE.—A health information trustee may disclose protected health information to an officer, employee, or agent of the trustee for a purpose that is compatible with and related to the purpose for which the information was collected or received by that trustee.

(c) SCOPE OF DISCLOSURE.—Every disclosure of protected health information by a health information trustee shall be limited to the minimum amount of information necessary to accomplish the purpose for which the information is disclosed.

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

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

(f) IDENTIFICATION OF DISCLOSED INFORMATION AS PROTECTED INFORMATION.—Except as provided in this subtitle, a health information trustee may not disclose protected health information unless such information is clearly identified as protected health information that is subject to this subtitle.

(g) INFORMATION IN WHICH PROVIDERS ARE IDENTIFIED.—The Secretary may issue regulations protecting information identifying providers in order to promote the availability of health care services.

**SEC. 5207. AUTHORIZATIONS FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION.**

A health information trustee may disclose protected health information pursuant to an authorization executed by the individual who is the subject of the information pursuant to regulations issued by the Secretary with regard to the form of such authorization, the information that must be provided to the individual for authorization, and the scope of the authorization.

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

A health information trustee may disclose protected health information to a certified health information protection organization for the purpose of creating non-identifiable health information.

#### Subpart B—Specific Disclosures Relating to Patient

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

(a) HEALTH CARE TREATMENT.—A health care provider, health plan, employer, or person who receives protected health information under section 5213, may disclose protected health information to a health care provider for the purpose of providing health care to an individual if the individual who is the subject of the information has been notified of the individual's right to object and has not previously objected in writing to the disclosure.

(b) DISCLOSURE FOR FINANCIAL AND ADMINISTRATIVE PURPOSES.—A health care provider or employer may disclose protected health information to a health care provider or health plan for the purpose of providing for the payment for, or reviewing the payment of, health care furnished to an individual.

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

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

(1) the individual who is the subject of the information—

(A) has been notified of the individual's right to object and has not objected to the disclosure;

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

(C) exigent circumstances exist such that it would not be practicable to notify the individual of the right to object; and

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

(b) DIRECTORY INFORMATION.—A health care provider and a person receiving protected health information under section 5213 may disclose protected health information to any person if—

(1) the information does not reveal specific information about the physical or mental condition of the individual who is the subject of the information or health care provided to that person;

(2) the individual who is the subject of the information—

(A) has been notified of the individual's right to object and has not objected to the disclosure;

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

(C) exigent circumstances exist such that it would not be practicable to notify the individual of the right to object; and

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

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

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

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

(ii) the general health status of the individual, described as critical, poor, fair, stable, or satisfactory or in terms denoting similar conditions.

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

**SEC. 5213. EMERGENCY CIRCUMSTANCES.**

A health care provider, health plan, employer, or person who receives protected health information under this section may disclose protected health information in emergency circumstances where there is a reasonable belief that such information is needed to protect the health or safety of an individual from imminent harm.

## Subpart C—Disclosure for Oversight, Public Health, and Research Purposes

**SEC. 5216. OVERSIGHT.**

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

(b) USE IN ACTION AGAINST INDIVIDUALS.—Notwithstanding section 5206(e), protected health information about an individual that is disclosed under this section may be used in, or disclosed in, an administrative, civil, or criminal action or investigation directed against the individual who is the subject of the information if the action or investigation arises out of or is directly related to—

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

(2) an action involving a fraudulent claim related to health; or

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

**SEC. 5217. PUBLIC HEALTH.**

A health care provider, health plan, public health authority, employer, or person who receives protected health information under section 5213 may disclose protected health information to a public health authority or other person authorized by law for use in a legally authorized—

(1) disease or injury reporting;

(2) public health surveillance; or

(3) public health investigation or intervention.

**SEC. 5218. HEALTH RESEARCH.**

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

(1) requires use of the protected health information for the effectiveness of the project; and

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

(b) RESEARCH REQUIRING DIRECT CONTACT.—A health care provider or health plan may disclose protected health information to a health researcher for a research project that includes direct contact with an individual who is the subject of protected health information if an institutional review board determines that direct contact is necessary and will be made in a manner that minimizes the risk of harm, embarrassment, or other adverse consequences to the individual.

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

(d) USE OF HEALTH INFORMATION NETWORK.—A health information trustee may disclose protected health information to a health researcher using the health information network only if the research project satisfies requirements established by the Secretary for protecting the confidentiality of information in the health information network.

## Subpart D—Disclosure For Judicial, Administrative, and Law Enforcement Purposes

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

A health care provider, health plan, health oversight agency, employer, or life insurer may disclose protected health information in connection with litigation or proceedings to which the individual who is the subject of the information—

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

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

**SEC. 5222. LAW ENFORCEMENT.**

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

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

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

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

(4) in the investigation or prosecution of criminal activity relating to or arising from the provision of health care or payment for health care.

## Subpart E—Disclosure Pursuant to Government Subpoena or Warrant

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

A health care provider, health plan, health oversight agency, employer, life insurer, or person who receives protected health information under section 5213 shall disclose protected health information under this section if the disclosure is pursuant to—

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

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

(3) an administrative subpoena or summons, a judicial subpoena or warrant, or a grand jury subpoena, and the disclosure otherwise meets the conditions of section 5216, 5217, 5218, 5221, or 5222.

**SEC. 5227. ACCESS PROCEDURES FOR LAW ENFORCEMENT SUBPOENAS AND WARRANTS.**

(a) PROBABLE CAUSE REQUIREMENT.—A government authority may not obtain protected health information about an individual under paragraph (1) or (2) of section 5226 for use in a law enforcement inquiry unless there is probable cause to believe that the information is relevant to a legitimate law enforcement inquiry being conducted by the government authority.

(b) WARRANTS.—A government authority that obtains protected health information about an individual under circumstances described in subsection (a) and pursuant to a warrant shall, not later than 30 days after the date the warrant was executed, serve the individual with, or mail to the last known address of the individual, a notice that protected health information about the individual was so obtained, together with a notice of the individual's right to challenge the warrant.

(c) SUBPOENA OR SUMMONS.—Except as provided in subsection (d), a government authority may not obtain protected health information about an individual under circumstances described in subsection (a) and pursuant to a subpoena or summons unless a copy of the subpoena or summons has been served on the individual, if the identity of the individual is known, on or before the date of return of the subpoena or summons, together with notice of the individual's right to challenge the subpoena or summons. If the identity of the individual is not known at the time the subpoena or summons is served, the individual shall be served not later than 30 days thereafter, with notice that protected health information about the individual was so obtained together with notice of the individual's right to challenge the subpoena or summons.

(d) APPLICATION FOR DELAY.—

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

(2) EX PARTE ORDER.—The court shall enter an ex parte order delaying or extending the delay of notice, an order prohibiting the disclosure of the request for, or disclosure of, the protected health information, and an order requiring the disclosure of the protected health information if the court finds that—

(A) the inquiry being conducted is within the lawful jurisdiction of the government authority seeking the protected health information;

(B) there is probable cause to believe that the protected health information being sought is relevant to a legitimate law enforcement inquiry;

(C) the government authority's need for the information outweighs the privacy interest of the individual who is the subject of the information; and

(D) there is reasonable ground to believe that receipt of notice by the individual will result in—

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

(ii) flight from prosecution;

(iii) destruction of or tampering with evidence or the information being sought;

(iv) intimidation of potential witnesses; or

(v) disclosure of the existence or nature of a confidential law enforcement investigation or grand jury investigation is likely to seriously jeopardize such investigation.

**SEC. 5228. CHALLENGE PROCEDURES FOR LAW ENFORCEMENT WARRANTS, SUBPOENAS, AND SUMMONS.**

(a) MOTION TO QUASH.—Within 15 days after the date of service of a notice of execution or

a copy of a warrant, subpoena, or summons of a government authority seeking protected health information about an individual under paragraph (1) or (2) of section 5226, the individual may file a motion to quash.

(b) STANDARD FOR DECISION.—The court shall grant a motion under subsection (a) unless the government demonstrates that there is probable cause to believe the protected health information is relevant to a legitimate law enforcement inquiry being conducted by the government authority and the government authority's need for the information outweighs the privacy interest of the individual.

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

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

### Subpart F—Disclosure Pursuant to Party Subpoena

**SEC. 5231. PARTY SUBPOENAS.**

A health care provider, health plan, employer, life insurer, or person who receives protected health information under section 5213 may disclose protected health information under this section if the disclosure is pursuant to a subpoena issued on behalf of a party who has complied with the access provisions of section 5232.

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

A party may not obtain protected health information about an individual pursuant to a subpoena unless a copy of the subpoena together with a notice of the individual's right to challenge the subpoena in accordance with section 5233 has been served upon the individual on or before the date of return of the subpoena.

**SEC. 5233. CHALLENGE PROCEDURES FOR PARTY SUBPOENAS.**

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

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

(1) there is reasonable ground to believe the information is relevant to a lawsuit or other judicial or administrative proceeding; and

(2) the need of the respondent for the information outweighs the privacy interest of the individual.

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

## PART 3—PROCEDURES FOR ENSURING SECURITY OF PROTECTED HEALTH INFORMATION

### Subpart A—Establishment of Safeguards

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

A health information trustee shall establish and maintain appropriate administrative, technical, and physical safeguards to ensure the integrity and confidentiality of protected health information created or received by the trustee.

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

A health information trustee shall create and maintain, with respect to any protected health information disclosed in exceptional circumstances, a record of the disclosure in accordance with regulations issued by the Secretary.

### Subpart B—Review of Protected Health Information By Subjects of the Information

**SEC. 5241. INSPECTION OF PROTECTED HEALTH INFORMATION.**

(a) IN GENERAL.—Except as provided in subsection (b), a health care provider or health plan shall permit an individual who is the subject of protected health information or the individual's designee to inspect any such information that the provider or plan maintains. A health care provider or health plan may require an individual to reimburse the provider or plan for the cost of such inspection.

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

(1) MENTAL HEALTH TREATMENT NOTES.—The information consists of psychiatric, psychological, or mental health treatment notes, and the provider or plan determines, based on reasonable medical judgment, that inspection or copying of the notes would cause sufficient harm.

(2) ENDANGERMENT TO LIFE OR SAFETY.—The provider or plan determines that disclosure of the information could reasonably be expected to endanger the life or physical safety of any individual.

(3) CONFIDENTIAL SOURCE.—The information identifies or could reasonably lead to the identification of a person (other than a health care provider) who provided information under a promise of confidentiality to a health care provider concerning the individual who is the subject of the information.

(4) ADMINISTRATIVE PURPOSES.—The information is used by the provider or plan solely for administrative purposes and not in the provision of health care to the individual who is the subject of the information.

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

**SEC. 5242. AMENDMENT OF PROTECTED HEALTH INFORMATION.**

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

(1) correct or amend such information; or

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

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

A health care provider or health plan shall provide written notice of the provider's or plan's information practices, including notice of individual rights with respect to protected health information.

### Subpart C—Standards for Electronic Disclosures

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

The Secretary shall promulgate standards for disclosing protected health information in accordance with this subtitle in electronic form.

## PART 4—SANCTIONS

### Subpart A—No Sanctions for Permissible Actions

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

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

### Subpart B—Civil Sanctions

**SEC. 5256. CIVIL PENALTY.**

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

(b) PROCEDURES FOR IMPOSITION OF PENALTIES.—Section 1128A of the Social Security Act, other than subsections (a) and (b) and the second sentence of subsection (f) of that section, shall apply to the imposition of a civil monetary penalty under this section in the same manner as such provisions apply with respect to the imposition of a penalty under section 1128A of such Act.

**SEC. 5257. CIVIL ACTION.**

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

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

(2) punitive damages;

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

(4) costs of litigation; and

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

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

### Subpart C—Criminal Sanctions

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

(a) OFFENSE.—A person who knowingly—

(1) obtains protected health information relating to an individual in violation of this subtitle; or

(2) discloses protected health information to another person in violation of this subtitle,

shall be punished as provided in subsection (b).

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

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

(2) if the offense is committed under false pretenses, be fined not more than $100,000, imprisoned not more than 5 years, or both; and

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

## PART 5—ADMINISTRATIVE PROVISIONS

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

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

(b) LAWS RELATING TO PUBLIC OR MENTAL HEALTH.—Nothing in this subtitle shall be construed to preempt or operate to the exclusion of any State law relating to public

health or mental health that prevents or regulates disclosure of protected health information otherwise allowed under this subtitle.

(c) PRIVILEGES.—Nothing in this subtitle is intended to preempt or modify State common or statutory law to the extent such law concerns a privilege of a witness or person in a court of the State. This subtitle does not supersede or modify Federal common or statutory law to the extent such law concerns a privilege of a witness or person in a court of the United States. Authorizations pursuant to section 5207 shall not be construed as a waiver of any such privilege.

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

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

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

(3) subpart II of part E of title XXVI of the Public Health Service Act (relating to notifications of emergency response employees of possible exposure to infectious diseases); or

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

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

(a) EFFECT OF DECLARATION OF INCOMPETENCE.—Except as provided in section 5268, if an individual has been declared to be incompetent by a court of competent jurisdiction, the rights of the individual under this subtitle shall be exercised and discharged in the best interests of the individual through the individual's representative.

(b) NO COURT DECLARATION.—Except as provided in section 5268, if a health care provider determines that an individual, who has not been declared to be incompetent by a court of competent jurisdiction, suffers from a medical condition that prevents the individual from acting knowingly or effectively on the individual's own behalf, the right of the individual to authorize disclosure may be exercised and discharged in the best interest of the individual by the individual's representative.

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

(a) INDIVIDUALS WHO ARE 18 OR LEGALLY CAPABLE.—In the case of an individual—

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

(2) who, acting alone, has the legal right, as determined by State law, to apply for and obtain a type of medical examination, care, or treatment and who has sought such examination, care, or treatment, the individual shall exercise all rights of an individual under this subtitle with respect to protected health information relating to such examination, care, or treatment.

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

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

(2) 14, 15, 16, or 17 years of age, the rights of inspection and amendment, and the right to authorize disclosure of protected health information of the individual may be exercised either by the individual or by the parent or legal guardian of the individual.

## Subtitle D—Health Care Fraud Prevention

**SEC. 5301. SHORT TITLE.**

This title may be cited as the ''Health Care Fraud Prevention Act of 1995''.

### PART A—ALL-PAYER FRAUD AND ABUSE CONTROL PROGRAM

**SEC. 5311. ALL-PAYER FRAUD AND ABUSE CONTROL PROGRAM.**

(a) ESTABLISHMENT OF PROGRAM.—

(1) IN GENERAL.—Not later than January 1, 1996, the Secretary of Health and Human Services (in this title referred to as the ''Secretary''), acting through the Office of the Inspector General of the Department of Health and Human Services, and the Attorney General shall establish a program—

(A) to coordinate Federal, State, and local law enforcement programs to control fraud and abuse with respect to the delivery of and payment for health care in the United States,

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

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

(D) to provide for the modification and establishment of safe harbors and to issue interpretative rulings and special fraud alerts pursuant to section 5313.

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

(3) REGULATIONS.—

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

(B) INFORMATION STANDARDS.—

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

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

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

(C) DISCLOSURE OF OWNERSHIP INFORMATION.—

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

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

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

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

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

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

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

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

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

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

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

(1) ESTABLISHMENT.—

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

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

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

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

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

(C) TRANSFER OF AMOUNTS.—

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

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

(ii) Administrative penalties and assessments imposed under titles XI, XVIII, and XIX of the Social Security Act (except as otherwise provided by law).

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

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

(2) USE OF FUNDS.—

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

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

(ii) investigations;

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

(iv) inspections and other evaluations; and

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

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

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

(4) USE OF FUNDS BY INSPECTOR GENERAL.—

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

(B) CREDITING.—Funds received by the Inspector General or the Inspectors General of the Departments of Defense, Labor, and Veterans Affairs and of the Office of Personnel Management, as reimbursement for costs of conducting investigations shall be deposited to the credit of the appropriation from which initially paid, or to appropriations for similar purposes currently available at the time of deposit, and shall remain available for obligation for 1 year from the date of their deposit.

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

(a) CRIMES.—

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

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

(B) In subsection (a)(1)—

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

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

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

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

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

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

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

''(f) The Secretary may—

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

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

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

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

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

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

(a) SOLICITATION AND PUBLICATION OF MODIFICATIONS TO EXISTING SAFE HARBORS AND NEW SAFE HARBORS.—

(1) IN GENERAL.—

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

(i) modifications to existing safe harbors issued pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987 (42 U.S.C. 1320a–7b note);

(ii) additional safe harbors specifying payment practices that shall not be treated as a criminal offense under section 1128B(b) of the Social Security Act the (42 U.S.C. 1320a–7b(b)) and shall not serve as the basis for an exclusion under section 1128(b)(7) of such Act (42 U.S.C. 1320a–7(b)(7));

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

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

(B) PUBLICATION OF PROPOSED MODIFICATIONS AND PROPOSED ADDITIONAL STATE HARBORS.—After considering the proposals described in clauses (i) and (ii) of subparagraph (A), the Secretary, in consultation with the Attorney General, shall publish in the Federal Register proposed modifications to existing safe harbors and proposed additional safe harbors, if appropriate, with a 60-day comment period. After considering any public comments received during this period, the Secretary shall issue final rules modifying the existing safe harbors and establishing new safe harbors, as appropriate.

(C) REPORT.—The Inspector General of the Department of Health and Human Services (hereafter in this section referred to as the ''Inspector General'') shall, in an annual report to Congress or as part of the year-end semiannual report required by section 5 of the Inspector General Act of 1978 (5 U.S.C. App.), describe the proposals received under clauses (i) and (ii) of subparagraph (A) and explain which proposals were included in the publication described in subparagraph (B), which proposals were not included in that publication, and the reasons for the rejection of the proposals that were not included.

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

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

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

(C) An increase or decrease in patient freedom of choice among health care providers.

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

(E) An increase or decrease in the ability of health care facilities to provide services in medically underserved areas or to medically underserved populations.

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

(G) An increase or decrease in the potential overutilization of health care services.

(H) The existence or nonexistence of any potential financial benefit to a health care professional or provider which may vary based on their decisions of—

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

(ii) whether to arrange for a referral of health care items or services to a particular practitioner or provider.

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

(b) INTERPRETIVE RULINGS.—

(1) IN GENERAL.—

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

(B) ISSUANCE AND EFFECT OF INTERPRETIVE RULING.—

(i) IN GENERAL.—If appropriate, the Inspector General shall in consultation with the Attorney General, issue an interpretive ruling in response to a request described in subparagraph (A). Interpretive rulings shall not have the force of law and shall be treated as an interpretive rule within the meaning of section 553(b) of title 5, United States Code. All interpretive rulings issued pursuant to this provision shall be published in the Federal Register or otherwise made available for public inspection.

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

(2) CRITERIA FOR INTERPRETIVE RULINGS.—

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

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

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

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

(c) SPECIAL FRAUD ALERTS.—

(1) IN GENERAL.—

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

(B) ISSUANCE AND PUBLICATION OF SPECIAL FRAUD ALERTS.—Upon receipt of a request described in subparagraph (A), the Inspector General shall investigate the subject matter of the request to determine whether a special fraud alert should be issued. If appropriate, the Inspector General shall in consultation with the Attorney General, issue a special fraud alert in response to the request. All special fraud alerts issued pursuant to this subparagraph shall be published in the Federal Register.

(2) CRITERIA FOR SPECIAL FRAUD ALERTS.—In determining whether to issue a special fraud alert upon a request described in paragraph (1), the Inspector General may consider—

(A) whether and to what extent the practices that would be identified in the special fraud alert may result in any of the consequences described in subsection (a)(2); and

(B) the volume and frequency of the conduct that would be identified in the special fraud alert.

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

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

## PART B—REVISIONS TO CURRENT SANCTIONS FOR FRAUD AND ABUSE

**SEC. 5321. MANDATORY EXCLUSION FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS.**

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

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

''(3) FELONY CONVICTION RELATING TO FRAUD.—Any individual or entity that has been convicted after the date of the enactment of the Health Care Fraud Prevention Act of 1995, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a program (other than those specifically described in paragraph (1)) operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.''.

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

(A) in the heading, by striking ''CONVICTION'' and inserting ''MISDEMEANOR CONVICTION''; and

(B) by striking ''criminal offense'' and inserting ''criminal offense consisting of a misdemeanor''.

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

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

''(4) FELONY CONVICTION RELATING TO CONTROLLED SUBSTANCE.—Any individual or entity that has been convicted after the date of the enactment of the Health Care Fraud Prevention Act of 1995, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.''.

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

(A) in the heading, by striking ''CONVICTION'' and inserting ''MISDEMEANOR CONVICTION''; and

(B) by striking ''criminal offense'' and inserting ''criminal offense consisting of a misdemeanor''.

**SEC. 5322. ESTABLISHMENT OF MINIMUM PERIOD OF EXCLUSION FOR CERTAIN INDIVIDUALS AND ENTITIES SUBJECT TO PERMISSIVE EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS.**

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

''(D) In the case of an exclusion of an individual or entity under paragraph (1), (2), or (3) of subsection (b), the period of the exclusion shall be 3 years, unless the Secretary determines in accordance with published regulations that a shorter period is appropriate because of mitigating circumstances or that a longer period is appropriate because of aggravating circumstances.

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

''(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B), the period of the exclusion shall be not less than 1 year.''.

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

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

''(15) INDIVIDUALS CONTROLLING A SANCTIONED ENTITY.—Any individual who has a direct or indirect ownership or control interest of 5 percent or more, or an ownership or control interest (as defined in section 1124(a)(3)) in, or who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of, an entity—

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

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

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

**SEC. 5324. SANCTIONS AGAINST PRACTITIONERS AND PERSONS FOR FAILURE TO COMPLY WITH STATUTORY OBLIGATIONS.**

(a) MINIMUM PERIOD OF EXCLUSION FOR PRACTITIONERS AND PERSONS FAILING TO MEET STATUTORY OBLIGATIONS.—

(1) IN GENERAL.—The second sentence of section 1156(b)(1) of the Social Security Act (42 U.S.C. 1320c–5(b)(1)) is amended by striking ''may prescribe)'' and inserting ''may prescribe, except that such period may not be less than 1 year)''.

(2) CONFORMING AMENDMENT.—Section 1156(b)(2) of such Act (42 U.S.C. 1320c–5(b)(2)) is amended by striking ''shall remain'' and inserting ''shall (subject to the minimum period specified in the second sentence of paragraph (1)) remain''.

(b) REPEAL OF ''UNWILLING OR UNABLE'' CONDITION FOR IMPOSITION OF SANCTION.—Section 1156(b)(1) of the Social Security Act (42 U.S.C. 1320c–5(b)(1)) is amended—

(1) in the second sentence, by striking ''and determines'' and all that follows through ''such obligations,''; and

(2) by striking the third sentence.

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

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

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

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

''(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this section; or

''(C) no longer substantially meets the applicable conditions of subsections (b), (c), (e), and (f).''.

(2) OTHER INTERMEDIATE SANCTIONS FOR MISCELLANEOUS PROGRAM VIOLATIONS.—Section 1876(i)(6) of such Act (42 U.S.C. 1395mm(i)(6)) is amended by adding at the end the following new subparagraph:

''(C) In the case of an eligible organization for which the Secretary makes a determination under paragraph (1) the basis of which is not described in subparagraph (A), the Secretary may apply the following intermediate sanctions:

''(i) Civil money penalties of not more than $25,000 for each determination under paragraph (1) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract.

''(ii) Civil money penalties of not more than $10,000 for each week beginning after the initiation of procedures by the Secretary under paragraph (9) during which the deficiency that is the basis of a determination under paragraph (1) exists.

''(iii) Suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.''.

(3) PROCEDURES FOR IMPOSING SANCTIONS.—Section 1876(i) of such Act (42 U.S.C. 1395mm(i)) is amended by adding at the end the following new paragraph:

''(9) The Secretary may terminate a contract with an eligible organization under this section or may impose the intermediate sanctions described in paragraph (6) on the organization in accordance with formal investigation and compliance procedures established by the Secretary under which—

''(A) the Secretary provides the organization with the opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under paragraph (1);

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

''(C) there are no unreasonable or unnecessary delays between the finding of a deficiency and the imposition of sanctions; and

''(D) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before imposing any sanction or terminating the contract.''.

(4) CONFORMING AMENDMENTS.—Section 1876(i)(6)(B) of such Act (42 U.S.C. 1395mm(i)(6)(B)) is amended by striking the second sentence.

(b) AGREEMENTS WITH PEER REVIEW ORGANIZATIONS.—

(1) REQUIREMENT FOR WRITTEN AGREEMENT.—Section 1876(i)(7)(A) of the Social Security Act (42 U.S.C. 1395mm(i)(7)(A)) is amended by striking ''an agreement'' and inserting ''a written agreement''.

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

(3) REPORT BY GAO.—

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

(B) REPORT TO CONGRESS.—Not later than July 1, 1998, the Comptroller General shall submit a report to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance and the Special Committee on Aging of the Senate on the study conducted under subparagraph (A).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to contract years beginning on or after January 1, 1996.

**SEC. 5326. EFFECTIVE DATE.**

The amendments made by this part shall take effect January 1, 1996.

## PART C—ADMINISTRATIVE AND MISCELLANEOUS PROVISIONS

**SEC. 5331. ESTABLISHMENT OF THE HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM.**

(a) GENERAL PURPOSE.—Not later than January 1, 1996, the Secretary shall establish a national health care fraud and abuse data collection program for the reporting of final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners as required by subsection (b), with access as set forth in subsection (c).

(b) REPORTING OF INFORMATION.—

(1) IN GENERAL.—Each government agency and health plan shall report any final adverse action (not including settlements in which no findings of liability have been made) taken against a health care provider, supplier, or practitioner.

(2) INFORMATION TO BE REPORTED.—The information to be reported under paragraph (1) includes:

(A) The name of any health care provider, supplier, or practitioner who is the subject of a final adverse action.

(B) The name (if known) of any health care entity with which a health care provider, supplier, or practitioner is affiliated or associated.

(C) The nature of the final adverse action.

(D) A description of the acts or omissions and injuries upon which the final adverse action was based, and such other information as the Secretary determines by regulation is required for appropriate interpretation of information reported under this section.

(3) CONFIDENTIALITY.—In determining what information is required, the Secretary shall include procedures to assure that the privacy of individuals receiving health care services is appropriately protected.

(4) TIMING AND FORM OF REPORTING.—The information required to be reported under this subsection shall be reported regularly (but not less often than monthly) and in such form and manner as the Secretary prescribes. Such information shall first be required to be reported on a date specified by the Secretary.

(5) TO WHOM REPORTED.—The information required to be reported under this subsection shall be reported to the Secretary.

(c) DISCLOSURE AND CORRECTION OF INFORMATION.—

(1) DISCLOSURE.—With respect to the information about final adverse actions (not including settlements in which no findings of liability have been made) reported to the Secretary under this section respecting a health care provider, supplier, or practitioner, the Secretary shall, by regulation, provide for—

(A) disclosure of the information, upon request, to the health care provider, supplier, or licensed practitioner, and

(B) procedures in the case of disputed accuracy of the information.

(2) CORRECTIONS.—Each Government agency and health plan shall report corrections of information already reported about any final adverse action taken against a health care provider, supplier, or practitioner, in such form and manner that the Secretary prescribes by regulation.

(d) ACCESS TO REPORTED INFORMATION.—

(1) AVAILABILITY.—The information in this database shall be available to Federal and State government agencies and health plans pursuant to procedures that the Secretary shall provide by regulation.

(2) FEES FOR DISCLOSURE.—The Secretary may establish or approve reasonable fees for the disclosure of information in this database. The amount of such a fee may not exceed the costs of processing the requests for disclosure and of providing such information. Such fees shall be available to the Secretary or, in the Secretary's discretion to the agency designated under this section to cover such costs.

(e) PROTECTION FROM LIABILITY FOR REPORTING.—No person or entity, including the agency designated by the Secretary in subsection (b)(5) shall be held liable in any civil action with respect to any report made as required by this section, without knowledge of the falsity of the information contained in the report.

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

(1) The term ''final adverse action'' includes:

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

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

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

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

(ii) any other loss of license of the provider, supplier, or practitioner, by operation of law, or

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

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

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

(2) The terms ''licensed health care practitioner'', ''licensed practitioner'', and ''practitioner'' mean, with respect to a State, an individual who is licensed or otherwise authorized by the State to provide health care services (or any individual who, without authority holds himself or herself out to be so licensed or authorized).

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

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

(5) The term ''Government agency'' shall include:

(A) The Department of Justice.

(B) The Department of Health and Human Services.

(C) Any other Federal agency that either administers or provides payment for the delivery of health care services, including, but not limited to the Department of Defense and the Veterans' Administration.

(D) State law enforcement agencies.

(E) State medicaid fraud and abuse units.

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

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

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

(g) CONFORMING AMENDMENT.—Section 1921(d) of the Social Security Act is amended by inserting ''and section 301 of the Health Care Fraud Prevention Act of 1995'' after ''section 422 of the Health Care Quality Improvement Act of 1986''.

## PART D—CIVIL MONETARY PENALTIES

**SEC. 5341. CIVIL MONETARY PENALTIES.**

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

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

(2) In subsection (f)—

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

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

''(3) With respect to amounts recovered arising out of a claim under a health plan, the portion of such amounts as is determined to have been paid by the plan shall be repaid to the plan, and the portion of such amounts attributable to the amounts recovered under this section by reason of the amendments made by the Health Care Fraud Prevention Act of 1995 (as estimated by the Secretary) shall be deposited into the Health Care Fraud and Abuse Control Account established under section 101(b) of such Act.''.

(3) In subsection (i)—

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

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

(b) EXCLUDED INDIVIDUAL RETAINING OWNERSHIP OR CONTROL INTEREST IN PARTICIPATING ENTITY.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)) is amended—

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

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

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

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

''(4) in the case of a person who is not an organization, agency, or other entity, is excluded from participating in a program under title XVIII or a State health care program in accordance with this subsection or under section 1128 and who, at the time of a violation of this subsection, retains a direct or indirect ownership or control interest of 5 percent or more, or an ownership or control interest (as defined in section 1124(a)(3)) in, or who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of, an entity that is participating in a program under title XVIII or a State health care program;''.

(c) MODIFICATIONS OF AMOUNTS OF PENALTIES AND ASSESSMENTS.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)), as amended by subsection (b), is amended in the matter following paragraph (4)—

(1) by striking ''$2,000'' and inserting ''$10,000'';

(2) by inserting ''; in cases under paragraph (4), $10,000 for each day the prohibited relationship occurs'' after ''false or misleading information was given''; and

(3) by striking ''twice the amount'' and inserting ''3 times the amount''.

(d) CLAIM FOR ITEM OR SERVICE BASED ON INCORRECT CODING OR MEDICALLY UNNECESSARY SERVICES.—Section 1128A(a)(1) of the Social Security Act (42 U.S.C. 1320a–7a(a)(1)) is amended—

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

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

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

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

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

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

''(3) Any person (including any organization, agency, or other entity, but excluding a beneficiary as defined in subsection (i)(5)) who the Secretary determines has violated section 1128B(b) of this title shall be subject to a civil monetary penalty of not more than $10,000 for each such violation. In addition, such person shall be subject to an assessment of not more than twice the total amount of the remuneration offered, paid, solicited, or received in violation of section 1128B(b). The total amount of remuneration subject to an assessment shall be calculated without regard to whether some portion thereof also may have been intended to serve a purpose other than one proscribed by section 1128B(b).''.

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

(g) PROCEDURAL PROVISIONS.—Section 1876(i)(6) of such Act (42 U.S.C. 1395mm(i)(6)) is further amended by adding at the end the following new subparagraph:

''(D) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under subparagraph (A) or (B) in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).''.

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

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

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

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

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

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

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

(2) REMUNERATION DEFINED.—Section 1128A(i) of such Act (42 U.S.C. 1320a–7a(i)) is amended by adding the following new paragraph:

''(6) The term 'remuneration' includes the waiver of coinsurance and deductible amounts (or any part thereof), and transfers of items or services for free or for other than fair market value. The term 'remuneration' does not include—

''(A) the waiver of coinsurance and deductible amounts by a person, if—

''(i) the waiver is not offered as part of any advertisement or solicitation;

''(ii) the person does not routinely waive coinsurance or deductible amounts; and

''(iii) the person—

''(I) waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need;

''(II) fails to collect coinsurance or deductible amounts after making reasonable collection efforts; or

''(III) provides for any permissible waiver as specified in section 1128B(b)(3) or in regulations issued by the Secretary;

''(B) differentials in coinsurance and deductible amounts as part of a benefit plan design as long as the differentials have been disclosed in writing to all third party payors to whom claims are presented and as long as the differentials meet the standards as defined in regulations promulgated by the Secretary; or

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

(i) EFFECTIVE DATE.—The amendments made by this section shall take effect January 1, 1996.

## PART E—AMENDMENTS TO CRIMINAL LAW

### SEC. 5351. HEALTH CARE FRAUD.

(a) IN GENERAL.—

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

**''§ 1347. Health care fraud**

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

''(1) to defraud any health plan or other person, in connection with the delivery of or payment for health care benefits, items, or services; or

''(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health plan, or person in connection with the delivery of or payment for health care benefits, items, or services;

shall be fined under this title or imprisoned not more than 10 years, or both. If the violation results in serious bodily injury (as defined in section 1365(g)(3) of this title), such person shall be imprisoned for any term of years.

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

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 63 of title 18, United States Code, is amended by adding at the end the following:

''1347. Health care fraud.''.

(b) CRIMINAL FINES DEPOSITED IN THE HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.—The Secretary of the Treasury shall deposit into the Health Care Fraud and Abuse Control Account established under section 5311(b) an amount equal to the criminal fines imposed under section 1347 of title 18, United States Code (relating to health care fraud).

### SEC. 5352. FORFEITURES FOR FEDERAL HEALTH CARE OFFENSES.

(a) IN GENERAL.—Section 982(a) of title 18, United States Code, is amended by adding after paragraph (5) the following new paragraph:

''(6)(A) The court, in imposing sentence on a person convicted of a Federal health care offense, shall order the person to forfeit property, real or personal, that—

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

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

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

''(i) section 1347 of this title;

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

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

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

(b) PROPERTY FORFEITED DEPOSITED IN HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.—The Secretary of the Treasury shall deposit into the Health Care Fraud and Abuse Control Account established under section 5311(b) an amount equal to amounts resulting from forfeiture of property by reason of a Federal health care offense pursuant to section 982(a)(6) of title 18, United States Code.

**SEC. 5353. INJUNCTIVE RELIEF RELATING TO FEDERAL HEALTH CARE OFFENSES.**

(a) IN GENERAL.—Section 1345(a)(1) of title 18, United States Code, is amended—

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

(2) by inserting ''or'' at the end of subparagraph (B); and

(3) by adding at the end the following:

''(C) committing or about to commit a Federal health care offense (as defined in section 982(a)(6)(B) of this title);''.

(b) FREEZING OF ASSETS.—Section 1345(a)(2) of title 18, United States Code, is amended by inserting ''or a Federal health care offense (as defined in section 982(a)(6)(B))'' after ''title)''.

**SEC. 5354. GRAND JURY DISCLOSURE.**

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

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

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

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

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

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

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

**SEC. 5355. FALSE STATEMENTS.**

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

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

''Whoever, in any matter involving a health plan, knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious, or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry, shall be fined under this title or imprisoned not more than 5 years, or both.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 47 of title 18, United State Code, in amended by adding at the end the following:

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

**SEC. 5356. VOLUNTARY DISCLOSURE PROGRAM.**

In consultation with the Attorney General of the United States, the Secretary of Health and Human Services shall publish proposed regulations not later than 9 months after the date of enactment of this Act, and final regulations not later than 18 months after such date of enactment, establishing a program of voluntary disclosure that would facilitate the enforcement of sections 1128A and 1128B of the Social Security Act (42 U.S.C. 1320a-7a and 1320a-7b) and other relevant provisions of Federal law relating to health care fraud and abuse. Such program should promote and provide incentives for disclosures of potential violations of such sections and provisions by providing that, under certain circumstances, the voluntary disclosure of wrongdoing would result in the imposition of penalties and punishments less substantial than those that would be assessed for the same wrongdoing if voluntary disclosure did not occur.

**SEC. 5357. OBSTRUCTION OF CRIMINAL INVESTIGATIONS OF FEDERAL HEALTH CARE OFFENSES.**

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

**''§ 1518. Obstruction of Criminal Investigations of Federal Health Care Offenses.**

''(a) IN GENERAL.—Whoever willfully prevents, obstructs, misleads, delays or attempts to prevent, obstruct, mislead, or delay the communication of information or records relating to a Federal health care offense to a criminal investigator shall be fined under this title or imprisoned not more than 5 years, or both.

''(b) FEDERAL HEALTH CARE OFFENSE.—As used in this section the term 'Federal health care offense' has the same meaning given such term in section 982(a)(6)(B) of this title.

''(c) CRIMINAL INVESTIGATOR.—As used in this section the term 'criminal investigator' means any individual duly authorized by a department, agency, or armed force of the United States to conduct or engage in investigations for prosecutions for violations of health care offenses.''.

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

''1518. Obstruction of Criminal Investigations of Federal Health Care Offenses.''.

**SEC. 5358. THEFT OR EMBEZZLEMENT.**

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

**''§ 669. Theft or Embezzlement in Connection with Health Care.**

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

''(b) FEDERAL HEALTH CARE OFFENSE.—As used in this section the term 'Federal health care offense' has the same meaning given such term in section 982(a)(6)(B) of this title.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 31 of title 18, United State Code, in amended by adding at the end the following:

''669. Theft or Embezzlement in Connection with Health Care.''.

**SEC. 5359. LAUNDERING OF MONETARY INSTRUMENTS.**

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

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

## PART F—PAYMENTS FOR STATE HEALTH CARE FRAUD CONTROL UNITS

**SEC. 5361. ESTABLISHMENT OF STATE FRAUD UNITS.**

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

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

**SEC. 5362. REQUIREMENTS FOR STATE FRAUD UNITS.**

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

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

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

(3) meet the other requirements of this section.

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

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

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

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

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

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

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

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

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

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

(3) the Secretary.

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

(f) FUNDING SOURCE; PARTICIPATION IN ALL-PAYER PROGRAM.—In addition to those sums expended by a State under section 5364(a) for purposes of determining the amount of the Secretary's payments, a State Fraud Unit may receive funding for its activities from other sources, the identity of which shall be reported to the Secretary in its application or annual report. The State Fraud Unit shall participate in the all-payer fraud and abuse control program established under section 5311.

**SEC. 5363. SCOPE AND PURPOSE.**

The State Fraud Unit shall carry out the following activities:

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

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

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

**SEC. 5364. PAYMENTS TO STATES.**

(a) MATCHING PAYMENTS TO STATES.—Subject to subsection (c), for each year for which a State has a State Fraud Unit approved under section 5362(b) in operation the Secretary shall provide for a payment to the State for each quarter in a fiscal year in an amount equal to the applicable percentage of the sums expended during the quarter by the State Fraud Unit.

(b) APPLICABLE PERCENTAGE DEFINED.—

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

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

(B) 75 percent, for any other quarters.

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

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

## TITLE VI—MALPRACTICE REFORM

**SEC. 6001. ALTERNATIVE DISPUTE RESOLUTION.**

(a) ESTABLISHMENT.—The Secretary of Health and Human Services (hereafter referred to in this title as the ''Secretary'') shall establish a program of grants to assist States in establishing alternative dispute resolution systems.

(b) USE OF FUNDS.—A State may use a grant awarded under subsection (a) to establish alternative dispute resolution systems that—

(1) identify claims of professional negligence that merit compensation;

(2) encourage early resolution of meritorious claims prior to commencement of a lawsuit; and

(3) encourage early withdrawal or dismissal of nonmeritorious claims.

(c) AWARD OF GRANTS.—The Secretary shall allocate grants under this section in accordance with criteria issued by the Secretary.

(d) APPLICATION.—To be eligible to receive a grant under this section, a State, acting through the appropriate State health authority, shall submit an application at such time, in such manner, and containing such agreements, assurances, and information as the Assistant Secretary determines to be necessary to carry out this section, including an assurance that the State system meets the requirements of section 6002.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of the 1996 through 1999 fiscal years.

**SEC. 6002. BASIC REQUIREMENTS.**

A State's alternative dispute resolution system meets the requirements of this section if the system—

(1) applies to all medical malpractice liability claims under the jurisdiction of the courts of that State;

(2) requires that a written opinion resolving the dispute be issued not later than 6 months after the date by which each party against whom the claim is filed has received notice of the claim (other than in exceptional cases for which a longer period is required for the issuance of such an opinion), and that the opinion contain—

(A) findings of fact relating to the dispute, and

(B) a description of the costs incurred in resolving the dispute under the system (including any fees paid to the individuals hearing and resolving the claim), together with an appropriate assessment of the costs against any of the parties;

(3) requires individuals who hear and resolve claims under the system to meet such qualifications as the State may require (in accordance with regulations of the Secretary);

(4) is approved by the State or by local governments in the State;

(5) with respect to a State system that consists of multiple dispute resolution procedures—

(A) permits the parties to a dispute to select the procedure to be used for the resolution of the dispute under the system, and

(B) if the parties do not agree on the procedure to be used for the resolution of the dispute, assigns a particular procedure to the parties;

(6) provides for the transmittal to the State agency responsible for monitoring or disciplining health care professionals and health care providers of any findings made under the system that such a professional or provider committed malpractice, unless, during the 90-day period beginning on the date the system resolves the claim against the professional or provider, the professional or provider brings an action contesting the decision made under the system; and

(7) provides for the regular transmittal to the Administrator for Health Care Policy and Research of information on disputes resolved under the system, in a manner that assures that the identity of the parties to a dispute shall not be revealed.

**SEC. 6003. ALTERNATIVE DISPUTE RESOLUTION ADVISORY BOARD.**

(a) ESTABLISHMENT.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall establish an Alternative Dispute Resolution Advisory Board to advise the Secretary regarding the establishment of alternative dispute resolution systems at the State and Federal levels.

(b) COMPOSITION.—The ADR Advisory Board shall be composed of members appointed by the Secretary from among representatives of the following:

(1) Physicians.

(2) Hospitals.

(3) Patient advocacy groups.

(4) State governments.

(5) Academic experts from applicable disciplines (including medicine, law, public health, and economics) and specialists in arbitration and dispute resolution.

(6) Health insurers and medical malpractice insurers.

(7) Medical product manufacturers.

(8) Pharmaceutical companies.

(9) Other professions and groups determined appropriate by the Secretary.

(c) DUTIES.—The ADR Advisory Board shall—

(1) examine various dispute resolution systems and provide advice and assistance to States regarding the establishment of such systems;

(2) not later than 1 year after the appointment of its members, submit to the Secretary—

(A) a model alternative dispute resolution system that may be used by a State for purposes of this title, and

(B) a model alternative Federal system that may be used by the Secretary; and

(3) review the applications of States for certification of State alternative dispute resolution systems and make recommendations to the Secretary regarding whether the systems should be certified under section 6004.

**SEC. 6004. CERTIFICATION OF STATE SYSTEMS; APPLICABILITY OF ALTERNATIVE FEDERAL SYSTEM.**

(a) CERTIFICATION.—

(1) APPLICATION BY STATE.—Each State shall submit an application to the ADR Advisory Board describing its alternative dispute resolution system and containing such information as the ADR Advisory Board may require to make a recommendation regarding whether the system meets the requirements of this title.

(2) BASIS FOR CERTIFICATION.—Not later than October 1 of each year (beginning with 1995), the Secretary, taking into consideration the recommendations of the ADR Advisory Board, shall certify a State's alternative dispute resolution system under this subsection for the following calendar year if the Secretary determines that the system meets the requirements of section 6002.

(b) APPLICABILITY OF ALTERNATIVE FEDERAL SYSTEM.—

(1) ESTABLISHMENT AND APPLICABILITY.—Not later than October 1, 1995, the Secretary, taking into consideration the model alternative Federal system submitted by the ADR Advisory Board under section 6003(c)(2)(B), shall establish by rule an alternative Federal ADR system for the resolution of medical malpractice liability claims during a calendar year in States that do not have in effect an alternative dispute resolution system certified under subsection (a) for the year.

(2) REQUIREMENTS FOR SYSTEM.—Under the alternative Federal ADR system established under paragraph (1)—

(A) paragraphs (1), (2), (6), and (7) of section 6002(a) shall apply to claims brought under the system;

(B) if the system provides for the resolution of claims through arbitration, the claims brought under the system shall be heard and resolved by arbitrators appointed by the Secretary in consultation with the Attorney General; and

(C) with respect to a State in which the system is in effect, the Secretary may (at the State's request) modify the system to take into account the existence of dispute resolution procedures in the State that affect the resolution of medical malpractice liability claims.

(3) TREATMENT OF STATES WITH ALTERNATIVE SYSTEM IN EFFECT.—If the alternative

Federal ADR system established under this subsection is applied with respect to a State for a calendar year, the State shall make a payment to the United States (at such time and in such manner as the Secretary may require) in an amount equal to 110 percent of the costs incurred by the United States during the year as a result of the application of the system with respect to the State.

**SEC. 6005. REPORTS ON IMPLEMENTATION AND EFFECTIVENESS OF ALTERNATIVE DISPUTE RESOLUTION SYSTEMS.**

(a) IN GENERAL.—Not later than 5 years after the date of the enactment of this Act, the Secretary shall prepare and submit to the Congress a report describing and evaluating State alternative dispute resolution systems operated pursuant to this title and the alternative Federal system established under section 6004(b).

(b) CONTENTS OF REPORT.—The Secretary shall include in the report prepared and submitted under subsection (a)—

(1) information on—

(A) the effect of the alternative dispute resolution systems on the cost of health care within each State,

(B) the impact of such systems on the access of individuals to health care within the State, and

(C) the effect of such systems on the quality of health care provided within the State; and

(2) to the extent that such report does not provide information on no-fault systems operated by States as alternative dispute resolution systems pursuant to this part, an analysis of the feasibility and desirability of establishing a system under which medical malpractice liability claims shall be resolved on a no-fault basis.

**SEC. 6006. OPTIONAL APPLICATION OF PRACTICE GUIDELINES.**

(a) DEVELOPMENT AND CERTIFICATION OF GUIDELINES.—Each State may develop, for certification by the Secretary if the Secretary determines appropriate, a set of specialty clinical practice guidelines.

(b) PROVISION OF HEALTH CARE UNDER GUIDELINES.—Notwithstanding any other provision of law, in any medical malpractice liability action arising from the conduct of a health care provider or health care professional, if such conduct was in accordance with a guideline developed by the State in which the conduct occurred and certified by the Secretary under subsection (a), the guideline—

(1) may be introduced by any party to the action (including a health care provider, health care professional, or patient); and

(2) if introduced, shall establish a rebuttable presumption that the conduct was in accordance with the appropriate standard of medical care, which may only be overcome by the presentation of clear and convincing evidence on behalf of the party against whom the presumption operates.

(c) RESTRICTION ON PARAMETERS CONSIDERED APPROPRIATE.—

(1) PARAMETERS SANCTIONED BY SECRETARY.—For purposes of subsection (a), a specialty clinical practice guideline may not be considered appropriate with respect to actions brought during a year unless the Secretary has sanctioned the use of the guideline for purposes of an affirmative defense to medical malpractice liability actions brought during the year in accordance with paragraph (2).

(2) PROCESS FOR SANCTIONING PARAMETERS.—Not less frequently than October 1 of each year (beginning with 1996), the Secretary shall review the practice guidelines and standards submitted by the State under subsection (a), and shall sanction those guidelines which the Secretary considers appropriate for purposes of an affirmative defense to medical malpractice liability actions brought during the next calendar year as appropriate practice parameters for purposes of subsection (a).

(d) PROHIBITING APPLICATION OF FAILURE TO FOLLOW PARAMETERS AS PRIMA FACIE EVIDENCE OF NEGLIGENCE.—No plaintiff in a medical malpractice liability action may be deemed to have presented prima facie evidence that a defendant was negligent solely by showing that the defendant failed to follow the appropriate practice guidelines.

## TITLE VII—HEALTH PROMOTION AND DISEASE PREVENTION

**SEC. 7001. DISEASE PREVENTION AND HEALTH PROMOTION PROGRAMS TREATED AS MEDICAL CARE.**

(a) IN GENERAL.—For purposes of section 213(d)(1) of the Internal Revenue Code of 1986 (defining medical care), qualified expenditures (as defined by the Secretary of Health and Human Services) for disease prevention and health promotion programs shall be considered amounts paid for medical care.

(b) EFFECTIVE DATE.—Subsection (a) shall apply to amounts paid in taxable years beginning after December 31, 1995.

**SEC. 7002. WORKSITE WELLNESS GRANT PROGRAM.**

(a) GRANTS.—The Secretary of Health and Human Services (hereafter referred to in this title as the ''Secretary'') shall award grants to States (through State health departments or other State agencies working in consultation with the State health agency) to enable such States to provide assistance to businesses with not to exceed 100 employees for the establishment and operation of worksite wellness programs for their employees.

(b) APPLICATION.—To be eligible for a grant under subsection (a), a State shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including—

(1) a description of the manner in which the State intends to use amounts received under the grant; and

(2) assurances that the State will only use amounts provided under such grant to provide assistance to businesses that can demonstrate that they are in compliance with minimum program characteristics (relative to scope and regularity of services offered) that are developed by the Secretary in consultation with experts in public health and representatives of small business.

Grants shall be distributed to States based on the population of individuals employed by small businesses.

(c) PROGRAM CHARACTERISTICS.—In developing minimum program characteristics under subsection (b)(2), the Secretary shall ensure that all activities established or enhanced under a grant under this section have clearly defined goals and objectives and demonstrate how receipt of such assistance will help to achieve established State or local health objectives based on the National Health Promotion and Disease Prevention Objectives.

(d) USE OF FUNDS.—Amounts received under a grant awarded under subsection (a) shall be used by a State to provide grants to businesses (as described in subsection (a)), nonprofit organizations, or public authorities, or to operate State-run worksite wellness programs.

(e) SPECIAL EMPHASIS.—In funding business worksite wellness projects under this section, a State shall give special emphasis to—

(1) the development of joint wellness programs between employers;

(2) the development of employee assistance programs dealing with substance abuse;

(3) maximizing the use and coordination with existing community resources such as nonprofit health organizations; and

(4) encourage participation of dependents of employees and retirees in wellness programs.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary in each of the fiscal years 1995 through 1999.

**SEC. 7003. EXPANDING AND IMPROVING SCHOOL HEALTH EDUCATION.**

(a) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out subsection (b), such sums as may be necessary for each of the fiscal years 1995 through 1999.

(b) GENERAL USE OF FUNDS.—The Secretary shall use amounts appropriated under subsection (a) to expand comprehensive school health education programs administered by the Centers for Disease Control and Prevention under sections 301 and 311 of the Public Health Service Act (42 U.S.C. 241 and 243).

(c) SPECIFIC USE OF FUNDS.—In meeting the requirement of subsection (b), the Secretary shall expand the number of children receiving planned, sequential kindergarten through 12th grade comprehensive school education as a component of comprehensive programs of school health, including

(1) physical education programs that promote lifelong physical activity;

(2) healthy school food service selections;

(3) programs that promote a healthy and safe school environment;

(4) schoolsite health promotion for faculty and staff;

(5) integrated school and community health promotion efforts; and

(6) school nursing disease prevention and health promotion services.

(d) COORDINATION OF EXISTING PROGRAMS.—The Secretary of Health and Human Services, the Secretary of Education and the Secretary of Agriculture shall work cooperatively to coordinate existing school health education programs within their Departments in a manner that maximized the efficiency and effectiveness of Federal expenditures in this area.

## TITLE VIII—TAX INCENTIVES FOR LONG-TERM CARE

**SEC. 8001. SHORT TITLE.**

This title may be cited as the ''Private Long-Term Care Family Protection Act of 1995''.

**SEC. 8002. AMENDMENT OF 1986 CODE.**

Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

### Subtitle A—Tax Treatment of Long-Term Care Insurance

**SEC. 8101. QUALIFIED LONG-TERM CARE SERVICES TREATED AS MEDICAL CARE.**

(a) GENERAL RULE.—Paragraph (1) of section 213(d) (defining medical care) is amended by striking ''or'' at the end of subparagraph (B), by striking subparagraph (C), and by inserting after subparagraph (B) the following new subparagraphs:

''(C) for qualified long-term care services (as defined in subsection (f)),

''(D) for insurance covering medical care referred to in—

''(i) subparagraphs (A) and (B), or

''(ii) subparagraph (C), but only if such insurance is provided under a qualified long-term care insurance policy (as defined in section 7702B(b)) and the deduction under this section for amounts paid for such insurance is not disallowed under section 7702B(d)(4), or

''(E) for premiums under part B of title XVIII of the Social Security Act, relating to

supplementary medical insurance for the aged.''.

(b) QUALIFIED LONG-TERM CARE SERVICES DEFINED.—Section 213 (relating to the deduction for medical, dental, etc., expenses) is amended by adding at the end the following new subsection:

''(f) QUALIFIED LONG-TERM CARE SERVICES.—For purposes of this section—

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

''(A) are required by an individual during any period the individual is an incapacitated individual (as defined in paragraph (2)),

''(B) have as their primary purpose—

''(i) the provision of needed assistance with 1 or more activities of daily living (as defined in paragraph (3)), or

''(ii) protection from threats to health and safety due to severe cognitive impairment, and

''(C) are provided pursuant to a continuing plan of care prescribed by a licensed professional (as defined in paragraph (4)).

''(2) INCAPACITATED INDIVIDUAL.—The term 'incapacitated individual' means any individual who has been certified by a licensed professional as—

''(A) being unable to perform, without substantial assistance from another individual, at least 2 activities of daily living (as defined in paragraph (3)),

''(B) having moderate cognitive impairment as defined by the Secretary in consultation with the Secretary of Health and Human Services, or

''(C) having a level of disability similar (as determined by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in subparagraph (A).

''(3) ACTIVITIES OF DAILY LIVING.—

''(A) IN GENERAL.—Each of the following is an activity of daily living:

''(i) Eating.

''(ii) Toileting.

''(iii) Transferring.

''(iv) Bathing.

''(v) Dressing.

''(vi) Continence.

''(B) DEFINITIONS.—For purposes of this paragraph:

''(i) EATING.—The term 'eating' means the process of getting food from a plate or its equivalent into the mouth.

''(ii) TOILETING.—The term 'toileting' means the act of going to the toilet room for bowel and bladder function, transferring on and off of the toilet, cleaning oneself after elimination, and arranging clothes.

''(iii) TRANSFERRING.—The term 'transferring' means the process of getting in and out of bed or in and out of a chair or wheelchair.

''(iv) BATHING.—The term 'bathing' means the overall complex behavior of using water for cleansing the whole body, including cleansing as part of a bath, shower, or sponge bath, getting to, in, and out of a tub or shower, and washing and drying oneself.

''(v) DRESSING.—The term 'dressing' means the overall complex behavior of getting clothes from closets and drawers and then getting dressed.

''(vi) CONTINENCE.—The term 'continence' means the ability to voluntarily control bowel and bladder function and to maintain a reasonable level of personal hygiene.

''(4) LICENSED PROFESSIONAL.—

''(A) IN GENERAL.—The term 'licensed professional' means—

''(i) a physician or registered professional nurse,

''(ii) a qualified community care case manager (as defined in subparagraph (B)), or

''(iii) any other individual who meets such requirements as may be prescribed by the Secretary after consultation with the Secretary of Health and Human Services.

''(B) QUALIFIED COMMUNITY CARE CASE MANAGER.—The term 'qualified community care case manager' means an individual or entity which—

''(i) has experience or has been trained in providing case management services and in preparing individual care plans,

''(ii) has experience in assessing individuals to determine their functional and cognitive impairment, and

''(iii) meets such requirements as may be prescribed by the Secretary after consultation with the Secretary of Health and Human Services.

''(5) CERTAIN SERVICES NOT INCLUDED.—The term 'qualified long-term care services' shall not include any services provided to an individual—

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

''(B) by a corporation or partnership which is related (within the meaning of section 267(b) or 707(b)) to the individual.

For purposes of this paragraph, the term 'relative' means an individual bearing a relationship to the individual which is described in paragraphs (1) through (8) of section 152(a).''.

(c) TECHNICAL AMENDMENTS.—Paragraph (6) of section 213(d) is amended—

(1) by striking ''subparagraphs (A) and (B)'' and inserting ''subparagraphs (A), (B), and (C)'', and

(2) by striking ''paragraph (1)(C) applies'' in subparagraph (A) and inserting ''subparagraphs (C) and (D) of paragraph (1) apply''.

**SEC. 8102. TREATMENT OF LONG-TERM CARE INSURANCE.**

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

**''SEC. 7702B. TREATMENT OF LONG-TERM CARE INSURANCE.**

''(a) IN GENERAL.—For purposes of this subtitle—

''(1) a qualified long-term care insurance policy (as defined in subsection (b)) shall be treated as an accident and health insurance contract,

''(2) any plan of an employer providing coverage under a qualified long-term care insurance policy shall be treated as an accident and health plan with respect to such coverage,

''(3) amounts (other than policyholder dividends (as defined in section 808) or premium refunds) received under a qualified long-term care insurance policy (including nonreimbursement payments described in subsection (b)(6)) shall be treated—

''(A) as amounts received for personal injuries and sickness, and

''(B) as amounts received for the permanent loss of a function of the body and as amounts computed with reference to the nature of injury under section 105(c) to the extent that such amounts do not exceed the dollar amount in effect under subsection (f) for the taxable year,

''(4) amounts paid for a qualified long-term care insurance policy described in subsection (b)(11) shall be treated as payments made for insurance for purposes of section 213(d)(1)(D), and

''(5) a qualified long-term care insurance policy shall be treated as a guaranteed renewable contract subject to the rules of section 816(e).

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

''(1) IN GENERAL.—The term 'qualified long-term care insurance policy' means any long-term care insurance policy (as defined in paragraph (10)) that—

''(A) limits benefits under such policy to incapacitated individuals (as defined in section 213(f)(2)), and

''(B) satisfies the requirements of paragraphs (2) through (9).

''(2) PREMIUM REQUIREMENTS.—The requirements of this paragraph are met with respect to a long-term care insurance policy if such policy provides that premium payments may not be made earlier than the date such payments would have been made if the policy provided for level annual payments over the life expectancy of the insured or 20 years, whichever is shorter. A policy shall not be treated as failing to meet the requirements of the preceding sentence solely by reason of a provision in the policy providing for a waiver of premiums if the insured becomes an incapacitated individual (as defined in section 213(f)(2)).

''(3) PROHIBITION OF CASH VALUE.—The requirements of this paragraph are met with respect to a long-term care insurance policy if such policy does not provide for a cash value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed, other than as provided in paragraph (4).

''(4) REFUNDS OF PREMIUMS AND DIVIDENDS.—The requirements of this paragraph are met with respect to a long-term care insurance policy if such policy provides that—

''(A) policyholder dividends are required to be applied as a reduction in future premiums or to increase benefits described in subsection (a)(2),

''(B) refunds of premiums upon a partial surrender or a partial cancellation are required to be applied as a reduction in future premiums, and

''(C) any refund on the death of the insured, or on a complete surrender or cancellation of the policy, cannot exceed the aggregate premiums paid under the policy.

Any refund on a complete surrender or cancellation of the policy shall be includable in gross income to the extent that any deduction or exclusion was allowable with respect to the premiums.

''(5) COORDINATION WITH OTHER ENTITLEMENTS.—The requirements of this paragraph are met with respect to a long-term care insurance policy if such policy does not cover expenses incurred to the extent that such expenses are also covered under title XVIII of the Social Security Act. For purposes of this paragraph, a long-term care insurance policy which coordinates expenses incurred under such policy with expenses incurred under title XVIII of such Act shall not be considered to duplicate such expenses.

''(6) REQUIREMENTS OF MODEL REGULATION AND ACT.—

''(A) IN GENERAL.—The requirements of this paragraph are met with respect to a long-term care insurance policy if such policy meets—

''(i) MODEL REGULATION.—The following requirements of the model regulation:

''(I) Section 7A (relating to guaranteed renewal or noncancellability), and the requirements of section 6B of the model Act relating to such section 7A.

''(II) Section 7B (relating to prohibitions on limitations and exclusions).

''(III) Section 7C (relating to extension of benefits).

''(IV) Section 7D (relating to continuation or conversion of coverage).

''(V) Section 7E (relating to discontinuance and replacement of policies).

''(VI) Section 8 (relating to unintentional lapse).

''(VII) Section 9 (relating to disclosure), other than section 9F thereof.

''(VIII) Section 10 (relating to prohibitions against post-claims underwriting).

''(IX) Section 11 (relating to minimum standards).

''(X) Section 12 (relating to requirement to offer inflation protection), except that any requirement for a signature on a rejection of inflation protection shall permit the signature to be on an application or on a separate form.

''(XI) Section 23 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

''(ii) MODEL ACT.—The following requirements of the model Act:

''(I) Section 6C (relating to preexisting conditions).

''(II) Section 6D (relating to prior hospitalization).

''(B) DEFINITIONS.—For purposes of this paragraph—

''(i) MODEL PROVISIONS.—The terms 'model regulation' and 'model Act' mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted in January of 1993).

''(ii) COORDINATION.—Any provision of the model regulation or model Act listed under clause (i) or (ii) of subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision.

''(7) TAX DISCLOSURE REQUIREMENT.—The requirement of this paragraph is met with respect to a long-term care insurance policy if such policy meets the requirements of section 4980C(d)(1).

''(8) NONFORFEITURE REQUIREMENTS.—

''(A) IN GENERAL.—The requirements of this paragraph are met with respect to a long-term care insurance policy, if the issuer of such policy offers to the policyholder, including any group policyholder, a nonforfeiture provision meeting the requirements specified in subparagraph (B).

''(B) REQUIREMENTS OF PROVISION.—The requirements specified in this subparagraph are as follows:

''(i) The nonforfeiture provision shall be appropriately captioned.

''(ii) The nonforfeiture provision shall provide for a benefit available in the event of a default in the payment of any premiums and the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying policies approved by the Secretary for the same policy form.

''(iii) The nonforfeiture provision shall provide at least 1 of the following:

''(I) Reduced paid-up insurance.

''(II) Extended term insurance.

''(III) Shortened benefit period.

''(IV) Other similar offerings approved by the Secretary.

''(9) RATE STABILIZATION.—

''(A) IN GENERAL.—The requirements of this paragraph are met with respect to a long-term care insurance policy, including any group master policy, if—

''(i) such policy contains the minimum rate guarantees specified in subparagraph (B), and

''(ii) the issuer of such policy meets the requirements specified in subparagraph (C).

''(B) MINIMUM RATE GUARANTEES.—The minimum rate guarantees specified in this subparagraph are as follows:

''(i) Rates under the policy shall be guaranteed for a period of at least 3 years from the date of issue of the policy.

''(ii) After the expiration of the 3-year period required under clause (i), any rate increase shall be guaranteed for a period of at least 2 years from the effective date of such rate increase.

''(iii) In the case of any individual age 75 or older who has maintained coverage under a long-term care insurance policy for 10 years, rate increases under such policy shall not exceed 10 percent in any 12-month period.

''(C) INCREASES IN PREMIUMS.—The requirements specified in this subparagraph are as follows:

''(i) IN GENERAL.—If an issuer of a long-term care insurance policy, including any group master policy, plans to increase the premium rates for a policy, such issuer shall, at least 90 days before the effective date of the rate increase, offer to each individual policyholder under such policy the option to remain insured under the policy at a reduced level of benefits that maintains the premium rate at the rate in effect on the day before the effective date of the rate increase.

''(ii) INCREASES OF MORE THAN 50 PERCENT.—If an issuer of a long-term care insurance policy, including any group master policy, increases premium rates for a policy by more than 50 percent in any 3-year period—

''(I) in the case of an individual long-term care insurance policy, the issuer shall discontinue issuing all individual long-term care policies in any State in which the issuer issues such policy for a period of 2 years from the effective date of such premium increase, and

''(II) in the case of a group master long-term care insurance policy, the issuer shall discontinue issuing all group master long-term care insurance policies in any State in which the issuer issues such policy for a period of 2 years from the effective date of such premium increase.

This clause shall apply to any issuer of long-term care insurance policies or any other person that purchases or otherwise acquires any long-term care insurance policies from another issuer or person.

''(D) MODIFICATIONS OR WAIVERS OF REQUIREMENTS.—The Secretary may modify or waive any of the requirements under this paragraph if—

''(i) such requirements will adversely affect an issuer's solvency,

''(ii) such modification or waiver is required for the issuer to meet other State or Federal requirements,

''(iii) medical developments, new disabling diseases, changes in long-term care delivery, or a new method of financing long-term care will result in changes to mortality and morbidity patterns or assumptions,

''(iv) judicial interpretation of a policy's benefit features results in unintended claim liabilities, or

''(v) in the case of a purchase or other acquisition of long-term care insurance policies of an issuer or other person, the continued sale of other long-term care insurance policies by the purchasing issuer or person is in the best interests of individual consumers.

''(10) LONG-TERM CARE INSURANCE POLICY DEFINED.—

''(A) IN GENERAL.—For purposes of this section, the term 'long-term care insurance policy' means any product which is advertised, marketed, or offered as long-term care insurance (as defined in subparagraph (B)).

''(B) LONG-TERM CARE INSURANCE.—

''(i) IN GENERAL.—The term 'long-term care insurance' means any insurance policy or rider—

''(I) advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis for 1 or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital, and

''(II) issued by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, health maintenance organizations or any similar organization to the extent such organizations are otherwise authorized to issue life or health insurance.

Such term includes group and individual annuities and life insurance policies or riders which provide directly or which supplement long-term care insurance and includes a policy or rider which provides for payment of benefits based on cognitive impairment or the loss of functional capacity.

''(ii) EXCLUSIONS.—The term 'long-term care insurance' shall not include—

''(I) any insurance policy which is offered primarily to provide basic coverage to supplement coverage under the medicare program under title XVIII of the Social Security Act, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage, or

''(II) life insurance policies—

''(aa) which accelerate the death benefit specifically for 1 or more of the qualifying events of terminal illness or medical conditions requiring extraordinary medical intervention or permanent institutional confinement,

''(bb) which provide the option of a lump-sum payment for such benefits, and

''(cc) under which neither such benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

''(11) NONREIMBURSEMENT PAYMENTS PERMITTED.—For purposes of subsection (a)(4), a policy is described in this paragraph if, under the policy, payments are made to (or on behalf of) an insured individual on a per diem or other periodic basis without regard to the expenses incurred or services rendered during the period to which the payments relate.

''(c) TREATMENT OF LONG-TERM CARE INSURANCE POLICIES.—For purposes of this title, any amount received or coverage provided under a long-term care insurance policy that is not a qualified long-term care insurance policy shall not be treated as an amount received for personal injuries or sickness or provided under an accident and health plan and shall not be treated as excludable from gross income under any provision of this title.

''(d) TREATMENT OF COVERAGE PROVIDED AS PART OF A LIFE INSURANCE CONTRACT.—Except as otherwise provided in regulations, in the case of any long-term care insurance coverage provided by rider on a life insurance contract, the following rules shall apply:

''(1) IN GENERAL.—This section shall apply as if the portion of the contract providing such coverage is a separate contract or policy.

''(2) PREMIUMS AND CHARGES FOR LONG-TERM CARE COVERAGE.—Premium payments for long-term care insurance policy coverage and charges against the life insurance contract's cash surrender value (within the meaning of section 7702(f)(2)(A)) for such coverage, shall be treated as premiums for purposes of subsection (b)(2).

''(3) APPLICATION OF 7702.—Section 7702(c)(2) (relating to the guideline premium limitation) shall be applied by increasing, as of any date, the guideline premium limitation with

respect to a life insurance contract by an amount equal to—

''(A) the sum of any charges (but not premium payments) described in paragraph (2) made to that date under the contract, reduced by

''(B) any such charges the imposition of which reduces the premiums paid for the contract (within the meaning of section 7702(f)(1)).

''(4) APPLICATION OF SECTION 213.—No deduction shall be allowed under section 213(a) for charges against the life insurance contract's cash surrender value described in paragraph (2), unless such charges are includable in income as a result of the application of section 72(e)(10) and the coverage provided by the rider is a qualified long-term care insurance policy under subsection (b).

For purposes of this subsection, the term 'portion' means only the terms and benefits under a life insurance contract that are in addition to the terms and benefits under the contract without regard to the coverage under a qualified long-term care insurance policy.

''(e) EMPLOYER PLANS NOT TREATED AS DEFERRED COMPENSATION PLANS.—For purposes of this title, a plan of an employer providing coverage under a qualified long-term care insurance policy shall not be treated as a plan which provides for deferred compensation by reason of providing such coverage.

''(f) DOLLAR AMOUNT FOR PURPOSES OF GROSS INCOME EXCLUSION.—

''(1) DOLLAR AMOUNT.—

''(A) IN GENERAL.—The dollar amount in effect under this subsection shall be $200 per day.

''(B) INFLATION ADJUSTMENTS.—In the case of any taxable year beginning in a calendar year after 1996, the dollar amount contained in subparagraph (A) shall be increased by an amount equal to—

''(i) such dollar amount, multiplied by

''(ii) 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 1995' for 'calendar year 1992' in subparagraph (B) thereof.

''(2) AGGREGATION RULE.—For purposes of this subsection, all policies issued with respect to the same taxpayer shall be treated as 1 policy.

''(g) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the requirements of this section, including regulations to prevent the avoidance of this section by providing long-term care insurance coverage under a life insurance contract and to provide for the proper allocation of amounts between the long-term care and life insurance portions of a contract.''.

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

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

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to policies issued after December 31, 1995. Solely for purposes of the preceding sentence, a policy issued prior to January 1, 1996, that satisfies the requirements of a qualified long-term care insurance policy as set forth in section 7702B(b) of the Internal Revenue Code of 1986 (as added by this section) shall, on and after January 1, 1996, be treated as having been issued after December 31, 1995.

(2) TRANSITION RULE.—If, after the date of enactment of this Act and before January 1, 1996, a policy providing for long-term care insurance coverage is exchanged solely for a qualified long-term care insurance policy (as defined in such section 7702B(b)), no gain or loss shall be recognized on the exchange. If, in addition to a qualified long-term care insurance policy, money or other property is received in the exchange, then any gain shall be recognized to the extent of the sum of the money and the fair market value of the other property received. For purposes of this paragraph, the cancellation of a policy providing for long-term care insurance coverage and reinvestment of the cancellation proceeds in a qualified long-term care insurance policy within 60 days thereafter shall be treated as an exchange.

(3) ISSUANCE OF CERTAIN RIDERS PERMITTED.—For purposes of determining whether section 7702 or 7702A of the Internal Revenue Code of 1986 applies to any contract, the issuance, whether before, on, or after December 31, 1995, of a rider on a life insurance contract providing long-term care insurance coverage shall not be treated as a modification or material change of such contract.

**SEC. 8103. TREATMENT OF QUALIFIED LONG-TERM CARE PLANS.**

(a) EXCLUSION FROM COBRA CONTINUATION REQUIREMENTS.—Subparagraph (A) of section 4980B(f)(2) (defining continuation coverage) is amended by adding at the end the following new sentence: ''The coverage shall not include coverage for qualified long-term care services (as defined in section 213(f)).''.

(b) BENEFITS INCLUDED IN CAFETERIA PLANS.—Section 125(f) (defining qualified benefits) is amended by adding at the end the following new sentence: ''Such term includes coverage under a qualified long-term care insurance policy (as defined in section 7702B(b)) which is includible in gross income only because it exceeds the dollar limitation of section 105(c)(2).''.

**SEC. 8104. TAX RESERVES FOR QUALIFIED LONG-TERM CARE INSURANCE POLICIES.**

(a) IN GENERAL.—Subparagraph (A) of section 807(d)(3) (relating to tax reserve methods) is amended by redesignating clause (iv) as clause (v) and by inserting after clause (iii) the following new clause:

''(iv) QUALIFIED LONG-TERM CARE INSURANCE POLICIES.—In the case of any qualified long-term care insurance policy (as defined in section 7702B(b)), a 1 year full preliminary term method, as prescribed by the National Association of Insurance Commissioners.''.

(b) CONFORMING AMENDMENTS.—Section 807(d)(3)(A) (relating to tax reserve methods), is amended—

(1) in clause (v), as redesignated by subsection (a), by striking ''or (iii)'' each place it appears and inserting ''(iii), or (iv)''; and

(2) in clause (iii), by inserting ''(other than a qualified long-term care insurance policy)'' after ''insurance contract''.

**SEC. 8105. TAX TREATMENT OF ACCELERATED DEATH BENEFITS UNDER LIFE INSURANCE CONTRACTS.**

Section 101 (relating to certain death benefits) is amended by adding at the end the following new subsection:

''(g) TREATMENT OF CERTAIN ACCELERATED DEATH BENEFITS.—

''(1) IN GENERAL.—For purposes of this section, any amount distributed to an individual under a life insurance contract on the life of an insured who is a terminally ill individual (as defined in paragraph (3)) shall be treated as an amount paid by reason of the death of such insured.

''(2) NECESSARY CONDITIONS.—

''(A) IN GENERAL.—Paragraph (1) shall not apply to any distribution unless—

''(i) the distribution is not less than the present value (determined under subparagraph (B)) of the reduction in the death benefit otherwise payable in the event of the death of the insured, and

''(ii) the percentage derived by dividing the cash surrender value of the contract, if any, immediately after the distribution by the cash surrender value of the contract immediately before the distribution is equal to or greater than the percentage derived by dividing the death benefit immediately after the distribution by the death benefit immediately before the distribution.

''(B) REDUCTION VALUE.—The present value of the reduction in the death benefit occurring by reason of the distribution shall be determined by—

''(i) using as the discount rate a rate not in excess of the highest rate set forth in subparagraph (C), and

''(ii) assuming that the death benefit (or the portion thereof) would have been paid at the end of a period that is no more than the insured's life expectancy from the date of the distribution or 12 months, whichever is shorter.

''(C) RATES.—The rates set forth in this subparagraph are the following:

''(i) the 90-day Treasury bill yield,

''(ii) the rate described as Moody's Corporate Bond Yield Average-Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto, for the calendar month ending 2 months before the date on which the rate is determined,

''(iii) the rate used to compute the cash surrender values under the contract during the applicable period plus 1 percent per annum, and

''(iv) the maximum permissible interest rate applicable to policy loans under the contract.

''(3) TERMINALLY ILL INDIVIDUAL.—For purposes of this subsection, the term 'terminally ill individual' means an individual who, as determined by the insurer on the basis of an acceptable certification by a licensed physician, has an illness or physical condition which can reasonably be expected to result in death within 12 months of the date of certification.

''(4) APPLICATION OF SECTION 72(e)(10).—For purposes of section 72(e)(10) (relating to the treatment of modified endowment contracts), section 72(e)(4)(A)(i) shall not apply to distributions described in paragraph (1).''.

**SEC. 8106. TAX TREATMENT OF COMPANIES ISSUING QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.**

(a) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—Section 818 (relating to other definitions and special rules) is amended by adding at the end the following new subsection:

''(g) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—For purposes of this part—

''(1) IN GENERAL.—Any reference to a life insurance contract shall be treated as including a reference to a qualified accelerated death benefit rider on such contract.

''(2) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.—For purposes of this subsection, the term 'qualified accelerated death benefit rider' means any rider on a life insurance contract which provides for a distribution to an individual upon the insured becoming a terminally ill individual (as defined in section 101(g)(3)).''.

(b) DEFINITIONS OF LIFE INSURANCE AND MODIFIED ENDOWMENT CONTRACTS.—Paragraph (5)(A) of section 7702(f) (defining qualified additional benefits) is amended by striking ''or'' at the end of clause (iv), by redesignating clause (v) as clause (vi), and by inserting after clause (iv) the following new clause:

''(v) any qualified accelerated death benefit rider (as defined in section 818(g)), or''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to contracts issued after December 31, 1995.

(2) TRANSITIONAL RULE.—For purposes of determining whether section 7702 or 7702A of the Internal Revenue Code of 1986 applies to any contract, the issuance, whether before, on, or after December 31, 1995, of a rider on a life insurance contract permitting the acceleration of death benefits (as described in section 101(g) of such Code (as added by section 8105)) shall not be treated as a modification or material change of such contract.

## Subtitle B—Standards For Long-Term Care Insurance

### SEC. 8201. NATIONAL LONG-TERM CARE INSURANCE ADVISORY COUNCIL.

(a) IN GENERAL.—Congress shall appoint an advisory board to be known as the National Long-Term Care Insurance Advisory Council (hereafter referred to in this subtitle as the ''Advisory Council'').

(b) MEMBERSHIP.—The Advisory Council shall consist of 5 members, each of whom has substantial expertise in matters relating to the provision and regulation of long-term care insurance or long-term care financing and delivery systems.

(c) DUTIES.—The Advisory Council shall—

(1) provide advice, recommendations on the implementation of standards for long-term care insurance, and assistance to Congress on matters relating to long-term care insurance as specified in this section and as otherwise required by the Secretary of Health and Human Services;

(2) collect, analyze, and disseminate information relating to long-term care insurance in order to increase the understanding of insurers, providers, consumers, and regulatory bodies of the issues relating to, and to facilitate improvements in, such insurance;

(3) develop educational models to inform the public on the risks of incurring long-term care expenses and private financing options available to them; and

(4) monitor the development of the long-term care insurance market and advise Congress concerning the need for statutory changes.

(d) ADMINISTRATION.—In order to carry out its responsibilities under this section, the Advisory Council is authorized to—

(1) consult individuals and public and private entities with experience and expertise in matters relating to long-term care insurance;

(2) conduct meetings and hold hearings;

(3) conduct research (either directly or under grant or contract);

(4) collect, analyze, publish, and disseminate data and information (either directly or under grant or contract); and

(5) develop model formats and procedures for insurance products, and develop proposed standards, rules and procedures for regulatory programs, as appropriate.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, for activities of the Advisory Council, $1,500,000 for fiscal year 1996, and each subsequent year.

### SEC. 8202. ADDITIONAL REQUIREMENTS FOR ISSUERS OF LONG-TERM CARE INSURANCE POLICIES.

(a) IN GENERAL.—Chapter 43 is amended by adding at the end the following new section:

**''SEC. 4980C. FAILURE TO MEET REQUIREMENTS FOR QUALIFIED LONG-TERM CARE INSURANCE POLICIES.**

''(a) GENERAL RULE.—There is hereby imposed on the issuer of any qualified long-term care insurance policy with respect to which any requirement of subsection (c) or (d) is not met a tax in the amount determined under subsection (b).

''(b) AMOUNT OF TAX.—

''(1) IN GENERAL.—

''(A) PER POLICY.—The amount of the tax imposed by subsection (a) shall be $100 per policy for each day any requirement of subsection (c) or (d) is not met with respect to the policy.

''(B) LIMITATIONS.—

''(i) PER CARRIER.—The amount of the tax imposed under subparagraph (A) against any insurance carrier, association, or any subsidiary thereof, shall not exceed $25,000 per policy.

''(ii) PER AGENT.—The amount of the tax imposed under subparagraph (A) against insurance agent or broker shall not exceed $15,000 per policy.

''(2) WAIVER.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that payment of the tax would be excessive relative to the failure involved.

''(c) ADDITIONAL RESPONSIBILITIES.—The requirements of this subsection with respect to any qualified long-term care insurance policy are as follows:

''(1) REQUIREMENTS OF MODEL PROVISIONS.—

''(A) MODEL REGULATION.—The following requirements of the model regulation shall be met:

''(i) Section 13 (relating to application forms and replacement coverage).

''(ii) Section 14 (relating to reporting requirements), except that the issuer shall also report at least annually the number of claims denied during the reporting period for each class of business (expended as a percentage of claims denied), other than claims denied for failure to meet the waiting period or because of any applicable preexisting condition.

''(iii) Section 20 (relating to filing requirements for marketing).

''(iv) Section 21 (relating to standards for marketing), including inaccurate completion of medical histories, other than sections 21C(1) and 21C(6) thereof, except that—

''(I) in addition to such requirements, no person shall, in selling or offering to sell a qualified long-term care insurance policy, misrepresent a material fact; and

''(II) no such requirements shall include a requirement to inquire or identify whether a prospective applicant or enrollee for qualified long-term care insurance has accident and sickness insurance.

''(v) Section 22 (relating to appropriateness of recommended purchase).

''(vi) Section 24 (relating to standard format outline of coverage).

''(vii) Section 25 (relating to requirement to deliver shopper's guide).

''(B) MODEL ACT.—The following requirements of the model Act must be met:

''(i) Section 6F (relating to right to return), except that such section shall also apply to denials of applications and any refund shall be made within 30 days of the return or denial.

''(ii) Section 6G (relating to outline of coverage).

''(iii) Section 6H (relating to requirements for certificates under group plans).

''(iv) Section 6I (relating to policy summary).

''(v) Section 6J (relating to monthly reports on accelerated death benefits).

''(vi) Section 7 (relating to incontestability period).

''(C) DEFINITIONS.—For purposes of this paragraph, the terms 'model regulation' and 'model Act' have the meanings given such terms by section 7702B(b)(6)(B).

''(2) DELIVERY OF POLICY.—If an application for a qualified long-term care insurance policy (or for a certificate under a group qualified long-term care insurance policy) is approved, the issuer shall deliver to the applicant (or policyholder or certificate-holder) the policy (or certificate) of insurance not later than 30 days after the date of the approval.

''(3) INFORMATION ON DENIALS OF CLAIMS.—If a claim under a qualified long-term care insurance policy is denied, the issuer shall, within 60 days of the date of a written request by the policyholder or certificate-holder (or representative)—

''(A) provide a written explanation of the reasons for the denial, and

''(B) make available all information directly relating to such denial.

''(d) DISCLOSURE.—The requirements of this subsection are met with respect to any qualified long-term care insurance policy if the following statement is prominently displayed on the front page of the policy and in the outline of coverage required under subsection (c)(1)(B)(ii):

'''This is a federally qualified long-term care insurance contract. The policy meets all the Federal consumer protection standards necessary to receive favorable tax treatment under section 7702B(b) of the Internal Revenue Code of 1986.'.

''(e) QUALIFIED LONG-TERM CARE INSURANCE POLICY DEFINED.—For purposes of this section, the term 'qualified long-term care insurance policy' has the meaning given such term by section 7702B(b).''.

(b) CONFORMING AMENDMENT.—The table of sections for chapter 43 is amended by adding at the end the following new item:

''Sec. 4980C. Failure to meet requirements for long-term care insurance policies.''.

### SEC. 8203. COORDINATION WITH STATE REQUIREMENTS.

Nothing in this subtitle shall be construed as preventing a State from applying standards that provide greater protection of policyholders of qualified long-term care insurance policies (as defined in section 7702B(b) of the Internal Revenue Code of 1986 (as added by section 8102)).

### SEC. 8204. UNIFORM LANGUAGE AND DEFINITIONS.

(a) IN GENERAL.—Not later than June 30, 1996, the Advisory Council shall promulgate standards for the use of uniform language and definitions in qualified long-term care insurance policies (as defined in section 7702B(b) of the Internal Revenue Code of 1986 (as added by section 8102)).

(b) VARIATIONS.—Standards under subsection (a) may permit the use of nonuniform language to the extent required to take into account differences among States in the licensing of nursing facilities and other providers of long-term care.

## Subtitle C—Incentives to Encourage the Purchase of Private Insurance

### SEC. 8301. ASSETS OR RESOURCES DISREGARDED UNDER THE MEDICAID PROGRAM.

(a) MEDICAID ESTATE RECOVERIES.—

(1) IN GENERAL.—Section 1917(b) of the Social Security Act (42 U.S.C. 1396p(b)) is amended—

(A) in paragraph (1), by striking subparagraph (C);

(B) in paragraph (3), by striking ''(other than paragraph (1)(C))''; and

(C) in paragraph (4)(B), by striking ''(and shall include, in the case of an individual to whom paragraph (1)(C)(i) applies)''.

(2) EFFECTIVE DATE.—Section 1917(b) of the Social Security Act (42 U.S.C. 1396p(b)) shall be applied and administered as if the provisions stricken by paragraph (1) had not been enacted.

(b) REPORTING REQUIREMENTS FOR CERTAIN ASSET PROTECTION PROGRAMS.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended by adding at the end the following new subsection:

''(aa)(1) The Secretary shall not approve any State plan amendment providing for an

asset protection program (as described in paragraph (2)) unless the State requires all insurers participating in such program to submit reports to the State and the Secretary at such times, and containing such information, as the Secretary determines appropriate. The information included in the reports required to be submitted under the preceding sentence shall be submitted in accordance with the data standards established by the Secretary under paragraph (3).

''(2) An asset protection program described in this paragraph is a program under which an individual's assets and resources are disregarded for purposes of the program under this subtitle—

''(A) to the extent that payments are made under a qualified long-term care insurance policy (as defined in section 7702B(b) of the Internal Revenue Code of 1986); or

''(B) because an individual has received (or is entitled to receive) benefits under a qualified long-term care insurance policy (as defined in section 7702B(b) of such Code).

''(3)(A) Not later than 90 days after the date of the enactment of the Private Long-Term Care Family Protection Act of 1995, the Secretary shall select data standards for the information required to be included in reports submitted in accordance with paragraph (1). Such data standards shall be selected from the data standards included in the Long-Term Care Insurance Uniform Data Set developed by the University of Maryland Center on Aging and Laguna Research Associates, and used by the States of California, Connecticut, Indiana, and New York for reports submitted by insurers under the asset protection programs conducted by such States.

''(B) The Secretary shall modify the standards selected under subparagraph (A) as the Secretary determines appropriate.''.

**SEC. 8302. DISTRIBUTIONS FROM INDIVIDUAL RETIREMENT ACCOUNTS FOR THE PURCHASE OF LONG-TERM CARE INSURANCE COVERAGE.**

(a) EXCLUSION FROM GROSS INCOME FOR CERTAIN INDIVIDUALS.—Subsection (d) of section 408 (relating to tax treatment of distributions from individual retirement accounts) is amended by adding at the end the following new paragraph:

''(8) DISTRIBUTIONS TO PURCHASE LONG-TERM CARE INSURANCE.—Paragraph (1) shall not apply to any amount paid or distributed out of an individual retirement account or individual retirement annuity to the individual for whose benefit the account or annuity is maintained if—

''(A) the individual has attained age 59½ by the date of the payment or distribution, and

''(B) the entire amount received (including money and any other property) is used within 90 days to purchase a qualified long-term care insurance policy (as defined in section 7702B(b)) for the benefit of the individual or the spouse of the individual (if the spouse has attained age 59½ by the date of the payment or distribution).''.

(b) NO PENALTY FOR DISTRIBUTIONS.—

(1) IN GENERAL.—Subparagraph (B) of section 72(t)(2) (relating to distributions from qualified retirement plans not subject to 10 percent additional tax) is amended to read as follows:

''(B) MEDICAL EXPENSES.—

''(i) IN GENERAL.—Distributions made to the employee (other than distributions described in clause (ii) or subparagraph (A) or (C)) to the extent such distributions do not exceed the amount allowable as a deduction under section 213 to the employee for amounts paid during the taxable year for medical care (determined without regard to whether the employee itemizes deductions for such taxable year).

''(ii) CERTAIN DISTRIBUTIONS TO PURCHASE LONG-TERM CARE INSURANCE.—Distributions made to the taxpayer out of an individual retirement plan if the entire amount received (including money and any other property) is used within 90 days to purchase a qualified long-term care insurance policy (as defined in section 7702B(b)) for the benefit of the individual or the spouse of the individual.''.

(2) CONFORMING AMENDMENT.—Subparagraph (A) of section 72(t)(3) is amended by striking ''(B)'' and inserting ''(B)(i)''.

(c) DEDUCTION FOR EXPENSES TO PURCHASE A QUALIFIED LONG-TERM CARE INSURANCE POLICY.—

(1) IN GENERAL.—Paragraph (8) of section 408(d) (relating to distributions from individual retirement accounts to purchase long-term care insurance), as added by subsection (a), is amended by adding at the end the following new subparagraph:

''(D) APPLICATION OF SECTION 213.—No deduction shall be allowed under section 213(a) for expenses incurred to purchase a qualified long-term care insurance policy (as defined in section 7702B(b)) using amounts paid or distributed out of an individual retirement account or individual retirement annuity in accordance with this paragraph.''.

(2) CONFORMING AMENDMENT.—Clause (ii) of section 213(d)(1)(D) (relating to definition of medical care), as added by section 8101(a), is amended by striking ''section 7702(d)(4)'' and inserting ''section 408(d)(8)(D) or section 7702(d)(4)''.

**Subtitle D—Effective Date**

**SEC. 8401. EFFECTIVE DATE OF TAX PROVISIONS.**

Except as otherwise provided in this title, the amendments made by this title to the Internal Revenue Code of 1986 shall apply to taxable years beginning after December 31, 1995.

**TITLE IX—BUDGET NEUTRALITY**

**SEC. 9001. ASSURANCE OF BUDGET NEUTRALITY.**

Notwithstanding any other provision of law, this Act and the amendments made by this Act shall not become effective until the date of the enactment of a provision of law, specifically referring to this section, that by its terms provides for the Federal budget neutrality of this Act.

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THE ACCESS TO AFFORDABLE HEALTH CARE ACT OF 1995—SECTION-BY-SECTION

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

TITLE I—HEALTH INSURANCE MARKET REFORM

*a. Non-discrimination based on health status*

In general, a health plan may not deny, limit, or condition the coverage under the plan (or vary the premium) for an individual on the basis of their health status, medical condition, claims experience, receipt of health care, medical history, anticipated need for services, disability, or lack of insurability.

The plan may limit or exclude benefits relating to a pre-existing condition that was diagnosed or treated during the 3-month period prior to enrollment in that plan for up to 6 months. However, if the individual had been in a period of continuous coverage under another health plan prior to enrollment, the exclusion period would be reduced by 1 month for each month of continuous coverage.

*b. Guaranteed issue and renewal*

Health plans offering coverage in the small group market shall guarantee each individual purchaser and small employer (and each employee of that small employer) access to the plan. In addition, health plans must be renewed at the option of the employer or individual if they remain eligible for coverage under the plan. Plans may refuse to renew a policy in the case of: nonpayment of premiums; fraud on the part of the employer or individual related to the plan; or misrepresentation by the employer or individual of material facts relating to an application for coverage of a claim or benefit.

*c. Rating limitations*

The Secretary of HHS shall request that the National Association of Insurance Commissioners develop specific standards in the form of a model Act and model regulations to implement rating stands for the small group market. Factors that health plans may use to vary premium rates include age (not to exceed a 3:1 ratio), family type and geography. Health plans would be prohibited from using gender, health status or health expenditures to vary rates. These factors would be phased out within three years in order to minimize market disruption and maximize coverage rates. The standards developed would also permit health plans to provide premium discounts based on workplace health promotion activities.

*d. Encouragement of State efforts*

None of the provisions of the bill shall be construed as preempting State law unless that State law directly conflicts with the bills' requirements. In addition, the following state consumer protection laws shall not be considered to directly conflict with any such requirement and are specifically not preempted: laws that limit the exclusions or limitations for preexisting medical conditions to periods that are less than those provided in this title; laws that limit variations in premium rates beyond the variations permitted in this title; and laws that would expand the small group market in excess of that provided for under this title. In addition, nothing in this bill shall be construed as prohibiting States from enacting health care reform measures that exceed the measures established in the bill, including reforms that expand access to health care services, control health care costs, and enhance quality of care.

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

Authorizes the Secretary of Health and Human Services to make grants to States for the establishment and operation of small group health insurance purchasing arrangements to increase access to more affordable coverage for small businesses and individuals.

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

Insurance would be made more affordable for low and middle-income individuals (individuals with incomes up to $23,000 and families with incomes up to $33,000) by providing a refundable tax credit to those without employer-provided insurance. A credit of 60 percent would apply to premiums of up to $1,200 a year for individuals and $2,400 for families. Individuals with adjusted gross incomes of less than $18,000 and families with adjusted gross incomes of less than $28,000 would be eligible for the full credit. The credit would be phased out for individuals with incomes between $18,000 and $23,000 and families with incomes between $28,000 and $33,000.

Also makes the tax deduction for health insurance costs for self-employed individuals permanent (retroactive to 1994) and phases it up from the current 25% level to 100% by 2000.

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

Provides a special tax credit and other incentives for physicians and other primary care providers serving in rural and other underserved areas. Increased funding is also provided to expand the National Health Service Corps and Area Health Education Centers, which will also help to increase the number of health care professionals in medically underserved areas. Increased grant funding would also be available to expand the number of community health centers, which provide comprehensive health services in rural and inner-city neighborhoods to millions of Americans who need care regardless of their ability to pay.

TITLE V—QUALITY AND CONSUMER PROTECTION

Authorizes the Secretary of Health and Human Services to award demonstration grants for the establishment and operation of regional Quality Improvement Foundations.

Improves the efficiency and effectiveness of the health care system by encouraging the development of a national health information network to reduce administrative complexity, paperwork, and costs; to provide information on cost and quality; and to provide information tools that allow improved fraud detection, outcomes research, and quality of care.

Establishes a stronger, better coordinated federal effort to combat fraud and abuse in our health care system. This section expands criminal and civil penalties for health care fraud to provide a stronger deterrent to the billing of fraudulent claims and to deter fraudulent utilization of health care services.

TITLE VI—MALPRACTICE REFORM

Encourages states to establish alternative dispute resolution mechanisms like prelitigation screening panels, which have had great success in a number of states in reducing medical malpractice costs. Also allows health care providers to use practice guidelines approved by the Secretary of HHS as a rebuttable defense in medical liability cases.

TITLE VII—HEALTH PROMOTION AND DISEASE PREVENTION

Encourages participation in qualified health promotion and prevention programs by clarifying that expenditures for these programs are considered amounts paid for medical care for tax purposes. Also establishes a new grant program for states to provide assistance to small businesses in the establishment and operation of worksite wellness programs for their employees. And finally, expands the comprehensive school health education programs administered by the Centers for Disease Control.

TITLE VIII—ACCESS TO AFFORDABLE LONG-TERM CARE

Removes tax barriers and creates incentives for individuals and their families to finance their future long-term care needs. Long-term care policies that meet federal consumer protection standards would receive favorable tax treatment. Like health insurance, business expenditures on premiums would be deductible as a business expense and employer-provided long-term care insurance would be excluded from an employee's taxable income. Also allows States to develop programs under which individuals can keep more of their assets and still qualify for Medicaid if they take steps to finance their own long-term care needs. And finally, provides various incentives, such as tax-free withdrawals from IRAs, 401(k) plans, and other qualified pension plans to promote the purchase of private long-term care insurance.

TITLE IX—ASSURANCE OF BUDGET NEUTRALITY

No amendment or provision made by the bill will take effect until legislation is enacted which provides for budget neutrality.

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By Mrs. KASSEBAUM (for herself, Mr. JEFFORDS, Mr. GREGG, and Mr. GORTON):

S. 295. A bill to permit labor management cooperative efforts that improve America's economic competitiveness to continue to thrive, and for other purposes; to the Committee on Labor and Human Resources.

TEAMWORK FOR EMPLOYEES AND MANAGEMENT ACT

Mrs. KASSEBAUM. Mr. President, I rise today to introduce, along with Senators JEFFORDS, GREGG, and GORTON, the Teamwork for Employees And Management [TEAM] Act, a bill to encourage worker-management cooperation.

Mr. President, when I served many years ago on the school board in Maize, KS, we frequently met on an informal basis with teachers to discuss problems the teachers faced in the classroom. The teachers had an important perspective to share, and we addressed their concerns. Sometimes we agreed with them and implemented their recommendations, and sometimes we agreed to disagree. But the important thing was that we felt free to exchange information.

School boards and teachers are governed by State law and not Federal law, so we did not face the problems on the school board that private sector workers and supervisors face today. We had the benefit of being able to work cooperatively with our teachers, and I continue to believe that we improved the quality of education for our students and enhanced the quality of work life for our teachers.

Mr. President, our current Federal labor laws do not allow this sort of cooperative effort, because our labor laws assume that labor and management have an adversarial relationship. This may have been true 50 years ago, but today, employers recognize that productivity and efficiency improve when workers operate in partnership with management, and that partnership occurs best in a cooperative rather than an adversarial environment. Yet our labor laws currently prohibit these cooperative efforts.

Mr. President, the TEAM Act responds to a National Labor Relations Board [NLRB] decision in 1992 called Electromation that has had significant consequences for attempts to improve cooperation between workers and employers. Specifically, the NLRB held that employer-employee committees, where workers met with management to discuss attendance, compensation and no-smoking policies, violated the National Labor Relations Act's [NLRA] prohibition against ''employer-dominated'' labor organizations.

The TEAM Act amends our Federal labor laws to permit these types of voluntary programs to continue. The legislation allows employers and employees to meet together to address issues of mutual interest, including issues related to quality, productivity, and efficiency, as long as the committees or other joint programs do not engage in collective bargaining.

I believe that our Federal labor laws should not stand in the way of work place cooperative efforts, such as quality circles and employee involvement programs. Our workers like to have input on their working conditions and our international competitors use employee involvement to improve plant productivity.

I urge my colleagues to support the TEAM Act.

I ask unanimous consent that the full text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 295

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

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''Teamwork for Employees And Management Act of 1995''.

**SEC. 2. FINDINGS AND PURPOSES.**

(a) FINDINGS.—Congress finds that—

(1) the escalating demands of global competition have compelled an increasing number of American employers to make dramatic changes in workplace and employer-employee relationships;

(2) these changes involve an enhanced role for the employee in workplace decisionmaking, often referred to as ''employee involvement'', which has taken many forms, including self-managed work teams, quality-of-worklife, quality circles, and joint labor-management committees;

(3) employee involvement structures, which operate successfully in both unionized and non-unionized settings, have been established by over 80 percent of the largest employers of the United States and exist in an estimated 30,000 workplaces;

(4) in addition to enhancing the productivity and competitiveness of American businesses, employee involvement structures have had a positive impact on the lives of those employees, better enabling them to reach their potential in their working lives;

(5) recognizing that foreign competitors have successfully utilized employee involvement techniques, Congress has consistently joined business, labor and academic leaders in encouraging and recognizing successful employee involvement structures in the workplace through such incentives as the Malcolm Baldridge National Quality Award;

(6) employers who have instituted legitimate employee involvement structures have not done so to interfere with the collective bargaining rights guaranteed by the labor laws, as was the case in the 1930s when employers established deceptive sham ''company unions'' to avoid unionization; and

(7) employee involvement is currently threatened by interpretations of the prohibition against employer-dominated ''company unions''.

(b) PURPOSES.—It is the purpose of this Act to—

(1) protect legitimate employee involvement structures against governmental interference;

(2) preserve existing protections against deceptive, coercive employer practices; and

(3) permit legitimate employee involvement structures where workers may discuss issues involving terms and conditions of employment, to continue to evolve and proliferate.

**SEC. 3. AMENDMENT TO SECTION 8(a)(2) OF THE NATIONAL LABOR RELATIONS ACT.**

Section 8(a)(2) of the National Labor Relations Act (29 U.S.C. 158(a)(2)) is amended by adding at the end thereof the following: ''*Provided further,* That it shall not constitute or be evidence of an unfair labor practice under this paragraph for an employer to establish, assist, maintain or participate in any organization or entity of any kind, in which employees participate to address matters of mutual interest (including issues of quality, productivity and efficiency) and which does not have, claim or seek authority to negotiate or enter into collective bargaining agreements under this Act with the employer or to amend existing collective bargaining agreements between the employer and any labor organization;''.

**SEC. 4. CONSTRUCTION CLAUSE LIMITING EFFECT OF ACT.**

Nothing in the amendment made by section 3 shall be construed as affecting employee rights and responsibilities under the National Labor Relations Act other than those contained in section 8(a)(2) of such Act.

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By Mr. KENNEDY (for himself, Mr. AKAKA, Mr. BINGAMAN, Mrs. BOXER, Mr. BRADLEY, Mr. CAMPBELL, Mr. DODD, Mr. FEINGOLD, Mr. HARKIN, Mr. INOUYE, Mr. LAUTENBERG, Mr. LEAHY, Ms. MIKULSKI, Ms. MOSELEY-BRAUN, Mr. MOYNIHAN, Mrs. MURRAY, Mr. PACKWOOD, Mr. PELL, Mr. ROBB, Mr. SIMON, and Mr. WELLSTONE):

S. 296. A bill to amend section 1977A of the Revised Statutes to equalize the remedies available to all victims of intentional employment discrimination, and for other purposes; to the Committee on Labor and Human Resources.

EQUAL REMEDIES ACT

Mr. KENNEDY. Mr. President, on behalf of myself and 20 other Senators, it is an honor to reintroduce the Equal Remedies Act to repeal the caps on the amount of damages available in employment discrimination cases brought under the Civil Rights Act of 1991.

The Civil Rights Act of 1991 for the first time gave women, religious minorities, and the disabled the right to recover compensatory and punitive damages when they suffer intentional discrimination on the job—but only up to specified limits. Victims of discrimination on the basis of race or national origin, by contrast, can recover such damages without such limits. No similar caps on damages exist in other civil rights laws, and they are not appropriate in this instance.

The Equal Remedies Act will end this double standard by removing the caps on damages for victims of intentional discrimination on the basis of sex, religion, or disability.

The caps on damages deny an adequate remedy to the most severely injured victims of discrimination. For example, if a woman proves that as a result of discrimination or sexual harassment she needs extensive medical treatment exceeding the caps, she will be limited to receiving only partial compensation for her injury.

In addition, the caps on punitive damages limit the extent to which employers who intentionally discriminate—particularly the worst violators—are punished for their discriminatory acts and deterred from engaging in such conduct in the future. The more offensive the conduct and the greater the damages inflicted, the more the employer benefits from the caps.

The caps on damages in the Civil Rights Act of 1991 were a compromise necessitated by concern about passing a bill that President Bush would sign. The issue was only one of the important issues covered in that piece of legislation, which also reversed a series of Supreme Court decisions that had made it far more difficult for working Americans to challenge discrimination.

The bill as a whole represented a significant advance in the ongoing battle to overcome discrimination in the workplace. In order to guarantee that the bill would become law, the unfortunate compromise on damages was included. However, many of us made clear that we intended to work for enactment of separate legislation to remove the caps. By reintroducing the Equal Remedies Act today, we reaffirm our commitment. We must end the double standard that relegates women, religious minorities, and the disabled to second-class remedies under the civil rights laws.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 296

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

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''Equal Remedies Act of 1995''.

**SEC. 2. EQUALIZATION OF REMEDIES.**

Section 1977A of the Revised Statutes (42 U.S.C. 1981a), as added by section 102 of the Civil Rights Act of 1991, is amended—

(1) in subsection (b)—

(A) by striking paragraph (3), and

(B) by redesignating paragraph (4) as paragraph (3), and

(2) in subsection (c), by striking ''section— '' and all that follows through the period and inserting ''section, any party may demand a jury trial.''.

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By Mr. ROCKEFELLER (for himself, Mr. DASCHLE, Mr. GRAHAM, Mr. AKAKA, Mr. CAMPBELL, Mr. JEFFORDS, Mr. LEAHY, and Mr. BINGAMAN):

S. 297. A bill to amend the Internal Revenue Code of 1986 to clarify the exclusion from gross income for veterans' benefits; to the Committee on Finance.

VETERANS' TAX FAIRNESS ACT

• Mr. ROCKEFELLER. Mr. President, as the ranking minority member of the Committee on Veterans' Affairs, I am introducing today the proposed Veterans' Tax Fairness Act of 1995. I am enormously pleased that a number of my colleagues, both members of the committee and others, have joined me as original cosponsors of this important measure—Senators TOM DASCHLE, BOB GRAHAM, DANIEL AKAKA, BEN NIGHTHORSE CAMPBELL, JIM JEFFORDS, PAT LEAHY, and JEFF BINGAMAN. This bill would clarify and reiterate the longstanding rule that veterans benefits are not taxable—a rule that, until action taken in 1992 by the Internal Revenue Service, had never been questioned.

On February 27, 1992, the Internal Revenue Service, in a letter to the general counsel of the Department of Veterans Affairs, reinterpreted a 1986 law and reached a conclusion that could jeopardize the historical tax-exempt status of many veterans benefits, including various benefits provided to service-disabled veterans, dependency and indemnity compensation for survivors, veterans and survivors pensions, education benefits under the Montgomery GI bill, and veterans medical care.

The IRS ruling addressed a narrow issue of whether veterans must pay taxes when VA forgives a debt the veteran owes to the Federal Government after VA pays a guaranty on the Veteran's home loan. Congress liberalized the criteria for VA debt waivers in 1989. In the February 1992 opinion, IRS interpreted a 1986 tax code provision as requiring taxation of any debt waiver granted under the 1989 law that would not have been granted under the old law. IRS concluded that any modification or adjustment of a veterans benefit would make the benefit taxable.

Mr. President, our committee strongly disagreed with the IRS interpretation, for reasons stated in a May 13, 1992, letter from then-Chairman Alan Cranston to then-Secretary of the Treasury Nicholas F. Brady.

Mr. President, although the IRS opinion attempts to address only the narrow question of the taxability of VA debt waivers, its conclusions could support IRS assessing taxes for many other veterans benefits that have been modified or adjusted after September 9, 1986.

Since 1986, for example, Congress has expanded and increased education benefits paid under the GI bill on rehabilitation benefits provided to disabled veterans; adjusted the categories of eligibility for VA medical care; overhauled the survivors Dependency and Indemnity Compensation [DIC] Program and made several adjustments in the rates of DIC; expanded various health care services; and increased other benefits, such as housing and

automobile grants for certain veterans with every severe service-connected disabilities. The IRS interpretation would exempt adjustment based on an inflation index, but fails to protect the many VA benefits that are adjusted without reference to an index. Under the February 27, 1992 IRS opinion, any of these modifications or adjustments might have made the benefits involved taxable.

Section 5301 of title 38, United States Code, explicitly exempts veterans benefits and services from taxation. The provision of the tax code interpreted by IRS concerns military benefits, and it seems clear to me that Congress did not intend to make veterans benefits taxable for the first time in our Nation's history through enactment of a tax code provision addressing military benefits. Veterans benefits, provided to veterans and their survivors under laws administered by VA, always have been distinct from military pay and benefits provided to active-duty or retired servicemembers under laws administered by the Department of Defense.

In fact, Mr. President, another tax code provision, section 136, explicitly references the title 38 provision exempting veterans benefits from taxation. I am not aware of any previous suggestion that the tax code section that IRS has interpreted was intended to make veterans benefits taxable. If Congress had wanted to make such a radical change in the tax-exempt status of veterans benefits, it certainly would have done so much more explicitly than through an ambiguously worded provision that does not even mention veterans or the Department of Veterans Affairs.

Mr. President, it is clear that, before February 1992, in previous administration had interpreted this tax code provision to require taxation of veterans benefits. During the almost 7 years since the provision took effect, IRS has not collected or attempted to collect any taxes based on the receipt of VA-administered benefits—even in connection with VA debt waivers, which the IRS opinion had concluded could be subject to taxation in certain circumstances.

In fact, every official IRS publication of which I am aware that mentions veterans benefits, including ''Publication 17—Your Income Taxes'' and a 1988 IRS private letter ruling, explicitly states that veterans benefits are not taxable. Many IRS publications even list all available veterans benefits to indicate that each is nontaxable.

Mr. President, in 1992, the committee found a very receptive ally in then-Senator Lloyd Bentsen, who chaired the Finance Committee. Senator Bentsen successfully inserted a version of our clarifying legislation into 1992's tax bill, H.R. 11. Unfortunately, President Bush vetoed H.R. 11.

Mr. President, during the last Congress, efforts were made, both by the administration—where Senator Bentsen was then serving as Secretary of Treasury—which submitted proposed legislation substantively identical to H.R. 11, and by me in the introduction of such legislation in S. 1083, to replicate the success we had with H.R. 11. Unfortunately, no action was taken on that legislation during the 103d Congress.

The legislation I am introducing today is substantively identical to H.R. 11, the legislation recommended by the administration last Congress, and to S. 1083, and I am hopeful that action will be taken on it in the first appropriate tax legislation.

I believe it is vitally important to reiterate and clarify by statute the tax-exempt status of all veterans benefits and services, in order to preclude any future tinkering with these most fundamental benefits, particularly in the current climate of anything goes in the name of deficit reduction.

Mr. President, it is obvious that, since IRS previously has not collected or attempted to collect taxes on veterans benefits, this legislation will not affect Federal revenues.

Mr. President, in closing, I acknowledge and thank Senator MOYNIHAN and the fine Finance Committee staff for the technical assistance provided in connection with the development of this measure. I urge my colleagues to support this bill and pledge to do all I can to see it enacted quickly.

Mr. President, I ask unanimous consent that a copy of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 297

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

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''Veterans' Tax Fairness Act of 1995''.

**SEC. 2. CLARIFICATION OF TREATMENT OF VETERANS' BENEFITS.**

(a) IN GENERAL.—Subsection (a) of section 134 of the Internal Revenue Code of 1986 (relating to certain military benefits) is amended to read as follows:

''(a) GENERAL RULE.—Gross income shall not include—

''(1) any qualified military benefit, and

''(2) any allowance or benefit administered by the Secretary of Veterans Affairs which is received by a veteran (as defined in section 101 of title 38, United States Code) or a dependent or survivor of a veteran.''

(b) TECHNICAL AMENDMENT.—Paragraph (3) of section 137(a) of such Code is amended to read as follows:

''(3) Benefits under laws administered by the Secretary of Veterans Affairs, see section 5301 of title 38, United States Code.''

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 1984.●

## ADDITIONAL COSPONSORS

S. 5

At the request of Mr. DOLE, the name of the Senator from South Dakota [Mr. PRESSLER] was added as a cosponsor of S. 5, a bill to clarify the war powers of Congress and the President in the post-Cold War period.

S. 105

At the request of Mr. DASCHLE, the name of the Senator from Nebraska [Mr. EXON] was added as a cosponsor of S. 105, a bill to amend the Internal Revenue Code of 1986 to provide that certain cash rentals of farmland will not cause recapture of special estate tax valuation.

S. 110

At the request of Mr. DASCHLE, the name of the Senator from Nebraska [Mr. EXON] was added as a cosponsor of S. 110, a bill to amend the Internal Revenue Code of 1986 to provide that a taxpayer may elect to include in income crop insurance proceeds and disaster payments in the year of the disaster or in the following year.

S. 112

At the request of Mr. DASCHLE, the name of the Senator from Nebraska [Mr. EXON] was added as a cosponsor of S. 112, a bill to amend the Internal Revenue Code of 1986 with respect to the treatment of certain amounts received by a cooperative telephone company.

S. 208

At the request of Mr. DASCHLE, the name of the Senator from New Jersey [Mr. LAUTENBERG] was added as a cosponsor of S. 208, a bill to require that any proposed amendment to the Constitution of the United States to require a balanced budget establish procedures to ensure enforcement before the amendment is submitted to the States.

S. 252

At the request of Mr. LOTT, the names of the Senator from North Carolina [Mr. HELMS], the Senator from Florida [Mr. MACK], the Senator from New Hampshire [Mr. SMITH], and the Senator from Alaska [Mr. STEVENS] were added as cosponsors of S. 252, a bill to amend title II of the Social Security Act to eliminate the earnings test for individuals who have attained retirement age.

S. 253

At the request of Mr. LOTT, the names of the Senator from New Mexico [Mr. DOMENICI], and the Senator from Wyoming [Mr. SIMPSON] were added as cosponsors of S. 253, a bill to repeal certain prohibitions against political recommendations relating to Federal employment, to reenact certain provisions relating to recommendations by Members of Congress, and for other purposes.

S. 254

At the request of Mr. LOTT, the names of the Senator from Maryland [Ms. MIKULSKI], the Senator from Alabama [Mr. HEFLIN], the Senator from Nebraska [Mr. EXON], the Senator from Oregon [Mr. HATFIELD], and the Senator from Hawaii [Mr. AKAKA] were added as cosponsors of S. 254, a bill to extend eligibility for veterans' burial benefits, funeral benefits, and related