Calendar No. 539

103D CONGRESS
2d Session

SENATE

REPORT
103–323

HEALTH SECURITY ACT

AUGUST 2 (legislative day, JULY 20), 1994.—Ordered to be printed

Mr. MOYNIHAN, from the Committee on Finance, submitted the following

REPORT

[To accompany S. 2351]

The Committee on Finance reports an original bill (S. 2351) to achieve universal health insurance coverage, and for other purposes, and recommends that the bill do pass.

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I. SUMMARY

The Finance Committee bill is designed to achieve universal health insurance coverage through:

(1) subsidies for the purchase of health insurance;

(2) affordable standardized health insurance;

(3) elimination of exclusionary practices by health insurance companies;

(4) a permanent National Health Care Commission which, beginning in 1996, will make recommendations every two years to the Congress on how to increase the number of people covered by health insurance;

(5) reduction of health costs through more open competitive markets and continued advances in medical education and research; and

(6) health care provided under the Medicare and Medicaid programs and health programs of the Department of Defense, Department of Veterans Affairs, and Indian Health Service.

A. INSURANCE REFORMS

The Finance Committee bill would establish Federal standards that insurers must meet. The Committee bill would require insurers to guarantee issue and guarantee renewal to all individuals and groups, and offer family coverage that includes coverage of dependent, unmarried children up to age 24.

The bill also limits the ability of insurers to exclude coverage of pre-existing illnesses and conditions and provides for an open enrollment period in which individuals with medical conditions can purchase insurance without any exclusion from coverage imposed by the insurer. Insurers would be required to community rate policies sold to individuals and businesses with fewer than 100 employees; the premium price could have limited variation for policy holder age and family size. States would establish geographic boundaries for community rating areas. These boundaries must meet Federal standards.

The bill would require all employers to offer employees a choice of at least three standard health plans and all employers would have to make payroll deductions for health insurance premiums if an employee requests it. Employers with fewer than 100 workers who contribute toward health insurance for employees generally would purchase community-rated policies.

Under current law, the Federal McCarran-Ferguson Act provides that the "business of insurance" is exempt from Federal antitrust laws, provided that such business is regulated by the State and that the challenged actions do not constitute a boycott or coercion or intimidation. Under the Committee bill, immunity from antitrust suits under the McCarran-Ferguson Act with respect to health insurance would be repealed. This would not alter immunity with respect to other forms of insurance.

B. COVERAGE

The Committee bill is designed to achieve universal health care coverage. An independent National Health Care Commission would be established to monitor trends in health insurance coverage. If it determines that 95 percent of all Americans will not be covered by 2002, the Commission would submit formal and specific recommendations to Congress by January 1, 2002 on how to reach the coverage goals in market areas that have failed to meet the target. Congress would consider these recommendations under expedited procedures with amendments in order.

C. PREMIUM AND COST-SHARING ASSISTANCE

The Committee bill provides a full subsidy for the purchase of health insurance premiums by individuals and families with incomes below 100 percent of the Federal poverty threshold. The eligibility level will be phased up so that by the year 2000, all those with incomes up to 200 percent of poverty will be eligible for either a full or a partial subsidy.

The maximum premium assistance amount will equal the cost of the premium for a certified standard health plan (minus the amount of any contribution made or offered to be made by the individual's employer to the premium of the certified health plan in which the individual is enrolled), but not to exceed the weighted average premium for the individual's class of enrollment for all community-rated certified standard health plans offered in the community rating area in which the individual resides. For purposes of determining premium assistance amounts, a certified standard health plan is defined to mean a certified standard health plan that offers the standard benefits package.

In addition, beginning in 1996, uninsured pregnant women and children up to age 18 will be eligible for a full subsidy if family income is below 185 percent of poverty. The amount of the subsidy will be phased out for those with family income between 185 percent and 240 percent of poverty.

The premium assistance program will be administered by the States. The Federal government will contribute 75 percent of all administrative costs. The Secretary of Health and Human Services is directed to develop standards to assure consistency among States with respect to data processing systems, application forms, and other administrative procedures.

Individuals and families with income below the poverty threshold will be eligible for reduced cost-sharing for out-of-pocket costs, as determined by the National Health Benefits Board. If States choose to provide assistance for cost-sharing for individuals and families between 100 percent and 200 percent of poverty they will be eligible to receive 50 percent Federal matching funds for this purpose, with a limit on Federal spending of $2 billion per year.

D. BENEFITS

The actuarial value of the benefits package would be the same as the Blue Cross/Blue Shield Standard Option Plan under the Federal Employees Health Benefits Program adjusted for an average population. However, the specific content of the package would

differ, and would be decided by the Board. The Finance Committee bill would establish a standard benefits package defined in general terms in law, with details worked out by a new National Health Benefits Board. The Board would determine the costs that will be shared by enrollees through co- payments, deductibles and co-insurance. There would be two standard benefits packages. An alternative standard package would have a high deductible amount and possibly fewer services.

The bill would create 12 categories of covered items and services including: 1. Inpatient and outpatient care (including hospital and health professional services); 2. emergency and ambulatory medical and surgical services including ambulance transportation; 3. clinical preventive services; 4. mental illness and substance abuse services; 5. family planning services and services for pregnant women; 6. outpatient prescription drugs and biologicals; 7. hospice care services; 8. home health care services; 9. outpatient laboratory, radiology and diagnostic services and medical equipment; 10. outpatient rehabilitation services; 11. vision care, hearing aids and dental care for individuals under 22 years of age; and 12. investigational treatments including routine care provided in research trials.

The Committee bill directs the new National Health Benefits Board to design the benefits package in a way which treats mental illness and substance abuse services in the same way other medical conditions are covered. Parity for mental health and substance abuse services means that whatever costs are paid by patients in the form of co- payments or deductibles or co-insurance would be the same as for all other medically necessary or appropriate treatments. Services for mental illness and substance abuse would use outpatient settings to the greatest extent possible.

Other responsibilities of the Board would include defining criteria for health plans for determining whether an item or service is medically necessary or appropriate for an enrollee, with special consideration for those under 22 years of age; clarifying and refining items and services (including periodicity schedules for preventive services); determining interim coverage decisions and refining policies regarding investigational treatments.

The Board would also be authorized to issue regulations to modify the categories of covered services and cost-sharing that would go into effect unless Congress overturns the regulations by joint resolution considered under expedited procedures.

The bill affirms that constitutionally valid State laws related to abortion services would continue. In addition, the bill provides that no individual or employer would be prevented from purchasing or offering a package excluding abortion, and any health professional, health facility, or commercial insurance company would not be required to offer a package including abortion or other services, if it is objectionable on the basis of a religious belief or moral conviction. The bill also provides that in areas where abortion services are not currently available, health plans would not have to offer such services.

E. HEALTH INSURANCE PURCHASING COOPERATIVES

The bill would allow employers with fewer than 100 employees, as well as individuals, to purchase insurance through Health Insur-

ance Purchasing Cooperatives. Participation in a cooperative would be voluntary for eligible purchasers. These same employer groups and individuals could also choose to purchase community rated health insurance from brokers or directly from insurers.

Cooperatives would be private, not-for-profit corporations run by a board elected by the members of the cooperative. Multiple cooperatives could serve a single community-rated region. If a private cooperative is not established in every community rating area, the State would be required to sponsor or establish one beginning in January 1996.

Cooperatives would be required to enroll all eligible individuals within the community-rating areas in which they operate, offer a choice of at least three health plans (including one with a point-of- service option), collect premium payments from employers and individuals, and forward premium payments to health plans. Cooperatives could exclude health plans, but if a cooperative negotiated a lower premium with a health plan, that premium would become the plan's new community rate. Cooperatives would be expressly prohibited from setting provider or premium payment rates, or bearing insurance risk.

All plans participating in the Federal Employees Health Benefits Program (FEHB), except nation-wide plans, would be required to offer coverage in the community-rated market. Non-Federal employee purchasers of these plans would pay a local community rate, and would not be part of the FEHB insurance pool.

F. COST CONTAINMENT

1. Ensuring health care financing

The bill as drafted, according to preliminary CBO estimates, would reduce the deficit over the next five years and over ten years. However, as a safeguard against unanticipated budgetary effects, the Committee bill includes a failsafe mechanism designed to prevent unanticipated spending increases or revenue losses due to this legislation or other Federal health programs, from causing increases in the Federal deficit.

Under the mechanism, if the President's budget for any fiscal year projects that the premium and cost-sharing assistance, tax deduction, and other new spending would not be fully paid for by the taxes on tobacco and high cost health plans, Medicare and Medicaid savings (offset by unanticipated increases in those programs), and other financing, then the President would be required to fully offset the difference through a combination of (a) reducing the phaseout threshold for premium assistance and reducing the cost-sharing grant program (with special protections for children and pregnant women); (b) limiting the new tax deduction; and (c) increasing the out-of-pocket limits in the standard benefit packages (to the extent measurable outlay savings can be achieved).

2. Malpractice reforms

Under the Committee bill, health plans would be required to establish alternative dispute resolution (ADR) procedures and malpractice claims could not be brought in court until the claims had gone through and reached a final resolution under the plan's proce-

dures. After the ADR procedure was completed, either party dissatisfied with the result could bring a lawsuit to seek damages or other redress to the extent permitted under State law. If such a person receives a worse result or damages one-third below what had been awarded in the ADR proceeding, that party would be required to pay the costs and attorney fees of the other party.

The total amount of damages for non-economic losses from an injury would be capped at $250,000, indexed annually by the CPI. Traditional rules of joint and several liability would be modified to limit the liability of each defendant to a proportion equal to that person's level of responsibility. Seventy-five percent of punitive damage awards would be paid to the State for licensure, certification, and other activities to improve the safety and quality of care.

Contingency fees paid to attorneys would be limited to a sliding-scale schedule, with the proportion to the attorney declining as the size of the award increases. The Secretary of HHS would be authorized to conduct demonstration projects on no-fault approaches to medical liability.

Federal malpractice reforms would preempt inconsistent State laws except to the extent such laws imposed greater restrictions on attorney fees or a person's liability, or permitted additional defenses to malpractice actions. The Federal malpractice provisions would govern actions in State courts and would not establish a basis for bringing malpractice actions in Federal court.

3. Fraud

The Social Security Act currently provides penalties for health care fraud and abuse within the Medicare and Medicaid programs. These penalties include exclusion from participation in the programs and the imposition of civil monetary penalties and criminal penalties. Under the Committee bill, similar protections would apply to fraud against health plans that involves Federal outlays. In addition, a new health care anti-fraud trust fund would be created with a portion of the monies collected from administrative penalties and assessments, civil monetary penalties, and other payments for related violations and actions. Amounts in the trust fund would be used by the Secretary of HHS and the Attorney General to cover the costs of combatting fraud.

4. High-cost plan assessment

See item 3 in summary of revenue provisions.

5. Administrative simplification and paperwork reduction

The Committee bill would implement a national health information network to reduce the burden of administrative complexity, paperwork, and cost on the health care system; to provide the information on cost and quality necessary for competition in the health care marketplace; and to provide information tools that allow improved fraud detection, outcomes research, and improved quality of care.

The bill would require the Secretary of HHS to adopt standards for the content and format of the information used in common administrative transactions of health care, for both paper and elec-

tronic forms. The Secretary would also establish standards for electronic transactions and for certification of network service organizations which would enable private sector implementation of the network.

Health care providers and plans would be required to participate in the network, at least for claims processing. Implementation would enable totally paperless claims processing and payment. The proposal would preempt State laws that require health records to be written.

The Secretary would establish standards for a Health Security Card so that a Card issued anywhere in the country would function in all other locations. Each Card would carry a unique identifier based on the Social Security Number and would be protected by law from being used or required for any purpose other than obtaining or paying for health care.

G. REVENUE PROVISIONS

Subtitle A—Financing Provisions

1. Increase in excise taxes on tobacco products (secs. 701–703)

The excise tax rate on cigarettes would be increased by $1.00 per pack with a comparable increase, generally based on tobacco content, imposed on pipe tobacco and cigars. A $1.00 increase would also be imposed on snuff (for each 1.2 oz. tin) and chewing tobacco (for each 3 oz. pouch). The bill also imposes the excise tax increases on tobacco products manufactured and sold in Puerto Rico. These increases would be effective January 1, 1995.

To provide full subsidies to children and pregnant women under part B of title XIX of the Social Security Act, the excise tax rate on small cigarettes set forth above would be temporarily increased an additional 30 cents per pack of 20 cigarettes (with comparable increases on other tobacco products). These additional increases would be effective for the period after June 30, 1996, and before January 1, 2002.

2. Assessments on insured and self-insured health plans (sec. 705)

The bill would impose a 1.75 percent assessment on health care premiums for insured and self-insured plans incurred after 1995. Revenue from this assessment would be used to fund the Academic Health Centers Trust Fund, the Graduate Medical and Nursing Education Trust Fund, and the Biomedical and Behavioral Research Trust Fund, which are used to fund medical research as described in section 665 of the bill.

3. Tax on high cost health plans (sec. 706)

Beginning in 1996, a 25 percent excise tax would be imposed on health plans that are among the highest-cost 40 percent of health plans in each region. The tax would apply to the amount by which the premiums (or imputed premiums in the case of a self-insured plan) charged by a high cost plan exceed the average premium in the region. The tax would be computed separately for plans in the community-rated and experience-rated markets. Plans which are among the lowest-cost 25 percent of plans in the nation, adjusted for regional cost-of- living variations, would be exempt from the tax

even if they fall within the highest 40 percent of health plans in their region.

To provide full subsidies to children and pregnant women under part B of title XIX of the Social Security Act, the excise tax rate set forth above would be temporarily increased to 29 percent for calendar years 1997 through 2001.

4. Recapture of certain health care subsidies received by high-Income individuals (sec. 711)

The bill would require high-income taxpayers (unmarried taxpayers with income in excess of $90,000 and married taxpayers filing joint returns with income in excess of $115,000) to pay additional Medicare Part B premiums sufficient to cover up to 75 percent of the estimated Part B program costs. The additional Medicare Part B premium also would be collected from Medicare participants that are residents of a U.S. possession. The provision would be effective for taxable years beginning after December 31, 1995.

5. Increase in excise tax on certain hollow point and large caliber handgun ammunition (sec. 715)

The bill would impose a 10,000 percent manufacturers excise tax on particularly destructive types of handgun ammunition: hollow point bullets that have a jacket which expands upon impact into sharp barb-like projections, and bullets that are .50 caliber or larger. The tax would apply to ammunition sold after December 31, 1994.

6. Modification to self-employment tax treatment of certain S Corporation shareholders and partners (sec. 716)

Effective for taxable years beginning after 1995, a shareholder owning more than two percent of an S corporation's stock and providing significant services to the corporation would pay payroll taxes on eighty percent of his or her share of the earnings from service businesses of the S corporation. Limited partners in a partnership would be subject to similar rules. Finally, forty percent of the income from inventory earned by sole proprietors, partners and S corporation shareholders would be exempted from employment taxes.

7. Extending Medicare Coverage of, and Application of Hospital Insurance Tax to, All State and Local Government Employees (sec. 717)

All State and local government employees would be required to be covered under Medicare without regard to their dates of hire. (Currently, participation is voluntary for some State and local government employees hired before April 1, 1986.) These employees, and their employers, also would be required to pay the Medicare Hospital Insurance (HI) tax. This provision would apply to services performed by State and local government employees after September 30, 1995.

Subtitle B—Tax Treatment of Employer-Provided Health Care

1. Tax treatment of voluntary employer health care contributions

Beginning in 1996, employer contributions to a health plan would receive favorable tax treatment only for "permitted coverage". Permitted coverage would include coverage under certified standard health plans, certified supplemental health plans, and certified long-term care insurance policies, as well as certain other types of coverage.

In addition, any employer that contributes towards the cost of coverage for any employee under a certified standard or supplemental health plan would be required to make an equal contribution on behalf of all employees who elect coverage. This rule would be applied separately to full-time and part-time employees.

Employers that violate the voluntary contribution rules would be subject to a nondeductible 35-percent excise tax designed to approximate the effect of denying the employer deduction for health expenses during the period of the violation.

2. Elimination of exclusion of health benefits provided through a flexible spending arrangement (sec. 722)

The bill would eliminate the present-law exclusion from taxable income for accident or health benefits provided to employees by their employers through a flexible spending arrangement. This provision generally would apply beginning in 1996, but with a delayed effective date for collectively bargained plans.

3. Two-year extension of the deduction for health insurance costs of self-employed individuals (sec. 723)

The bill would extend the 25-percent deduction for health insurance expenses of self-employed individuals for taxable years beginning in 1994 and 1995.

4. Limitation on prepayment of medical insurance costs (sec. 724)

The bill would provide that amounts paid after 1994 for medical care to be provided more than 12 months after the month of payment would be treated, for purposes of the itemized deduction for medical expenses and the 100-percent deduction for qualified health care costs of individuals, as paid ratably over the period during which the care is provided.

Subtitle C—Deduction for Individuals Purchasing Own Health Insurance

1. Deduction for health insurance costs of individuals (sec. 731)

Beginning January 1, 1996, individuals (including self-employed individuals) who are not eligible for employer-subsidized health coverage would be permitted to deduct 100 percent of the cost of a certified standard health plan.

Subtitle D—Exempt Organizations

1. Tax treatment of organizations providing health care services and related organizations (secs. 741–742)

The bill would impose four statutory requirements on tax-exempt health care providers, such as hospitals, clinics, nursing homes, old age homes, and HMOs. In order to retain their tax-exempt status, these organizations generally would be required to satisfy the following four requirements: (1) Provide (directly or indirectly) significant "qualified outreach services," which are defined as health care services, or related preventive care, educational, or social services programs, provided in (a) an area that is medically underserved, (b) below cost to individuals otherwise unable to afford such services, or (c) at specialty emergency care facilities; (2) Annually assess the health care and qualified outreach service needs of the community and develop a written plan to meet those needs; (3) Not discriminate when providing health care services on the basis of whether the individual is insured by a government-sponsored health plan; and (4) Not discriminate when providing emergency health care services on the basis of the individual's ability to pay. These provisions would take effect on January 1, 1995.

The bill provides that, as of the date of enactment, an HMO may be tax exempt under section 501(c)(3) if it furnishes substantially all of its primary care health services at its own facilities through health care professionals who do not provide substantial health care services other than on behalf of such organization, e.g., so-called "staff model" or "dedicated-group model" HMOs.

The bill would impose penalty excise taxes as a sanction where tax-exempt health care organizations engage in a transaction resulting in improper "private inurement" (e.g., paying unreasonably high compensation to officers, doctors or other insiders, and other transactions where an individual receives excessive benefits in relation to the services provided to the organization). These provisions apply to inurement occurring after June 30, 1994.

Effective January 1, 1995, tax-exempt health care organizations would be subject to additional disclosure and reporting requirements, such as making the written community health care and outreach service needs plan available to the general public. Such organizations would also be required to comply with requests for copies of the organization's written community health care and outreach service needs plan and the Form 990. The Secretary of the Treasury could waive this requirement if the organization is subject to a harassment campaign.

2. Treatment of health maintenance organizations, parent organizations, and health insurance purchasing cooperatives (sec. 743)

The bill would clarify the definition of "commercial-type insurance" under Code section 501(m). Providing medical care on a prepaid basis would not be treated as providing commercial-type insurance if such medical care is provided (1) by the organization to its members at its own facilities with health care professionals who do not provide substantial health care services other than on behalf of the organization, (2) on a basis under which substantially all of the risk of rates of utilization is assumed by the provider of such

care, (3) pursuant to a referral if it is other than primary care, and (4) outside the member's area of residence if it is emergency care.

The bill clarifies that organizations serving as parent holding companies for hospitals or medical research organizations may qualify as public charities rather than private foundations.

Qualified health insurance purchasing cooperatives established under the bill are eligible for Federal tax-exempt status, provided that private inurement, lobbying, and political activity restrictions (similar to present law) are satisfied.

These provisions would be effective as of the date of enactment.

3. Tax treatment of taxable organizations providing health insurance and other prepaid health care services (sec. 744)

The bill would treat as taxable property and casualty insurance companies certain organizations issuing accident and health insurance contracts, reinsuring accident and health risks, operating as an HMO, or entering into certain arrangements under which fixed payments are received by the organization for providing health care services. This provision would be effective for taxable years beginning after December 31, 1994.

4. Organizations subject to section 833 (sec. 745)

The bill would extend the special tax rules currently applicable to certain Blue Cross and Blue Shield organizations to certain nonprofit health-related organizations, effective for taxable years beginning after 1986.

5. Tax exemption for high-risk insurance pools (sec. 746)

The bill expands the list of tax-exempt organizations to include qualified high risk insurance pools. These entities are established by a State or local government to provide health insurance, on a nonprofit basis, to persons unable to obtain health insurance because of health conditions. The bill requires the State or local government to participate in the ongoing governance of the entity and subsidize the operation of the entity. In addition, no part of the net earnings of the entity can inure to the benefit of any individual, including any private shareholder or member. This provision applies to taxable years beginning after December 31, 1989, and before January 1, 1997.

6. Tax treatment of 501(c)(3) bonds similar to governmental bonds (sec. 748)

Under current law, nonprofit organizations are limited to a total of $150 million of tax-exempt bonds outstanding. This limit applies to bonds for all nonprofit health care facilities except hospital facilities, defined to include only acute care, primarily inpatient, entities. The bill would repeal the $150 million limit for all nonprofit health care organizations and other nonprofit organizations. This provision applies to bonds issued after December 31, 1994.

Subtitle E—Tax Treatment of Long-Term Care Insurance

1. Tax treatment of long-term care insurance and services (secs. 751 and 752)

Beginning in 1996, expenses for qualified long-term care services and long-term care insurance premiums would be deductible on the same basis as medical expenses. In addition, up to $150 per day (indexed) received under a long-term care insurance contract generally would not be subject to tax. However, employer payments for long-term care insurance would not be excludable from an employee's taxable income, and long-term care insurance could not be offered through a cafeteria plan.

2. Tax treatment of accelerated death benefits under life insurance contracts (secs. 753–754)

The bill would provide tax-free treatment for amounts received from a life insurance policy if the insured is terminally ill. An individual is considered terminally for this purpose if a physician certifies that the individual has an illness that is reasonably expected to result in death within 12 months of the certification. A life insurance company generally would be allowed to treat a qualified accelerated death benefit rider as life insurance for tax purposes. This provision generally applies to amounts received after the date of enactment, except that the provision treating a death benefit rider as life insurance is effective on January 1, 1995.

Subtitle F—Health Care Trust Funds

1. Establishment of health care trust funds (sec. 761)

There would be established a Health Security Trust Fund consisting of the following amounts: net revenues from the increase in tobacco taxes; taxes on high cost health plans; Medicaid savings; Federal savings due to the automobile insurance coordination provisions; amounts equivalent to various civil and criminal fines, penalties, and assessments collected; and interest. These amounts would be allocated to the following five accounts within the Trust Fund: a Health Insurance Account; an Infrastructure Development Account; the State Health Quality and Consumer Protection Account; the Long-Term Care Account; and the Federal Outlay Program Fraud and Abuse Account.

The various payments and programs under this Act would be appropriated from these accounts.

Subtitle G—Other Revenue Provisions

1. Employment status proposal required from Department of the Treasury (sec. 771)

The bill would direct the Secretary of Treasury to submit a legislative proposal providing statutory standards relating to the classification of workers as employees or independent contractors by January 1, 1996.

2. Increase in services reporting penalties (sec. 772)

The bill would modify the penalty for failure by a trade or business to file correct information returns with respect to service providers. This provision would apply to information returns due more than 30 days after the date of enactment of the bill.

3. Nonrefundable Credit for Certain Primary Health Services Providers (sec. 775)

For taxable years beginning after 1994, physicians providing full-time primary health care services in an area with a shortage of health professionals generally would be eligible for an income tax credit of $1,000 per month for up to 36 months ($500 per month if already located in the area). In addition, physician assistants, nurse-practitioners, and certified nurse-midwives serving in health professional shortage areas would obtain a $500 per month credit.

4. Expensing of medical equipment (sec. 776)

Physicians providing full-time primary health care services in an area with a shortage of health professionals generally would be permitted to deduct an additional $15,000 annually for medical equipment costs in the first year of equipment use. This proposal would apply to property placed in service in taxable years beginning after December 31, 1994.

5. Post-retirement medical and life insurance reserves (sec. 781)

Beginning in 1995, the minimum period during which the cost of post-retirement medical and life insurance coverage could be funded under a welfare benefit fund would be 10 years.

6. Coordination with health care continuation provisions (sec. 782)

The bill would provide that the maximum period of continuation coverage that can be elected by an individual that loses coverage under an employer group health plan after 1996 is the longer of 6 months or until the end of the calendar year.

7. Credit for cost of personal assistance services required by employed individuals (sec. 783)

Physically impaired taxpayers would be entitled to an income tax credit equal to half of the first $15,000 of personal assistance expenses, not to exceed half of the taxpayer's earned income. This credit would phase out over the income range of $50,000 to $70,000. This provision would apply to taxable years beginning after December 31, 1995.

8. Disclosure of return information for administration of certain programs under the Health Security Act (sec. 784)

Effective on the date of enactment, the bill would permit disclosure of certain taxpayer return information to officers and employees of any Federal, State, or local agency administering health subsidy programs under the bill.

9. Special rule for deferred compensation plans of group medical practices (sec. 785)

Beginning in 1995, the limit on annual deferrals under a section 457 plan would not apply in the case of an individual covered under an excess benefit arrangement maintained by a group medical practice that is exempt from tax under section 501(c)(3).

H. MEDICAID

The Committee bill would integrate AFDC and non-cash Medicaid recipients into the private health care system. They would purchase private insurance and receive Federal subsidies on the same basis as other low-income people.

The Medicaid program would be retained to provide any services that would not be covered in the basic benefit package (supplemental services) for all groups currently eligible for Medicaid.

The Committee bill also would make improvements in Medicaid home and community based long term care services, including an enhanced Federal matching rate for those services and improvements in eligibility.

I. LONG-TERM CARE AND SUPPLEMENTAL INSURANCE STANDARDS

1. Home and community based care

The Committee bill would create a new home and community based long term care program for people who need assistance with three or more activities of daily living, or who have either severe mental retardation or cognitive impairment, or who are children under age six with a severe disability or a chronic medical condition. States may offer a range of services but must offer personal care attendant services and, where appropriate, case management.

Beneficiaries would have to meet deductible and coinsurance obligations. Funding for the program would be phased in over seven years.

2. Long term care insurance

The Committee bill would create Federal minimum standards that long term care insurance policies must meet in order to be certified. Among the new standards, insurers would be required to guarantee renewal and limit exclusions for pre-existing conditions. Long term care insurance policies would have to include non-forfeiture benefits and insurance companies must offer inflation protection. Policies would be required to provide equal treatment of all conditions requiring long term care.

3. Standards for supplemental insurance

Supplemental health benefits would be defined to include two types of policies: supplemental services policies and cost-sharing policies. Supplemental services policies would include coverage for services and items not offered in the certified standard health plan, and coverage for items in the certified standard health plan, but not covered because of limitations in amount, duration or scope. Cost-sharing policies would include those that provide coverage for out-of-pocket payments, including co-insurance, deductibles and copayments.

Federal standards would be established for supplemental health benefits policies. States, or in the case of multistate self-insured plans the Secretary of Labor, would be required to certify that the supplemental health benefits policies meet Federal standards. A health plan or insurer offering a supplemental policy in violation of the standards would be subject to civil money penalties.

Certain policies would be excluded from the definition of supplemental health benefits plans. In general, supplemental policies would be required to comply with the insurance reforms applied to certified standard plans. Cost-sharing plans would be subject to different standards.

J. MEDICARE

1. Provisions related to part A

The Committee bill would reduce payments to providers, change payment methodologies, and enhance payments to rural hospitals.

The payment reductions include a 2 percent decrease in the update factor for inpatient hospital services, a reduction in payments for capital-related costs for inpatient hospital services, a 25 percent reduction in payments for disproportionate share hospitals, reductions in payments for skilled nursing facilities, and a moratorium on long-term hospitals.

The payment methodology changes include new base cost years for rehabilitation and long-term hospitals, and separate payment rates for sole community hospitals that merge, when one of the hospitals is a teaching hospital.

Rural hospital payment enhancements include: an extension of the Medicare Dependent Hospital provisions; continuation of rural health transition grants; and a new limited service hospital program which would make the Medical Assistance Facility demonstration permanent, amend the Essential Access Community Hospital (EACH)/Rural Primary Care Hospital (RPCH) program, and establish a new rural emergency medical services program.

2. Provisions related to part B

a. Updates for physicians' services

The Committee bill would reduce the 1995 default update by 4.0 percentage points for surgical services, 4.0 percentage points for non-surgical services, and 1.0 percentage point for primary care services.

b. Substitution of real gross domestic product (GDP) for volume and intensity in the volume performance standard

The bill would specify that the historical rate of increase in the volume and intensity of services delivered would be deleted from the MVPS. Substituted in its place would be the average per capita growth in real (inflation-adjusted) GDP for the 5 year-period beginning with the previous fiscal year (1994). The performance standard factor would be repealed. In addition, the lower limit on the default update would be repealed.

c. Payments for physician services relating to inpatient stays in certain hospitals

The Secretary of Health and Human services would be directed to develop for all hospitals paid under the prospective payment system, annual, hospital-specific case-mix adjusted relative value units per admission and determine whether a hospital exceeds the allowable average per admission relative value units applicable to the medical staff for the year. If the Secretary determines that the rate for the hospital exceeds the allowable average per admission, the Secretary would reduce payments for physician services to hospital inpatients.

d. Incentives for physicians to provide primary care

The bill would increase the bonus payment for primary care services, as defined in Sec. 1842(i)(a) of the Social Security Act, to 20 percent for each physician service. The bonus payment for other physician services (excluding primary care) would be set at 10 percent for services delivered in health professional shortage areas located in rural areas. The 10 percent bonus payment for non-primary care services delivered in health professional shortage areas located in urban areas would be eliminated.

e. Development and implementation of resource-based methodology for practice expenses

The Secretary would be required to develop a methodology for implementing in 1997 a resource-based system for determining practice expense relative value units for each physician service.

f. Elimination of formula-driven overpayment for certain hospital outpatient services

Using the current blend percentages, the payment formula would be changed to determine the blended payment limit prior to the application of beneficiary cost-sharing provisions. Medicare's payment amount would be determined based on the lesser of (1) the lower of the hospital's reasonable costs or customary charges, or (2) the blended payment limit. Medicare would then pay the lesser of (1) 80 percent of the lowest amount, or (2) the lowest amount less the beneficiary cost-sharing amounts.

g. Payments to eye and to eye and ear specialty hospitals

The use of the 75/25 blend for eye hospitals, and eye and ear hospitals would be extended to services provided until September 30, 1997.

h. Imposition of co-insurance for laboratory services

The bill would require Medicare beneficiaries to pay co-insurance equal to 20 percent of the approved Medicare payment amount for clinical laboratory services.

i. Application of competitive acquisition process for part B items and services

The bill would direct the Secretary to establish competitive acquisition areas for procurement of (CT) computer-axial tomography

scans, (MRI) magnetic resonance imaging tests and oxygen and oxygen equipment.

j. Application of competitive acquisition process for clinical laboratory services

The bill would direct the Secretary to establish competitive acquisition areas for procurement of clinical laboratory services.

k. Part B premium

The bill would permanently set Part B premiums at 25 percent of Part B spending for aged beneficiaries.

3. Provisions related to Medicare parts A and B

a. Medicare secondary payer

The authority to transfer data regarding Medicare secondary payers (enacted in OBRA 89 and extended in OBRA 93) would be made permanent. The Medicare secondary payer requirements for disabled beneficiaries would be made permanent. The Medicare secondary payer requirements for beneficiaries with end stage renal disease would be made permanent.

b. Expand centers of excellence

The bill would direct the Secretary to expand the demonstration projects for coronary artery bypass and cataract surgery in urban areas. Payment would be made on the basis of a negotiated or all-inclusive rate, beginning with fiscal year 1995.

c. Medicare select

The bill would permit Medicare Select policies to be offered in all States. The three year limitation would be eliminated.

d. Medicare supplemental insurance polices (Medigap)

The bill would require Medicare supplemental policies (Medigap) to have an annual open enrollment period of 30 days.

e. Reduction in routine cost limits for home health care services

The upper limit on payment for allowable visit-related costs for home health services would be limited to 100 percent. The cost limits are changed from a percentage of the mean cost to a percentage of the median cost.

f. Improvements in risk contracts

The bill would make a number of improvements in Medicare risk contracts designed to encourage more beneficiaries to enroll in risk contracts and more organizations to enter into risk contracts.

g. Reimbursement for nurse practitioners and physician's assistants

The bill provides for direct reimbursement for nurse practitioners and physician assistants in all outpatient settings. Reimbursement would be set at 85 percent of the amount paid to physicians for the same services under the physician fee schedule. Nurse practitioners

assisting at surgery would be reimbursed at 65 percent of the amount paid to physicians in urban settings for situations in which the nurse practitioner who practices in a rural setting refers a patient into an urban setting and subsequently provides services to that patient in the urban setting.

4. Medicare and Medicaid coverage bank data

The proposal would delay the implementation of Medicare and Medicaid Coverage Data Bank until 1996, when it would be repealed.

K. ACADEMIC HEALTH CENTERS, GRADUATE MEDICAL AND NURSING EDUCATION, DENTAL EDUCATION, AND BIOMEDICAL AND BEHAVIORAL RESEARCH

The Committee bill establishes two new trust funds to assist academic health centers and teaching hospitals with the additional expenses associated with running programs for graduate medical education, taking care of more seriously ill patients, and providing highly specialized care. Payments will also go for dental education, advanced nursing education, and high-intensity rural hospitals. The trust funds will be financed by a new assessment of 1.5 percent on private health insurance premiums that will provide $21 billion during 1996–99 and $43.2 billion in 2000–04, plus payments from Medicare at the current rate.

These trust funds will, for the first time, establish a permanent stream of funds to sustain academic health centers and teaching hospitals.

Academic health centers currently receive grants for biomedical and behavioral research from the National Institutes of Health (NIH) that are funded by appropriations authorized under Titles III and IV of the Public Health Service Act. Under the bill, a third trust fund will be created to make additional payments for biomedical and behavioral research. The research trust fund will receive the proceeds of an assessment of 0.25 percent on premiums, amounting to approximately $5.0 billion during 1996–99 and $8.0 billion in 2000–04. One-fifth of these funds will be set aside for applied research on the delivery of health services and the quality of medical care.

L. ACCESS TO HEALTH CARE IN DESIGNATED RURAL AND URBAN AREAS

The Committee bill includes several provisions that would improve access in underserved rural and urban areas. The legislation would create a $1.3 billion account within the Health Care Trust Fund to support the development of community health networks and health plans that will improve the delivery of health care services in underserved areas. Funding could be used to provide capital assistance and operating assistance to address financial, geographic and other barriers to health services. The Secretary of Health and Human Services would designate underserved areas; States may also identify underserved areas subject to the approval of the Secretary of Health and Human Services.

M. STATE SINGLE-PAYER OPTION

States would be permitted to opt out of the Federal system and enact their own single-payer system if certain conditions are satisfied. Multiemployer union plans and multistate employers with at least 5,000 employees would not have to participate in the system.

N. PRIVACY AND CONFIDENTIALITY

1. Rule of Nondisclosure for Protected Health Information

All health information that could reasonably be related to a specific individual would be protected from disclosure. Comprehensive protections of this protected health information would apply regardless of form or medium, whether kept in paper files or in electronic databases, whether retained in doctors' offices or insurance company files, or available from an information system or over a computer network.

2. Penalties

Unauthorized disclosures of protected health information would be subject to criminal sanctions, civil actions, and administrative penalties. Penalties would range from fines of up to $50,000 and prison terms of up to one year for wrongful disclosure or obtaining of protected health information, to fines of up to $100,000 and prison terms of up to five years for violations committed under false pretenses, to fines of up to $250,000 and prison terms of up to ten years for offenses committed with intent to sell protected health information for commercial advantage or personal gain.

3. Individual Authorization of Disclosures

An individual would be able to authorize disclosure of protected health information about himself or herself under circumstances that ensure the authorization is a knowing and meaningful choice, that circumscribe the uses of the disclosure, and that allow for time limitation and revocation of permission. Requests for authorization for disclosure would be structured to serve these purposes.

4. Limit on Amount of Information Disclosed; Patient Rights

When protected health information is disclosed, it would be limited to the minimum necessary to accomplish the purposes for which the information was disclosed. An individual would have the right to inspect and annotate records of health information about himself or herself through his or her health care providers. He or she would also have the right to prohibit the disclosure of sensitive and personal information so that it would not be included in the health information that providers are otherwise permitted to share.

5. Exceptions to the Rule of Nondisclosure

An exception to the rule of nondisclosure would be created for the following: health care providers would be permitted to share relevant protected health information in the process of diagnosis and treatment; health care providers and plans would be permitted to share protected health information for the purposes of payment and for such other financial and administrative functions as necessary to the effective operations of the health system; oversight

agencies would have access to information to uncover fraud and other abuses; disclosure of information would be permitted to meet public health requirements and the need for disease and injury reporting, to protect the health of an individual from imminent harm, to provide health information to health research projects, for which an institutional review board has determined that disclosures are necessary, and for court ordered examinations and disclosure of protected health information when a party has placed his or her medical condition at issue. In addition, disclosure of protected health information would be permitted to law enforcement authorities to investigate or prosecute a health care provider or plan or to identify a victim or witness in a law enforcement inquiry; and disclosure of protected health information would be permitted when ordered by a subpoena or warrant.

O. HEALTH PLAN STANDARDS

The Committee bill directs the Secretary of HHS, in consultation with the Health Plan Standards and Quality Advisory Committee, to develop specific standards and evaluation criteria to be used in the certification of all health plans. The health plans would have to meet standards in the categories of alternative dispute resolution, participation in the health information network, reporting of standardized data to produce comparative value information, capital and solvency, quality, patient protection, and access.

States are required to develop Accreditation, Certification, Enforcement, and Information (ACEI) programs meeting Federal guidelines to certify all health plans except multistate self-insured plans which are certified by the Secretary of Labor. The establishment of an ACEI program is a condition of receiving Medicaid funds, and no Federal health care subsidies could be paid to any health plan not certified as meeting Federal standards. The States would receive funding for their ACEI programs.

P. QUALITY AND CONSUMER INFORMATION

The Committee bill includes health services and quality improvement research on the effects of health care reform on health delivery systems, medical effectiveness, measuring population health status, and national quality performance measures.

The Secretary of HHS would be required to establish demonstration projects and grants to test and evaluate mechanisms to provide technical assistance to health plans for the purpose of implementing quality improvement research into medical practice. These demonstrations would be funded through Health Research Trust Fund monies and appropriations.

The consumer information component of quality is included in the State Accreditation, Certification, Enforcement, and Information programs. The ACEI programs would produce annual, standardized comparative value information on the performance of all health plans in each community rating area, develop distribution mechanisms for the comparative value information, educate and provide outreach for consumers on comparative value information, and receive and seek to resolve complaints. The Secretary of HHS would develop criteria for consumer information, determine wheth-

er each State meets the criteria, and provide technical assistance to the ACEI programs.

Under the Committee bill, individuals would have the same remedies for a denial, reduction or termination of benefits regardless of whether their plan is an employee benefit plan or an individual insurance policy.

Each plan would be required to establish an appeals process that includes procedures for the review of an initial decision, and for reconsideration of an adverse decision. After the plan's appeals process renders a final decision, individuals would be free to pursue other remedies, including a State-run complaint review process, a non-binding dispute resolution program established by the State, or filing suit in State or Federal court. If a court ruled that a plan had acted unreasonably, it could award all appropriate relief.

II. Explanation of Provisions

SEC. 1. PURPOSE

It is the purpose of the Committee bill to achieve universal health insurance coverage through:

(1) subsidies for the purchase of health insurance;

(2) affordable standardized health insurance;

(3) elimination of exclusionary practices by health insurance companies;

(4) a permanent National Health Care Commission which, beginning in 1996, will make recommendations every two years to the Congress on how to increase the number of people covered by health insurance;

(5) reduction of health costs through more open competitive markets and continued advances in medical education and research; and

(6) health care provided under the Medicare and Medicaid programs and health programs of the Department of Defense, Department of Veterans Affairs, and Indian Health Service.

Title I—Health Insurance and Delivery System Reform

Subtitle A—Federal Standards for State Regulatory Programs

Sec. 101. State plan for certification and regulation of health insurance and delivery systems

PARTICIPATING STATE PROGRAM—GENERAL RESPONSIBILITIES

Present law

Federal law generally does not govern the sale of insured health plans to individuals or groups. The two exceptions are Title XVIII of the Social Security Act that regulates the sale of supplemental Medicare policies (Medigap policies) and Title XIII of the Public Health Service Act which sets out standards (including benefit package and rating) for health maintenance organizations that choose to be federally qualified. States set standards for insurance policies and many States have enacted insurance reforms in the past three years.

Committee provision

General definitions

Appropriate Certifying Authority.—For all multistate self-insured health plans the Secretary of Labor. For other standard health plans, nonstandard health plans, supplemental health benefits plans, and long-term care policies the State Commissioner or superintendent of insurance or other State authority through the participating State ACEI program.

Certified Long Term Care Policy.—A long-term care policy which is certified by the appropriate certifying authority as meeting the standards applicable to long-term care policies.

Certified Nonstandard Health Plan.—A health plan which is certified by the appropriate certifying authority as meeting the applicable requirements of the Health Security Act (including the insurance and delivery system reform standards), except that the plan does not provide the standard benefits package or alternative standard benefits package. Certified nonstandard health plans do not include certified supplemental health benefits plans.

Certified Standard Health Plan.—A health plan which provides the standard benefits package or the alternative standard benefits package and is certified by the appropriate certifying authority as meeting the other applicable requirements of the Health Security Act (including the insurance and delivery system reform standards).

Certified Supplemental Health Benefits Plan.—A health plan which is certified by the appropriate certifying authority as meeting the standards applicable to supplemental health benefits plans.

Community-Rated Individual.—An individual who is not an experience-rated individual or who is a part-time, seasonal, or temporary employee of an experience-rated employer who chooses not to enroll in one of the health plans offered by such employer.

Delivery System.—Health plan delivery systems include fee-for-service, use of preferred providers, staff or group model health maintenance organizations, and such other arrangements as the Secretary may recognize.

Equivalent Health Care Program.—Other health care programs defined as follows:

(A) Part A or Part B of the Medicare program under title XVIII of the Social Security Act.

(B) The Medicaid program under title XIX of the Social Security Act.

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

(D) The Veterans health care program under chapter 17 of title 38, United States Code.

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

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

(G) A State single-payer system approved by the Secretary.

(H) Any governmental health care program for institutionalized individuals.

Experience-Rated Employee.—An individual who is the employee of an experience-rated employer, except that an experience-rated individual who is the spouse (or dependent) of a community-rated individual may choose to be treated as a community-rated individual for purposes of enrolling in the community-rated health plan of the community-rated spouse.

Experience-Rated Employer.—Any employer who employed 100 or more full-time employees the preceding calendar year.

Full-time Employee.—An employee (other than a temporary or seasonal employee) who normally performs at least 24 hours of service per week for an employer.

Health Plan.—Any plan or arrangement which provides, or pays the cost of, health benefits. The term health plan does not include the following, or any combination thereof:

(A) Coverage only for accidental death or dismemberment.

(B) 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.

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

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

(E) Worker's compensation or similar insurance.

(F) Automobile medical-payment insurance.

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

(H) An equivalent health care program.

(I) Any other plan or arrangement that the Secretary determines is not a health plan.

Health Plan Sponsor.—With respect to an insured health plan, the insurer, with respect to a self-insured health plan, the experience-rated employer sponsor.

Health Professional.—An individual who is legally authorized to provide services in the State in which such services are provided.

Insured Health Plan.—Any health plan which is a hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization group contract offered by an insurer.

Insurer.—A licensed insurance company, prepaid hospital or medical service plan, health maintenance organization, or any other similar entity which is engaged in the business of providing a plan of health insurance or health benefits or services.

Resident Population.—Includes any individual who is residing in the United States and who is: (A) a citizen or national of the United States, or (B) an alien permanently residing in the United States under color of law.

Self-Insured Health Plan.—An employee welfare benefit plan, church plan, government plan, or other arrangement which provides health benefits funded in a manner other than through the purchase of one or more insured health plans, but does not include any coverage or insurance described in (A) through (I) of the health plan definition.

State Accreditation, Certification, Enforcement, Information (ACEI) Programs.—Participating State programs which provide for the accreditation and certification of health plans as certified standard health plans, certified nonstandard health plans, certified supplemental health benefits plans, and long-term care policies, and carry out other participating State responsibilities.

State.—Each of the fifty States, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

STATE ACCREDITATION, CERTIFICATION, ENFORCEMENT, AND INFORMATION PROGRAMS

Health plan and long term care policy accreditation and certification

To be a participating State, States would be required to develop Accreditation, Certification, Enforcement, and Information (ACEI) programs by January 1, 1996 to certify all health plans and long-term care policies except multistate self-insured plans. States would be required to establish an ACEI program for standard health plans by January 1, 1996, for supplemental health plans by January 1, 1997, and for long-term care policies by April 1, 1997. Establishment of an ACEI program would be a condition for receiving Medicaid funds.

A State ACEI program could use private accreditation agencies for the accreditation element of their programs.

The Secretary of Health and Human Services would be required to develop guidelines for ACEI programs, and approve ACEI programs as meeting Federal guidelines.

The Secretary would be required to distribute funds to States from the Health Security Trust Fund in the amounts of $100,000,000 in 1995, and $300,000,000 in each of 1996-2004, for State ACEI programs.

The Secretary would be required to develop a bonus payment schedule for States that institute Independent Review Committees to provide recommendations concerning health plans that fail certification.

Health plan and long term care policy standards enforcement

State ACEI programs, in conjunction with private accreditation agencies where appropriate, would be required to determine a process for imposing santions on all health plans and long-term care policies. Sanctions could include prohibiting new member enrollment, allowing existing enrollees to exit the plan without penalty, operating a health plan to provide transitional access, developing a correction program for the plan, or decertification of the health plan after the plan has been given a reasonable opportunity to make corrections.

Supplemental health plans and long-term care policies not certified as meeting Federal standards would be subject to a civil penalty not to exceed 50 percent of gross premiums (or 50 percent of health expenses for self-insured plans), enforceable by the State.

Consumer information

The State ACEI programs would establish and operate a consumer information program to provide consumers in the State with comparative value information on the performance of all health plans in each community rating area of the State.

Comparative value information would present, in a standard format, the following information:

Descriptive data about the health plans, including certification status, benefits, premiums, risk and referral arrangements, provider information, complaint and appeals process, and other appropriate information;

Data from the national measures of quality performance;

Data from annual surveys of health care consumers conducted by the information program concerning access to care, use of health services, health outcomes, and enrollee satisfaction;

A subset of measures of quality performance for health care professionals and facilities.

The Committee intends that standardized comparative value information should emphasize actuarially adjusted cost and health outcomes data. Measures should transition away from existing process measures towards patient and population-centered health outcomes, with particular emphasis on function and wellbeing, prevention focused on risk management reduction, and consumer satisfaction. To facilitate rapid application of these measures, standardized and scientifically validated instruments should be used where currently available.

A State consumer information program may join with one or more other State ACEI programs to prepare comparative value information for a geographic area that includes adjoining portions of contiguous States.

A State consumer information program would be responsible for promoting effective consumer participation in choosing health plans and obtaining care. They would perform the following functions to enhance consumer participation:

Distribute comparative value information and educate consumers about comparability of health plan characteristics and quality;

Provide information and referral to assist in health plan enrollment and receipt of subsidies;

Conduct outreach to underserved and at-risk populations on consumer responsibilities and rights to ensure their full participation in the health care system;

Receive and seek to resolve complaints, and would have appropriate access to relevant information.

The State ACEI program may operate the consumer information program through a contract with a nonprofit organization selected by the State in a competitive process.

A State ACEI program would be permitted to impose appropriate certification fees on health plans and long-term care policies seeking certification.

Effective date

Upon enactment.

OTHER STATE RESPONSIBILITIES

Establishment of community rating areas

Each participating State shall, by January 1, 1996, create one or more community rating areas within the State. The boundaries may be revised from time to time.

In creating these boundaries no metropolitan statistical area or primary metropolitan statistical area may be divided into separate community rating areas. Each community rating area must have a population of at least 250,000. All parts of a State must be contained in one and only one community rating area.

In establishing community rating areas, a participating State may not discriminate on the basis of, or otherwise take into account, disability, health status, or perceived need for health services of a particular population. This restriction shall not prohibit a State from establishing community rating areas that ensure that underserved and vulnerable populations are better served.

Two or more contiguous States may provide for an interstate community rating area so long as that area is in compliance with the above provisions.

State-defined health plan service areas

The State ACEI program would be required to designate, based on guidelines from the Secretary, standard health plan service areas for the health plan standards related to essential community providers and capacity to deliver services. The health plan service areas would prevent the isolation of low-income and vulnerable populations by preventing the division of governmental boundaries of counties, towns, or cities and including adjacent designated urban or rural underserved areas.

Reinsurance pools, risk adjustment, and cost-sharing subsidy adjustments

The State ACEI program would be required to develop a reinsurance pool for community-rated standard health plans, and a reinsurance pool for self-insured standard health plans (other than multistate self-insured health plans) by January 1, 1996; a risk adjustment program for community-rated standard health plans by January 1, 1997; and a cost-sharing adjustment program for all standard health plans (except multistate self-insured health plans) by January 1, 1997.

Specification of annual general enrollment period

Each participating State shall specify for the State (or for each community rating area) an annual period of at least 30 days during which individuals in the State (or area) may enroll in, or switch, health plans.

Premium approval process for long term care policies

Each State shall provide for a process for approving or disapproving proposed premium increases or decreases with respect to long-term care policies.

This process shall not apply to a group long-term care policy issued to a group described in section 4(E)(1) of the NAIC Long Term

Care Insurance Model Act (effective January 1991), except that such group policy shall, pursuant to guidelines, provide notice to policyholders and certificate holders of any premium change under such group policy. The approval process shall apply to group conversion policies, the group continuation feature of a group policy if the carrier separately rates employee and continuation coverage, and group policies where the function of the employer is limited solely to collecting premiums and remitting such premiums to the carrier.

This provision shall not be construed as preventing the NAIC from promulgating standards, or a State from enacting and enforcing laws, with respect to premium rates or loss ratios for all, including group, long-term care policies.

The State shall provide for consumer access to actuarial memoranda, including financial information, provided under this provision.

Effective date

For premium approval process for long term care policies, January 1, 1997. Except as noted, the remaining provisions are effective on January 1, 1996.

REQUIREMENTS FOR STATE SINGLE-PAYER SYSTEMS

State single-payer systems

A State may apply to the Secretary for authority to operate a single-payer system in the State or in one or more community-rating areas in the State.

The Secretary would be required to approve a State's application to administer a single-payer system if the State system: (1) Is established under State law and is operated by a State agency; (2) provides for the enrollment of at least all persons who are eligible to participate in the community-rated market, including all Medicare eligible individuals if the State has received approval for Medicare integration; (3) the State makes payments to providers directly, or through fiscal intermediaries, and assumes all financial risk; (4) the State provides the standard benefit package to all persons and maintains cost-sharing requirements no greater on any subgroup of individuals than those permitted under the bill; (5) Federal health care outlays to the State are not increased; and (6) the system is expected by the State to increase coverage or control health care costs in the State or community-rating area.

A State generally may require experience-rated individuals to participate in an approved single-payer system. However, the State may not require participation by individuals who are enrolled in a multistate self-insured multiemployer plan or a multistate self-insured plan maintained by a employer with at least 5,000 employees. Employers of exempt individuals also are exempt from participation in the system with respect to these individuals.

A State operating a single-payer system generally is required to satisfy the requirements for participating States under the bill. However, the State is not required to satisfy requirements in the bill that are inconsistent with or otherwise not appropriate to apply to a single-payer system.

Effective date

Upon enactment.

TREATMENT OF CERTAIN STATE LAWS

Preemption of State law restrictions on network plans

State laws would be preempted to the extent that they constrain the development of managed care plans. In particular, such laws would be preempted if they have the effect of making it unlawful for plans that are not fee-for-service plans (or fee-for-service components of plans) to do the following:

(1) create incentives for the use of participating providers;

(2) require enrollees to obtain care from participating providers;

(3) require enrollees to obtain referrals for specialty treatment;

(4) establish different payment rates for network and nonnetwork providers;

(5) limit the number and types of participating providers;

(6) use single source suppliers for pharmacy services, medical equipment, and other supplies and services;

(7) prohibit or limit the corporate practice of medicine.

State law restrictions on health professional licensure

State laws restricting through licensure or otherwise the practice of any class of health professionals beyond what is justified by the skills and training of such professionals would be preempted.

A State would be prohibited from restricting the participation, reimbursement, or indemnification of a health professional solely on the basis of the academic degree of the professional if the professional is acting within the scope of the professional's license.

Preemption from State benefit mandates

No State could require any health plan to cover items and services that are different from the items and services specified in the Health Security Act.

Preemption of State law regulating utilization management and review

A State could not regulate utilization management and review programs of a health plan except as provided in the Health Security Act.

Effective date

January 1, 1996.

FEDERAL RESPONSIBILITIES

Federal role with respect to multistate health plans

Multistate self-insured health plans, and multistate self-insured supplemental health benefits plans, shall be certified by the Secretary of Labor. For these plans the Secretary of Labor shall perform all of the duties of a participating State.

A self-insured health plan, or a self-insured supplemental health benefits plan, shall be considered a multistate health plan if it is established or maintained by an experience-rated employer which has a substantial number of employees enrolled in such plan in each of two or more States (as determined by the Secretary of Labor).

The provisions of sections 502 (relating to civil enforcement), 504 (relating to investigative authority), and 506 (relating to criminal enforcement) of the Employee Retirement Income Security Act of 1974 shall apply to enforcement by the Secretary of Labor of the requirements under the bill for multistate employers and multistate self-insured health plans.

Establishment of residency rules

The Secretary shall establish rules to identify the State and community rating area in which an individual resides. These rules shall be based on the individual's principal residence.

Workplace wellness program

The Secretary shall develop criteria for workplace wellness programs. Health plans may offer a premium discount, not to exceed 10 percent, to employers maintaining certified workplace wellness programs. Such discounts shall be applied uniformly to qualified employers.

Employee leasing rules

The Secretary of Labor shall promulgate regulations to prevent the avoidance of the requirements of this title through the use of employee leasing businesses.

Approval of private accreditation programs

The Secretary shall certify private accreditation entities used by States to certify health plans.

Effective date

Upon enactment.

FEDERAL STANDARDS FOR REFORM

ESTABLISHMENT AND APPLICATION OF STANDARDS

The Secretary would establish a National Health Plan Standards and Quality Advisory Committee to advise the Secretary on guidelines for the State ACEI programs, and standards and evaluation criteria to be used in the certification of standard health plans, and supplemental health plans.

The National Health Plan Standards and Quality Advisory Committee would interact with the Board of the Health Security Trust Fund concerning funding and program accountability.

The Secretary, in consultation with the Health Plan Standards and Quality Advisory Committee, would develop standards and evaluation criteria to be used in the certification of standard health plans and supplemental health plans.

The Secretary, in consultation with the Secretary of Labor, would develop standards for multistate self-insured standard health plans and supplemental health plans.

The Secretary, in consultation with the National Association of Insurance Commissioners, would develop standards for long-term care policies.

The Secretary, in consultation with the National Association of Insurance Commissioners, would develop a risk-based capital standards formula. The Committee intends that the Secretary would consider whether there is a need for flexibility in establishing the financial capacity of health plans by addressing the different characteristics of types of delivery systems and the appropriateness of and need to use capital to build and maintain the capacity to deliver services as compared to just retaining liquid assets.

The Secretary would adapt the reform standards to different types of delivery systems, and insured versus self-insured health plans. The Secretary may adopt provisional standards for health plans operating in underserved areas.

The Secretary would develop standards for State reinsurance pools, risk adjustment programs, and subsidy adjustment programs. The Secretary of Labor would develop standards for a reinsurance program for multistate self-insured health plans.

Effective date

Guidelines for ACEI programs, standards for standard health plans, including capital, and standards for multistate plans would be developed by July 1, 1995. Standards for supplemental health plans would be developed by January 1, 1996. Standards for long-term care policies would be developed by September 1, 1996.

STANDARDS APPLICABLE TO STANDARD HEALTH PLAN INSURANCE STANDARDS

Guaranteed issue and renewal

In general, a standard health plan sponsor offering a community-rated health plan would be required to offer such a plan to any community-rated individual applying for coverage. Any health plan sponsor offering an experience-rated health plan would be required to offer such a plan to any experience-rated individual eligible for coverage under the plan through the individual's employer.

A community-rated standard plan shall be made available throughout the entire community rating area (or areas) in which it is offered. A community-rated standard plan may deny coverage to community-rated individuals outside of the community rating areas in which they operate as long as such denial is consistently applied.

A standard health plan may impose capacity limits if it is permitted to do so by the appropriate certifying authority. The plan must demonstrate to the certifying authority that it will cease to enroll all new applicants, that its financial or provider capacity will be impaired if enrollment is not ceased, and that individuals are enrolled on a first-come-first-served basis.

A standard health plan sponsor must renew all plans. It can refuse to renew, or terminate, only for nonpayment of premiums, fraud on the part of the eligible individual, or misrepresentation of material facts on the part of the eligible individual relating to an application for coverage or claim for benefits.

Any Comprehensive Medical Plan (as described in 5 USC 8903(4)) participating in the Federal Employees Health Benefits Program shall offer a community-rated standard health plan in the community rating area(s) in which it operates.

Religious fraternal benefits societies in existence as of September 1993, which bear the risk of providing insurance to members, and which are an organization described in section 501(c)(8) of the Internal Revenue Code of 1986 and which are exempt from taxation under section 501(a) of such code shall not be subject to the guaranteed issue requirements of this provision. These societies shall only be required to guarantee renewal to members.

Except as provided above, upon enactment until the implementation of community rating (January 1, 1996), an insured health plan shall renew coverage to all individual policyholders and firms with less than 100 employees unless the health plan sponsor elects not to renew coverage for all individual policyholders and all firms with fewer than 100 employees in insured health plans which utilize the same delivery system as the plan being canceled. Furthermore, the sponsor shall provide notice to the appropriate certifying authority and to all individuals covered under the plan at least 180 days before the date of expiration. An insured health plan sponsor that terminates a plan or plans under this provision shall not sell policies to individuals nor to firms with fewer than 100 employees in the State using the same delivery system for a period of five years.

Effective date

Insured health plans must guarantee issue as of January 1, 1996; self-insured health plans must guarantee issue as of January 1, 1995. All health plans must guarantee renewal as of June 28, 1994.

Enrollment

Standard health plans shall be required to have at least one annual 30 day open enrollment period, as established by the State. In addition, standard health plans will be required to have an open enrollment period from January 1, 1996 to March 31, 1996 to coincide with the implementation of community rating. A second extended open enrollment period shall begin on January 1, 1997 and end on March 31, 1997 for the enrollment of premium subsidy eligibles as defined in Sec. 1958. Standard health plans shall be required to accept enrollment of individuals outside of the annual open enrollment period when the individual's enrollment status changes due to: change in family status such as marriage, divorce or separation, death, or birth or adoption of a child; change in employment status; changes in residence; disenrollment for cause from another health plan; disenrollment from another health plan due to failure of that health plan.

Coverage under a standard health plan shall begin no more than 15 days after enrollment. Newborn and adopted children shall be

automatically covered for a period of 45 days regardless of class of enrollment.

Rating limitation for community-rated market

Each community-rated standard health plan shall establish, within each community rating area in which the plan is offered, a standard premium for the standard benefits package and/or the alternative standard benefits package.

Family adjustment factors shall reflect the actuarial costs of the benefits package for different classes of enrollment. There are six classes of enrollment: (1) Individual, (2) Child (an individual less than 18 years of age), (3) Multiple children (under age 18), (4) Married couple without children, (5) Individual with one or more children, and (6) Married couple with one or more children.

The premium charged to enrollees shall be equal to the product of the standard premium, the family adjustment factor (for classes of enrollment other than individual enrollment), and the age adjustment factor. The standard premium shall not include charges that vary with method of enrollment (through a purchasing cooperative, directly through a health plan, or through another purchasing agent). Variable charges include marketing, enrollment, and premium processing expenses.

For purposes of community rating, the Secretary, in consultation with the National Association of Insurance Commissioners, shall specify age adjustment factors. For individuals who have attained 18 years of age but not age 65, the highest age adjustment factor may not exceed twice the lowest age adjustment factor.

Standard health plans may add a separate administrative charge, which shall be published. This charge shall cover the marketing, enrollment, and premium processing costs that vary with method of enrollment in the health plan. This administrative charge must be applied uniformly with respect to the size of the group enrolling. The Secretary shall promulgate standards regarding the amount by which the highest administrative charge can exceed the lowest administrative charge of a health plan.

Standard health plans shall be prohibited from charging a separate administrative charge for individuals enrolling through a purchasing cooperative. The total charge for enrollment to an individual enrolling through a cooperative shall be the standard premium (appropriately adjusted for family class and age) and the cooperative administrative charge.

Community rating shall be maintained. Notwithstanding any other provision of this section, the standard premium charged to an individual shall be identical regardless of whether that individual purchases coverage directly from the standard health plan sponsor, through a purchasing cooperative, or through any other purchasing agent.

Rating practices and payment of premiums

Standard health plan sponsors shall fully disclose, to the appropriate certifying authority, rating practices for plans offered. Such sponsors shall also provide notice, at least 60 days before the date of expiration of the plan, as to terms for renewal of the plan. Each standard health plan sponsor shall file annually with the appro-

priate certifying authority a written statement by a member of the American Academy of Actuaries (or other individual acceptable to such authority) certifying that the actuarial assumptions and methods used by the sponsor are in compliance with the regulations regarding standard premiums and are actuarially sound.

For new enrollees, standard health plan sponsors may require advance payment of one month's premium at the time of enrollment. If a standard health plan sponsor fails to receive premium payment, the sponsor shall provide notice of such failure within 20 days after the date on which payment was due.

Nondiscrimination based on health status

In general, standard health plans may not (1) deny, limit, or condition coverage, (2) engage in any other activity, including the selection of service area, or (3) in the case of a self-insured standard health plan vary the premium, based upon health status, medical condition, claims experience, receipt of health care, medical history, anticipated need for health care expenses, disability, or lack of evidence of insurability, of an individual.

A standard health plan may impose a pre-existing condition limitation if (1) the condition was diagnosed or treated within three months (six months during 1996 only) of enrollment under the plan, (2) the limitation or exclusion extends no more than 6 months after enrollment in the plan, (3) the limitation or exclusion does not apply to an individual who, as of date of birth, was covered under the plan, and (4) the limitation or exclusion does not apply to pregnancy. For each month of continuous coverage as of the date of enrollment, any period of exclusion or limitation of coverage with respect to a pre-existing condition shall be reduced by one month. A period of continuous coverage begins on the date an individual is enrolled under a health plan or health care program which provides, with respect to the pre-existing condition, benefits equivalent to those of the plan in which the individual is seeking to enroll. The period ends on the date on which the individual is disenrolled for more than three months.

During the January through March open enrollment period of 1996 (and 1997 with respect to individuals eligible for premium subsidies) there shall be a one-time amnesty during which standard health plan sponsors shall be prohibited from imposing any limitation or exclusion due to pre-existing health conditions.

Effective June 28, 1994 through January 1, 1996 a self-insured health plan may not reduce or limit coverage of any condition or course of treatment that is expected to cost $5,000 or more during a twelve-month period.

Effective date

For insured health plans, January 1, 1996. For self-insured health plans, January 1, 1995.

Benefits offered

A standard health plan shall offer to all enrollees in the plan the standard benefits package or the alternative standard benefits package established under Subtitle C of Title XXI.

Effective date

Insured health plans must guarantee issue as of January 1, 1996; self-insured health plans must guarantee issue as of January 1, 1995. All health plans must guarantee renewal as of June 28, 1994. For all other provisions January 1, 1996.

DELIVERY SYSTEM STANDARDS

Reinsurance, risk adjustment and cost-sharing adjustment

Community-rated, single State self-insured, and multistate self-insured standard health plans would be required to participate in the relevant reinsurance pool.

Community-rated standard health plans would be required to participate in State risk-adjustment programs.

Community-rated, experience-rated, and single State self-insured standard health plans would be required to participate in the State cost-sharing adjustment program.

Capital requirements

Standard health plans would be required to meet the risk-based capital formula.

The Committee intends that the Secretary, in consultation with the Secretary of Labor, would include appropriate solvency standards for all self-insured health plans, including church plans, multiemployer, and qualified association plans and that the capital and solvency standards may vary by different type of health plan sponsor.

Collection and provision of standardized information

Standard health plans would be required to submit to the Consumer Information Center, in a standardized format, the data required to produce comparative value information. Health care professionals and facilities would be required to report a standard set of data to the Consumer Information Center.

Quality improvement and assurance

Quality Improvement and Assurance.—Standard health plans would be required to develop and implement an internal quality improvement program designed to measure, assess and improve enrollee health status, enrollee outcomes, enrollee processes of care, and enrollee satisfaction.

Standard health plans would be required to develop and implement quality improvement goals based on the results of population health status measurements.

Standard health plans would be required to maintain a program to assure the quality of health care services furnished to enrollees meets minimum standards of safety and clinical practice.

Utilization Management.—Standard health plans would be required to use licensed or certified health professionals with appropriate clinical training in making review determinations.

Standard health plans would be required to base utilization management on current scientific knowledge, stress the efficient delivery of health care and outcomes, rely primarily on evaluating and

comparing practice patterns rather than routine case-by-case review, and be consistent and timely in application.

Utilization management could not create direct financial incentives for reviewers to reduce or limit medically necessary or appropriate services.

Upon request, each integrated health plan would be required to provide a description to a participating or prospective provider, enrollee or prospective enrollee, of utilization review protocols. The standards would address the need to protect proprietary business information.

Credentialing.—Standard health plans would be required to credential participating physicians and practitioners.

Standard health plans would be required to ensure that participating providers and facilities are appropriately accredited, certified and licensed.

Continuity of Care.—Standard health plans would be required to develop and implement mechanisms for coordinating the delivery of care across provider settings.

Medical Recordkeeping.—Standard health plans would be required to assure that pertinent information is readily available to appropriate professionals.

Patient protections and provider selection

Patient Information.—Standard health plans would be required to provide to enrollees clear descriptive information and information about their rights and responsibilities.

The Committee encourages health plans, physicians, and other health care providers to use instructional and informational materials to explain recommended medical procedures and treatments to patients, caregivers, and third-party payers to educate them concerning potential benefits and risks, the need to follow pre- and post-treatment instructions, and descriptions of medical warning signs.

Information Regarding a Patient's Right to Self-Determination in Health Care Services.—Each integrated health plan would be required to notify enrollees of their rights to self-determination in health care decisionmaking, notify enrollees of the plan's policy regarding advance directives, and provide for educational activities for patients and providers. Patients' primary care physicians would be required to include in the patients' charts their wishes concerning advance directives.

Confidentiality of Patient Records.—Standard health plans would be required to have explicit procedures to protect the confidentiality of individual patient information.

Marketing (does not apply to self-insured plans).—Standard health plans could not engage in selective marketing that would have the effect of avoiding high-risk subscribers within a health plan service area. Marketing materials could not contain false or materially misleading information.

No Patient Liability for Unpaid Plan Obligation.—Standard health plans would be required to hold enrollees harmless with respect to any plan obligations for payment to providers.

Remedies and Enforcement.—Standard health plans would be required to comply with the remedies and enforcement requirements

of the Health Security Act, including the internal appeals process for benefit denial, reduction, or termination.

Standard health plans would be required to establish a grievance process for patients dissatisfied with matters other than denial of payment or provision of benefits by the plan.

Provider Selection.—In selecting among providers of health services for membership in a provider network, or in establishing the terms and conditions of such membership, a standard health plan may not engage in any practice that discriminates against a provider based on the health status of a patient of the provider.

A standard health plan could not restrict the participation, reimbursement, or indemnification of a health professional solely on the basis of the academic degree of the professional if the professional is acting within the scope of the professional's license.

Nothing in the Health Security Act would prevent a standard health plan from matching the number and type of health care providers to the needs of the plan members; require any standard health plan to contract with any type of provider legally authorized to provide services in the State; or establish any other measure designed to maintain quality or control costs, except as provided in the Health Security Act.

Physician Incentive Plans.—Physician incentive plans operated by standard health plans would have to meet the requirements of section 1876(i)(8)(A) of the Social Security Act, including the provision that no specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services to enrollees.

Physician Participation.—Standard health plans would be required to establish a mechanism through which physicians have input into matters affecting patient care, and that patients would be able to choose their primary care physician from available practitioners.

Standard health plans would be required to provide reasonable (at least 30 days) notification to physicians of decisions to cancel or deny renewal of contracts and establish an informal, non-binding and advisory review process for appeals.

Ethical Business Conduct.—A standard health plan would be required to develop and implement a code of ethical business conduct for its activities, including those of its components, and assure proficient management and planning functions.

Enrollment.—A standard health plan may not knowingly enroll an individual who is currently enrolled in another health plan.

Alternative dispute resolution procedures relating to malpractice claims

Standard health plans would be required to establish and maintain an alternative dispute resolution procedures program.

Essential community provider

All standard health plans, including self-insured plans, would be required to offer a contract with at least one of each category of Essential Community Providers in State-defined service areas during the five year period beginning on January 1, 1996. The Secretary would be required to develop guidelines for the definition of State-

defined health plan service areas. The State-defined service area could be smaller than a community-rated area, but could not divide cities or towns and would, at a minimum, include any adjacent designated urban and rural underserved areas. The Secretary may make exceptions and require contracts to be offered to more than one Essential Community Provider if the Secretary determines extra capacity is required to serve the needs of enrollees.

The Committee intended this provision to balance the right of managed care organizations to choose their own partners and the value of traditional providers to underserved areas, while beginning the transition to a more competitive marketplace. The Committee envisions the Secretary making exceptions in large service areas such as Los Angeles or New York City where entire communities are underserved, thus, requiring contracting with only one provider may not be adequate to ensure access.

A participation agreement between a standard health plan sponsor and an essential community provider would provide that the plan agrees to treat the provider in accordance with terms and conditions at least as favorable as those that are applicable to other providers with a participation agreement with the plan with respect to the scope of services and the basis for which payment is made by the plan to the provider.

The Secretary would be required to certify as an Essential Community Provider (i) migrant health centers; (ii) community health centers; (iii) homeless program providers; (iv) public housing providers; (v) family planning clinics; (vi) Indian Health Programs; (vii) HIV providers under the Ryan White Act; (viii) Maternal and Child Health Providers; (ix) federally qualified community health centers; (x) rural health clinics; (xi) providers of school health services; (xii) community networks receiving development funding in designated urban and rural underserved areas; (xiii) non-profit and public hospitals meeting the criteria for public hospitals which are eligible entities under section 340B of the Public Health Service Act (Medicare disproportionate share adjustment exceeding 11.75 percent); (xiv) children's hospitals meeting comparable criteria determined appropriate by the Secretary.

During the five year transition, the Secretary could set standards for the designation of additional health professionals and institutions as Essential Community Providers if the Secretary determines that health plans operating in areas served by the applicant would not be able to assure adequate access to the comprehensive benefit package without contracting with the applicant.

The Office of Technology Asessment would be required to conduct a study on improving access in underserved areas.

Health plan service area capacity

After the expiration of Essential Community Provider provisions, standard health plans would be required to have the capacity within the plan's network, or through contracts with a sufficient number, distribution, and variety of providers to deliver the standard benefits package to all parts of any State-defined health plan service area in which the health plan is offered, with reasonable promptness and in a manner which assures continuity.

Standard health plans would be required to make available and accessible, translation, case management, and transportation services, if necessary to deliver the standardized benefit package, and any supplemental benefits.

Standard health plans would be required to ensure that criteria for the selection of participating providers take into account the needs of diverse populations.

The standards in this section would apply to self-insured plans only to the extent necessary to deliver services to employees.

Specialized services

Standard health plans would be required to have within their network, or contract with, a sufficient number, distribution, and variety of providers of specialized services to assure that such services would be available and accessible to adults, children, infants, and persons with disabilities.

Standard health plans would be required to demonstrate that adults, children, and persons with disabilities have access to specialized treatment expertise by meeting evaluation criteria established by the Secretary.

Standard health plans may satisfy the standard contracting with and demonstrating sufficient referrals (as determined by standards set by the Secretary) of adults, children, infants, and persons with disabilities requiring specialized services to designated Centers of Excellence. For children, such specialized expertise would be in pediatrics.

The Secretary would designate Centers of Excellence in the field of institutional care that meet evaluation criteria established by the Secretary for the delivery of care for complex cases requiring specialized treatment and also meet two or more of the following requirements:

A. Provide specialized education and training through approved graduate medical education programs with multi-specialty, multi-disciplinary teaching and services in both inpatient and outpatient settings, with medical staff with faculty appointments at an affiliated medical school;

B. Attract patients from outside the center's local geographic region, from across the State or nation;

C. Either sponsor or participate in, or have medical staff who participate in, peer-reviewed research.

Evaluation criteria would be determined by the Secretary for standard health plans who choose to provide specialized services and treatments within a network setting, including requirements for staff credentials and experience, and requirements for measured outcomes in the diagnosis and treatment of patients. For children, such specialized treatment expertise would be in pediatrics.

The Secretary would develop evaluation criteria for outcomes of specialized treatment as research findings become available. The Committee intends that these evaluation criteria move away from the claims data and procedure driven measurements to disease management measures, that is, indicators of success in treating the entirety of a disease across the continuum of care. In addition to basic clinical indicators such as mortality rates and complication

rates, outcomes measurements will address such issues as patient compliance with diagnostic and therapeutic guidelines.

Participating physician program

Standard health plans would be required to establish a program under which physicians would agree to accept the plan's payment schedule as payment in full, and not to charge patients more than the coinsurance required by that plan. Each such plan would be required to make available the list of participating physicians to enrollees. Each plan would be required to have an appropriate number of physicians in each specialty as participating physicians.

Out-of-area coverage

Standard health plans would be required to provide for urgent and emergency out-of-area coverage for enrollees of the health plan.

Effective date

January 1, 1996.

STANDARDS APPLICABLE TO SUPPLEMENTAL HEALTH BENEFITS PLANS

Imposition of requirements on supplemental health benefits plans

Supplemental health benefits policies would be defined to include two types of policies: (a) supplemental services policies, and (b) cost-sharing policies. Supplemental services policies would include: (a) coverage for services and items not offered in the certified standard health plan, and (b) coverage for items in the certified standard health plan, but not covered because of limitation in amount, duration or scope. Cost-sharing policies would include those that provide coverage for out-of-pocket payments, including co-insurance, deductibles and copayments.

Standards for supplemental services plans

Health plans or insurers offering policies that supplement services in the certified standard health plan would be required to meet the following Federal standards: (a) guaranteed issue, with one annual open enrollment period of at least 30 days, except in cases where supplemental service policies are offered to employees by their employer or to individuals based on their membership in a fraternal, religious, professional, educational or other similar organization; (b) guaranteed renewal, except for nonpayment of premiums, fraud, or misrepresentation of a material fact; and (c) community rating, with rates modified by community-rating area, family size and age, as in certified standard health plans. Health plans or insurers would not be permitted to deny coverage or vary premiums for eligible persons based on health status, medical condition, claims experience, receipt of health care, or medical necessity.

By January 1, 1996, the Secretary would be required to develop (in consultation with the States) minimum standards that prohibit marketing practices by entities offering supplemental services policies that involve: (1) providing monetary incentives for, or tying, or otherwise conditioning the sale of the plan to enrollees in a certified standard plan of the entity; (2) using or disclosing to any

ina certified standard plan of the entity; (2) using or disclosing toany party information about the health status or claims experience ofparticipants in a certified standard health plan for the purpose ofmarketing a supplemental services plan; and (3) providing asupplemental services plan by a managed care plan to an individual notenrolled in such managed care plan.

Standards for cost-sharing plans

Persons are only permitted to obtain a cost-sharing policy fromthe same certified standard health plan in which they are enrolled.Health plans would only be permitted to offer cost-sharing policies topersons enrolled in their certified standard health plan. Nothingwould require a person to obtain a cost-sharing policy and nothingwould require a health plan to provide one.

Certified standard health plans offering cost-sharing policieswould be required to offer them to all individuals enrolled in theircertified standard health plan. Cost-sharing policies would beoffered during the same open enrollment period established forcertified standard health plans and supplemental services policies.Certified standard health plans would be required to provide coveragefor items and services in the cost-sharing health plan to the sameextent as provided in the certified standard health plan. Certifiedstandard health plans would be required to offer a cost-sharingpolicy at the same price to all individuals (community rating). Theprice at which the cost-sharing policy is offered would be required totake into account any increase in utilization for items and servicesin the certified standard health plan.

Prohibition on offering multiple packages to individual

A supplemental health benefits plan could not be offered to anindividual who is covered under another such plan unless theindividual's coverage under the new plan begins only after theindividual's coverage under the original plan is terminated.

Effective date

January 1, 1997 for all supplemental health plans.

STANDARDS APPLICABLE TO LONG-TERM CARE POLICIES

Definition of long-term care policies

Policies covered under this Part include any insurance policy, rider or certificate that is 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 one or more diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care hospital. Policies not covered under this Part include policies designed to provide basic Medicare supplemental coverage, basic hospital expense coverage, basic medical-surgical expense coverage, disability income or related asset protection coverage, accident-only coverage, specified disease coverage or limited health benefit coverage. Policies that accelerate death benefits and that provide the option of lump sum payments are not covered in this Part.

Regulatory oversight of long-term care policies

Participating States would be required to certify policies as meeting new Federal standards. An insurer selling a policy not certified by the State would be subject to a civil monetary penalty not to exceed 50 percent of gross premiums received from sale of the policy. States would be permitted to develop stricter standards as long as no State provision is inconsistent with Federal standards.

The Secretary of HHS, in consultation with the National Association of Insurance Commissioners (NAIC), would be required to develop model standards incorporating the requirements of this Part within one year of enactment.

Participating States would be required to develop a long-term care insurance standard regulatory and enforcement program as part of their ACEI program, which includes adoption of the NAIC model act standards, a process for individuals to file complaints about violations of the standards, consumer access to those complaints, and a premium review and approval process.

Long-term care policy marketing requirements

Insurers or agents would be prohibited from knowingly making any misleading representation, or incomplete or fraudulent comparison, of any long-term care insurance policy. They would be prohibited from using any force, fright, threat, or undue pressure, whether implicit or explicit. They also would be prohibited from employing any marketing method that fails to be explicit that the purpose of the marketing is solicitation of insurance.

The Secretary of HHS in consultation with the NAIC would be required to develop minimum financial standards for the purpose of advising potential purchasers as to the costs and amounts of coverage needed.

Insurers and agents would be prohibited from knowingly selling a long-term care insurance policy to an individual who is eligible for Medicaid.

Insurers and agents could not knowingly sell policies that duplicate coverage already held by the potential purchaser unless the purchaser provides written documentation that the new coverage did not duplicate the coverage already held or that the new policy would replace existing coverage.

Any agent who sells, or offers for sale, a policy in violation of the marketing and sales standards would be subject to a civil monetary penalty not to exceed $15,000 for each violation. An insurer or carrier that offers for sale a policy in violation of these requirements would be subject to a civil monetary penalty not to exceed $25,000 for each violation.

The Secretary in consultation with the NAIC would be required to establish standards for the training of agents who sell long-term care policies and specify procedures for the certification of agents who have completed such training.

Requirements relating to long-term care coverage under a policy

If an application for coverage is denied by an insurer, the insurer would be required to return directly to the applicant any premiums paid within 30 days of the date of denial.

If an application for coverage is accepted, the insurer shall provide the insurance policy and an outline of coverage within 30 days of coverage approval.

If a claim for coverage under a policy is denied, the insurer would be required to notify the policyholder in writing within 15 days of the reason(s) for the denial of coverage. The insurer shall make available all records related to the denial and inform the policyholder how to appeal the denial.

Reporting requirements

Insurers would be required to report annually, to the State Insurance Commissioner, information including the number and type of long-term care policies in effect and the associated premiums, the rate of premium increase for these policies, the lapse rates and replacement rates for these policies, and the number of claims denied.

Agent compensation

Agent commissions from the sale of a long-term care policy to a first-time holder of the policy would be limited to the greater of no more than 200 percent of the commission paid for renewing the policy in the second year or no more than 50 percent of the first year premium. Agent commissions or compensation would be required to be level for policy renewals over the next 5 years.

Rules for issue, renewals and cancellations

A long-term care policy could only be canceled due to nonpayment of premiums, or material misrepresentation or fraud on the part of the policyholder.

Each group long-term care insurance policy would be required to provide covered individuals with the option for continuation or conversion from a group to an individual policy that meets certain criteria. Conversions from a group policy would be required to meet certain premium pricing requirements.

Insurers and agents would be required to guarantee the issue of a policy if the individual meets the minimum medical underwriting guidelines.

The Secretary in consultation with the NAIC would be required to develop standards concerning policy rating and pricing of policy benefit upgrades.

The Secretary in consultation with the NAIC would be required to develop standards concerning policy rate stabilization.

A long-term care policy must allow for reinstatement of a policy canceled due to non-payment of premium if the policyholder is determined to be cognitively incapacitated and the policyholder acts to reinstate (with full payment of back premiums) within five months.

Use of standardized long-term care definitions and terminology

The Secretary of HHS, in consultation with the NAIC, would be required to develop standard definitions and terminology, and standard policy description formats for use in all long-term care policies.

Benefits standards

Benefits would not be permitted to be conditioned on the need for, or receipt of, any other service, nor on the medical necessity for the benefit, nor on services furnished by providers or facilities meeting conditions beyond those required by State licensure or certification.

If home health benefits are covered under a policy, the policy would not be permitted to restrict these services to those provided by registered nurses or licensed practical nurses, nor to services provided by Medicare certified agencies. Services would be required to include those of a home health aide or other home care employee under certain conditions, and would be required to provide personal care, respite, and certain other basic community-based services.

If nursing facility benefits are covered under a policy, the policy would not be permitted to restrict the type of nursing facility covered.

A per diem policy could not condition benefit payments on the receipt of specific services nor on the receipt of services from specific types of providers.

A long-term care policy would not be permitted to treat covered benefits for individuals with Alzheimer's disease, other progressive degenerative dementia, mental illness, or mental retardation differently from benefits for individuals with a functional impairment.

An insurer would be permitted to exclude or condition benefits based on a medical condition for which the policyholder received treatment or was otherwise diagnosed within 6 months before the issuance of the policy. The policy would be permitted to exclude coverage of that pre-existing condition for up to 6 months from the start of coverage under the policy.

An insurer could not deny coverage due to a pre-existing condition if the application for coverage did not request such information with resepct to such condition.

Functional assessments and appeals process

Functional assessments would be conducted by individuals or organizations not under the control of the insurer. Each insurer would provide for an independent process, meeting certain standards, for appeal of functional assessments and claims denials.

Inflation protection

Long-term care policies would be required to include inflation protection meeting minimum Federal standards unless the insurer obtains from the policyholder a written rejection of this coverage.

Non-forfeiture

Long-term care policies would be required to include mandatory non-forfeiture benefits in a form to be established by the Secretary, in consultation with the NAIC.

Effective date

States would be required to implement enforcement programs for long term care policies by April 1, 1997. States without such a program would be subject to a loss of Federal Medicaid matching payments for long-term care services.

BENEFITS AND COST-SHARING

STANDARD BENEFITS PACKAGE

General description of standard benefits packages and cost-sharing

The actuarial value of the standard benefits package would be required to be equivalent to the actuarial value of the Blue Cross/Blue Shield Standard Option (BC/BS-SO) under the Federal Employees Health Benefits (FEHB) program, adjusted for an average population, and adjusted for the particular cost-sharing schedule provided for in the package, as determined by the National Health Benefits Board established under Section 21211.

Cost-sharing arrangements could include co-payments, co-insurance, and deductible amounts for services other than clinical preventive services.

1. Cost-sharing arrangements would be specified by the National Health Benefits Board.

2. There would be at least two options for standard benefits packages. Both would have the same categories of covered services, however one would contain higher cost-sharing and/or fewer covered services. The latter is referred to as an alternative standard benefits package.

No cost-sharing schedule established by the Board may include life-time limits. The deductibles and out-of-pocket limits on cost-sharing for a year would be based upon expenses incurred for items and services furnished in the year. However, a plan may count expenses incurred in the last three months of the previous year towards the cost-sharing requirements of the current year.

Description of categories of items and services

Standard health plans would be required to offer a standardized set of covered services as specified in statute. Items and services under these categories would be furnished to standard health plan enrollees only when medically necessary or appropriate.

The definition of what is medically necessary or appropriate for an enrollee would be that the items and services are:

(1) for the treatment or diagnosis of a health condition;

(2) generally regarded as being safe and effective;

(3) indicated for the enrollee; or

(4) intended to maintain or improve the biological or psychological or functional condition of the enrollee or to prevent or mitigate an adverse health outcome or limitation in functional capacity for the enrollee. For individuals under 22 years of age, the Board would be directed to give consideration to age and health status to prevent or ameliorate the effects of a condition, illness, injury or disorder, to aid in the individual's overall physical and mental growth and development, or assist the individual in achieving or maintaining maximum functional capacity.

Categories of covered services and equipment would include:

1. Inpatient and outpatient care, including hospital and health professional services. Health professional services would be those lawfully provided by a physician or another health professional

who is legally authorized to provide such services in the State in which the services are provided.

2. Emergency services, including appropriate transport services.

3. Clinical preventive services, including services for high risk populations, and age-appropriate immunizations, tests, or clinician visits.

4. Mental illness and substance abuse services.

5. Family planning services and services for pregnant women.

6. Prescription drugs and biologicals.

7. Hospice care services.

8. Home health care services.

9. Outpatient laboratory; radiology and diagnostic services; and durable medical equipment. Nothing in this section should be construed to prevent an individual from purchasing equipment or services that are more expensive than equipment or services that are determined to be medically necessary or appropriate for that individual. The Committee intends that an individual would be allowed to purchase or rent the more expensive equipment or services by paying the difference between the cost of such equipment or services and the cost of equipment or services determined to be medically necessary or appropriate for that individual. The supplier, in turn, would bill and receive payment directly from the health plan for the cost of the medically necessary or appropriate equipment or services.

10. Outpatient rehabilitation services.

11. Vision care, hearing aids and dental care for individuals under 22 years of age.

12. Investigational treatments, including routine care, (but excluding the direct costs of an investigational drug treatment or device) provided in research trials approved by the Secretary of HHS, the Directors of the National Institutes of Health, the Commissioner of the Food and Drug Administration, the Secretary of Veterans Affairs, the Secretary of Defense, or a qualified nongovernmental research entity as defined in guidelines of the National Institutes of Health, including guidelines for National Cancer Institute-designated cancer center support grants; or a peer-reviewed and approved research program as defined by the Secretary of HHS.

Effective date

January 1, 1996.

NATIONAL HEALTH BENEFITS BOARD

A National Health Benefits Board would be established within the Department of Health and Human Services. The Board would communicate with the National Health Care Commission about issues related to benefits. The Board would consist of 7 members nominated by the President and confirmed by the Senate who would serve for six-year, staggered terms. No more than 4 members may be affiliated with the same political party. Members of the Board would be appointed not later than 90 days after enactment and would be selected on the basis of their experience and expertise in relevant subjects.

The Board, in consultation with expert groups, would be authorized to promulgate regulations to: clarify covered services and cost-sharing (to permit the existence of a variety of delivery systems), develop appropriate schedules for covered services, and refine policies regarding coverage of investigational treatments.

The Board would be directed to refine covered services by reference to standards of medical necessity or appropriateness for the enrollee. Certified standard health plans would provide coverage of the categories of services described in this section for treatment and diagnostic procedures that are medically necessary or appropriate for the enrollee.

The Board would:

(1) Develop interim coverage decisions in limited circumstances;

(2) Design the benefits package to prevent adverse risk selection;

(3) Not specify types of providers when clarifying covered services;

(4) Not specify particular procedures or treatments or classes of procedures or treatments;

(5) Give priority to the following within the constraints of the actuarial limits set in this Act:

(a) Parity for mental illness and substance abuse services with other medical services, using the standard of medical necessity or appropriateness for the enrollee, so as to ensure that arbitrary day or visit limits or cost-sharing requirements would not be applied to mental illness and substance abuse services that are not applied to medical services. Such services should encourage use of outpatient treatments to the greatest extent possible;

(b) The needs of children and vulnerable populations (including rural and underserved individuals);

(c) Improving the health of individuals through prevention. For guidance in establishing these services, the Board could consider consultation with appropriate governmental agencies, task forces and professional groups (for example, using recommendations of the Advisory Committee on Immunization Practices, the US Preventive Services Task Force, and for children, the American Academy of Pediatrics.)

There would be authorized to be appropriated to the Board such sums as may be necessary to carry out the purposes of this part.

The Board would also be authorized to issue regulations to modify the categories of covered services and cost-sharing that would go into effect unless Congress overturns the regulations by joint resolution considered under expedited procedures.

Effective Date

Board members would be named by the President within 90 days after enactment.

PROVISIONS RELATING TO ABORTION AND RELIGIOUS BELIEFS

Nothing in this title shall be construed to conflict with any constitutionally permissible regulation of abortion by a State.

Nothing in this title shall be construed to:

1. require the creation or maintenance of abortion clinics or other abortion providers within a State or any region of a State; or

2. authorize any Federal agency or State to require the creation or maintenance of abortion clinics or other abortion providers, deny certification, or any other benefit granted by this title, to a standard health plan based on the number of, or the presence or absence of, abortion clinics or other abortion providers in or affiliated with the plan.

Nothing in this title shall be construed to:

1. prevent any individual from purchasing a standard benefits package which excludes coverage of abortion services, if the individual objects to abortion on the basis of a religious belief or moral conviction;

2. prevent any employer from contributing to the purchase of a standard benefits package which excludes coverage of abortion or other services, if the employer objects to such services on the basis of a religious belief or moral conviction;

3. require any health professional or health facility to perform or assist in the performance of any health care service, if the health professional or facility objects to performing or assisting in the performance of such a service on the basis of a religious belief or moral conviction; and

4. require any commercial insurance company, Blue Cross plan, integrated health plan, or any other organization that assumes health insurance risk to offer coverage of abortion or other services, if the plan objects to covering such services on the basis of a religious belief or moral conviction.

Effective date

January 1, 1996.

EXPANDED ACCESS TO HEALTH PLANS

ACCESS THROUGH EMPLOYERS

General employer responsibilities

All employers would be required to make standard health coverage available to each of the employer's employees. Employers generally would be required to offer enrollment in one of at least 3 standard plans providing the standard benefits package. In rural areas in which the Governor has determined that there is insufficient population density to support 3 community-rated health plans, employers need only make available the plans offered in the area.

Each employer would be required to make available to each employee the consumer information published by the State pursuant to section 21013. The employer must forward the name, address, and other identifying information as the Secretary may specify to the standard plan or purchasing cooperative in which the employee is enrolling. At the request of the plan, cooperative, or employee, the employer must withhold the employee's share of premiums from the employee's wages and forward the amounts withheld to the plan or cooperative. The employer may charge a nominal proc-

essing fee (to be specified by the Secretary) for this service for employees enrolled in a plan or cooperative that is not one of the 3 or more plans made available by the employer.

These requirements would not apply with respect to seasonal and temporary employees who work for the employer less than 6 months in a calendar year, or to part-time domestic employees.

Maintenance of effort for coverage of children

Any employer that as of July 1, 1994 made contributions toward the health coverage of the children of employees (including any coverage through a family policy) is required to continue such employer contributions for children of employees enrolled in any certified standard health plan offering the standard benefits package.

Development of large employer purchasing groups

The committee provision would permit 2 or more experience-rated employers to join together to purchase insurance (but not self- insure). Each employer in such an arrangement would be responsible for meeting the employer's requirements under the bill with respect to the employer's employees. Community-rated employers could not participate in a large employer group.

Enforcement

Participating States would monitor and enforce the requirements of the bill that apply to employers that operate in the State (including multistate employers to the extent of their in-State operations). An employer that fails to comply with any requirement of the bill is subject to a civil penalty equal to not more than 25 percent of the wages of any employee adversely affected by such failure during the period of the failure.

Effective date

January 1, 1996.

ACCESS THROUGH HEALTH INSURANCE PURCHASING COOPERATIVES

FUNCTIONS OF PURCHASING COOPERATIVES

Enrollment of community rated individuals in certified standard health plans

The committee provision would permit purchasing cooperatives to offer certified standard health plans with whom they have entered into agreements only to community-rated individuals residing in or employed in the community rating area served by the purchasing cooperative. In carrying out its responsibilities, purchasing cooperatives would be required to perform necessary activities, including outreach, to actively seek the enrollment of community-rated individuals, pregnant women eligible for subsidies, and individuals who reside in medically underserved areas.

Duties of cooperatives

Purchasing cooperatives would be required to: (1) enroll community-rated individuals in certified standard health plans; (2) collect and forward premiums to certified health plans; (3) enter into agreements with certified health plans; (4) ensure that the services

of the purchasing cooperative are accessible throughout the community rating area; (5) ensure such availability by providing required information; (6) establish a process for the receipt and disposition of complaints regarding the performance of its duties; (7) coordinate activities with other purchasing cooperatives; (8) report to the State information regarding marketing, enrollment, and administrative expenses, as required by the Secretary; (9) comply with such fiduciary responsibilities as the Secretary requires; and (10) carry out other functions.

Cooperatives would be expressly prohibited from: (1) approving or enforcing provider payment rates; (2) regulating premium rates for health plans; (3) certifying or enforcing payment rates for providers; (4) assuming financial risk; (5) performing any other activities identified by a participating State as inconsistent with the performance of cooperative duties.

If a participating State finds that a purchasing cooperative is not carrying out its duties, the State would be required to notify the Board of Directors and to permit the Board an opportunity to take action to correct the deficiencies.

If, after the Board has an opportunity to correct a deficiency, a participating State would be authorized to: (1) order the cooperative to hold a new election for members of the Board; (2) take appropriate actions to assure the performance of duties; or (3) both.

A participating State would be required to develop criteria concerning the performance of duties by cooperatives.

Agreements with certified standard health plans

Purchasing cooperatives would be permitted to enter into agreements with any certified standard health plan. Purchasing cooperatives would be required to enter into an agreement with at least 3 community-rated certified standard health plans which provide the standard benefit package, including, if available, a fee-for- service plan and a health plan with a point of service option. Cooperatives would also be permitted to enter into an agreement with community-rated certified standard health plans that provided the alternative standard benefit package and with community-rated certified supplemental health benefit plans.

The Governor of a participating State would be permitted to waive the requirement that at least 3 plans be offered for rural areas if there is insufficient population density to support 3 community-rated certified standard health plans.

Agreements made with health plans would remain in effect for a 12-month period, except that cooperatives would be permitted to terminate an agreement if the certified standard health plan's certification is terminated of for other good cause.

Nothing in the section would prohibit a certified standard health plan with whom a purchasing cooperative has declined to enter into an agreement from offering a certified standard health plan to community-rated individuals in a community rating area.

Payment of premiums which an employer is required to make would be required to be made directly to the purchasing cooperative. Otherwise, individuals would make payments directly to a purchasing cooperative.

Purchasing cooperatives would be permitted to provide for reasonable penalties and grace periods for late payment.

Nothing in this section would be construed as placing upon a purchasing cooperative any risk associated with the failure of individuals and employers to make prompt payment of premiums (other than the portion of the premium representing the purchasing cooperative administrative fee).

Purchasing cooperatives would be required to forward the premiums it collects on behalf of health plans within a period of time specified by the Secretary, but not to exceed 7 days after receipt of the premium.

Provision of information

Purchasing cooperatives would be required to make available to each employer within the community rating area and each individual residing in the community rating it serves the following: (1) specified enrollment information; and (2) the opportunity to enter into an agreement with the cooperative for the purchase of a certified standard health plan. Information may also be provided as designated public access sites, including public libraries and local government offices.

Administrative fees

Purchasing cooperatives would be permitted to impose an administrative fee with respect to a community-rated individual enrolled in a certified standard health plan offered through a purchasing cooperative. The Secretary would be required to establish criteria for administrative fees charged by cooperatives.

Effective date

Upon enactment.

ORGANIZATION AND OPERATION OF PURCHASING COOPERATIVES

Establishment

Any person meeting the requirements for purchasing groups may establish a purchasing cooperative. If a not-for-profit purchasing cooperative has not been organized in a community rating area in a participating State, the State would be required to establish or sponsor, by legislation or otherwise, at least one not-for-profit cooperative in the community rating area.

Nothing in this section would be construed as requiring that there be only one purchasing cooperative serving a community rating area, or preventing a single not-for-profit corporation from being a purchasing cooperative form more than one community rating area. If a purchasing cooperative serves more than one community rating area in more than one State, the purchasing cooperative would be required to separately report to each State with respect to the residents of that State.

Insurers would be prohibited from forming or underwriting a purchasing cooperative, but would be permitted to administer a cooperative. Units of State or local governments would be permitted to form a purchasing cooperative.

Board of directors

A purchasing cooperative would be governed by a Board of Directors, which would be vested with all powers granted to purchasing cooperatives. Members of the Board would consist of individuals representing other individuals who purchase insurance through the cooperative, including employees, and individuals who represent employers who purchase coverage through a cooperative. Board members would be equally divided between those representing individual consumers and those representing employers. The following individuals would be prohibited from serving on the Board, because of conflicts of interest: (1) health care providers; (2) employees or a member of the board of directors that has a substantial ownership interest in, or derives substantial income from a health care provider, health plan, pharmaceutical company, or supplier of medical equipment, devices or services; (3) an individual who derives substantial income from the provision of health care; or (4) a member or employee of an association, law firm, or other institution representing the interests of health care providers, health plans, or others involved in health care, or an individual who practices as a professional in an area involving health care.

Compensation to members of the Board would be limited to reimbursement for reasonable and necessary expenses incurred in the performance of duties.

The Board would be required to establish a provider advisory board consisting of representatives of health care providers and professionals who provide health care items and services through certified standard health plans.

Prohibition against self-dealing and conflicts of interest

Participating States would be required to promulgate standards of conduct for any administrator, officer, trustee, fiduciary, custodian, counsel, agent or employee of any purchasing cooperative. These standards would be required to include; (1) the types of investment interest, ownership affiliations, or other employment considered improper during the tenure of an individual's service or employment with a purchasing cooperative; and (2) the circumstances that would constitute impermissible conflicts of interest or self-dealing by such employees. Such individuals would be specifically prohibited from directly or indirectly: (1) operating, representing, or being employed by, or affiliated with a health plan participating in the same community rating area; (2) using any of the information acquired through a relationship with a purchasing cooperative for purposes unrelated to the person or entity's duties with the purchasing cooperative.

Coordination among purchasing cooperatives

The State would be required to establish rules for coordination among purchasing cooperatives in cases where employers are located in one community rating area and their employees who are community-rated individuals resident in different community rating areas.

Effective Date

Enactment.

ACCESS THROUGH ASSOCIATION PLANS

QUALIFIED ASSOCIATION PLANS

Multiple Employer Welfare Arrangements (MEWAs), rural ele tric cooperative plans, and rural telephone cooperative associatic plans that are not "qualified association plans," would no longer l permitted to provide health coverage. A qualified association pla is a plan that (1) covered at least 500 participants in the Unite States on June 1, 1994, (2) has been in operation at all times a a MEWA, a rural electric cooperative plan, or a rural telephone c operative association plan during the 3-year period before enac ment of the bill, and (3) is sponsored by a bona fide organizatic that is organized and maintained for substantial purposes oth than to provide a health plan.

Existing MEWAs that were established before December 1, 19 also would be treated as qualified association plans if, as of Jur 1, 1994, the MEWA (1) covered at least 500 participants in th United States and (2) had, or had applied for, a certificate of ope ation as a health plan from the State insurance commissioner (u less the State rejects or revokes the certification for cause).

By the effective date of the bill, each sponsor of a qualified ass ciation plan (including a MEWA treated as a qualified associatic plan under the preceding paragraph) that has not made an irre ocable election to be treated as a purchasing cooperative must sa isfy the requirements of the bill that apply to certified standar health plans offering the standard benefits package. In addition, qualified association plan must satisfy solvency standards deve oped by the Secretary of Labor and must comply with reportin and disclosure rules developed by the Secretary to enable the Se retary to monitor and enforce such standards. A qualified associa tion plan may provide health coverage only to members of the ass ciation, their employees, and spouses and dependents, and th number of enrollees in the plan cannot increase by more than 1 percent each year. The provisions of parts 4 and 5 of subtitle B title I of the Employee Retirement Income Security Act of 197 (ERISA), as well as the enforcement provisions generally availabl under the bill, shall apply to association plans to the exter deemed necessary by the Secretary to enforce these requirement

A qualified association plan that has been certified by the Se retary of Labor as satisfying these standards shall be treated as plan maintained by an experience-rated employer.

Effective date

January 1, 1996.

SPECIAL RULE FOR CHURCH AND MULTIEMPLOYER PLANS

A church plan or a multiemployer plan described in this sectio and which is certified by the Secretary of Labor would be treate under the bill as a certified standard health plan maintained by single experience-rated employer.

A church plan is described in this section if it is a church pla described in section 414(e) of the Internal Revenue Code that ha at least 100 participants in the United States.

A multiemployer plan is described in this section if, as of June 1, 1994, it (1) covered at least 500 participants in the United States or (2) was maintained by one or more affiliates of the same labor organization, or one or more affiliates of labor organizations representing employees in the same industry, covering at least 500 employees in the United States.

A church plan or multiemployer plan described in this section would be certified by the Secretary of Labor if it satisfied the requirements under the bill that apply to standard health plans offering the standard benefit package and any additional solvency or other standards similar to those that apply to qualified association plans to the extent the Secretary deems necessary to ensure that benefits will be provided in full when due.

An employer bound by a collective bargaining agreement to offer an employee participation in a multiemployer plan described in this section would be exempt from the requirement that the employer make available to such employee at least 3 standard health plans.

Effective date

January 1, 1996.

IMPLEMENTATION OF CONSUMER INFORMATION PROGRAMS AND QUALITY RESEARCH

Consumer information program

To support the consumer information program established by each participating State, the Secretary, in consultation with the National Health Plan Standards and Quality Advisory Committee would do the following:

(A) Develop a set of national measures of quality performance in the categories of consumer access to services, appropriateness of health care services provided to consumers, outcomes of health care services and procedures, health promotion, prevention of diseases, disorders, and other health conditions, consumer satisfaction with care, risk assessment factors, and population health status.

(B) Determine a national standard survey design and sampling strategy.

(C) Determine a standard format for comparative value information.

(D) Determine appropriate case-mix adjustments for data comparisons.

(E) Approve interstate geographic areas for comparative value information where community rating areas cross State lines.

(F) Establish standards for the distribution of comparative value information.

(G) Provide technical assistance and training.

The Secretary, in consultation with public health experts and the Health Plan Standards and Quality Advisory Panel, would develop and define methods to measure population health status, including risk factor assessment. Results of population health status meas-

ures would become the basis for customer focused quality improvement goals and health plan standards.

Health services and quality improvement research

The Secretary would direct the Agency for Health Care Policy and Research (ACHPR) and the Health Care Financing Administration (HCFA) to conduct and support research on the effects of health care reform on health care delivery systems and methods for risk adjustment.

The Secretary would direct and Research (ACHPR) to conduct and support research on medical effectiveness including outcomes research, clinical practice guidelines, technology assessment, and dissemination and implementation techniques.

In addition to any other amounts appropriated from the Biomedical and Behavioral Research Trust Fund, there would be authorized to be appropriated $150,000,000 for fiscal year 1995, $400,000,000 for fiscal year 1996, $500,000,000 for fiscal year 1997, and $600,000,000 for each of the fiscal years 1998 through 2004.

Implementing quality improvement research

The Secretary would award grants to States or community-based, independent, not-for-profit organizations to establish demonstration projects that provide certified standard health plans with the technical assistance to implement the results of quality improvement research into medical practice.

There would be available $50,000,000 from the Health Security Trust Fund for fiscal years 1996-2004 for quality improvement demonstration projects.

Implementing quality improvement research

The Secretary would provide an annual report to Congress which reviews the results of the quality improvement demonstration projects, evaluates consumer information programs established by participating States, tracks the evolution of national performance measures and other research, and evaluates State, regional, and national trends on the quality of health care.

Effective date

Upon enactment.

PROGRAMS TO IMPROVE ACCESS TO UNDERSERVED AREAS

GRANTS FOR THE DEVELOPMENT AND OPERATION OF COMMUNITY HEALTH GROUPS AND FOR CAPITAL ASSISTANCE

Creation of trust fund account

An infrastructure development account is created within the Health Security Trust Fund to support the development of community health networks and certified community health plans, and to provide operating and capital assistance to such networks and plans. The Secretary of Health and Human Services would have available $1.3 billion annually to administer all programs funded through the account.

Designation of rural and urban underserved areas

The Secretary of Health and Human Services would be required to develop standards for identifying designated urban and rural underserved areas taking into account financial and geographic access to certified health plans; the availability, adequacy, and quality of providers and health care facilities; and the health status of an area's residents. States would have the authority to identify designated urban and rural underserved areas, subject to the approval of the Secretary. The Secretary could also designate such urban and rural areas based on the above criteria.

Community health group; certified community health plan; community health network; eligible entities; isolated rural facilities

Community health networks would be defined as organizations that provide at least some services included in the standardized benefits package either directly through their members or through affiliations with other entities. A network must ensure that services are available and accessible to each enrollee with reasonable promptness. The network would have to include two or more of the following: (1) institutions, physicians, and other providers serving a Health Professional Shortage Area (HPSA) or serving large numbers of medically underserved individuals; (2) qualified migrant and community health centers; (3) qualified homeless programs; (4) family planning providers; (5) HIV providers; (6) maternal and child health block grant recipients; (7) rural health clinics and Federally Qualified Health Centers; (8) providers of services in urban areas under Title V of the Indian Health Care Improvement Act, or providers of services under the Indian Self-Determination Act; (8) State or local public health agencies; and (9) isolated rural facilities.

A certified community health plan would be defined a public or nonprofit private health plan that provides a significant volume of services to medically underserved populations or to individuals residing in HPSAs; includes at least one of the providers listed above under the definition of a community health network; and meets all of the other criteria of a certified health plan.

Grants and contracts for development of plans and networks

The Secretary would be directed to award grants from the infrastructure development account to public and private non-profit health care organizations to assist them in becoming community health networks and certified community health plans.

Grant funds could be used to assist in recruitment and retention of health care professionals; develop information, billing, and reporting systems; link providers together (including through information systems); meet reserve requirements; and support other activities related to developing certified community health plans and community health networks.

In awarding grants, the Secretary would be directed to give priority to networks and plans that include the largest number of entities listed under the definition of a community health network, and that are serving populations with the highest degree of unmet need.

The Committee intends that one outcome of the grants to networks and plans is increased expertise in the development of reimbursement methodologies for rural based managed care.

As a condition of funding from the Secretary, grantees would be required to serve a designated urban or rural underserved area, and to serve all individuals regardless of their financial or insurance status.

Grants and contracts for operation of plans and networks

The Secretary would be required to use funds from the infrastructure development account to provide operating assistance to certified community health plans and community health networks in order to address geographic, financial, and other barriers to health care services in designated urban and rural areas. Grant funds could be used to provide consumer information and related services that will increase access to care. Grant funds could also be used for transportation, including rural and frontier emergency transportation systems, patient outreach, patient education, translation services, and other services related to the provision of health care services. As a condition of funding, grantees would be required to serve a designated urban or rural underserved area and to provide care to all individuals regardless of their financial or insurance status.

Loans, loan guarantees, and grants for capital investment

The Secretary would be directed to use funds from the infrastructure development account to provide capital assistance to community health plans, community health networks, and isolated rural facilities in designated urban and rural underserved areas. The assistance would be provided in the form of loans, loan guarantees, and direct grants.

Funds could be used for the acquisition, modernization, conversion, and expansion of facilities, and for the purchase of major equipment, including hardware for information systems. The Secretary would be required to develop criteria for restricting the use of direct grants to urgent capital needs.

At least ten percent of the funds available for capital assistance would be reserved for applicants seeking to serve designated rural areas, provided that a sufficient number of such qualified applications were approved.

The Secretary would be required to give preference to applicants who need capital assistance to: prevent or eliminate safety hazards in essential facilities; avoid noncompliance with licensure or accreditation standards; and improve the provision of essential services.

As a condition of funding for capital assistance, grantees would be required to serve a designated urban and rural area. They would also be required to serve all individuals regardless of their financial and insurance status.

Any loans made under this part would be required, subject to the Federal Credit Reform Act of 1990, to meet such terms and conditions as the Secretary determined to be necessary to protect the financial interests of the United States.

Effective date

Upon enactment.

DEMONSTRATION PROJECTS TO PROMOTE TELEMEDICINE AND OTHER USES OF THE TELECOMMUNICATIONS NETWORK IN RURAL AREAS

Demonstration projects to promote telemedicine and other uses of the network

The Secretary of HHS would be authorized to use $20 million per year from the infrastructure development account to establish a three year telemedicine demonstration program. Four projects funded under this section would be used to develop a Medicare reimbursement methodology for telemedicine services.

Health care providers located in rural areas would be eligible to receive funding under this section if they established partnerships with other community institutions to identify and implement telemedicine projects. They would be required to match Federal grants at a rate of at least twenty percent.

Grants could be used to support: the establishment and operation of a telemedicine system that provides specialty consultation to rural communities; the demonstration of the application of telemedicine for preceptorship of medical and other health professions students; the payment of transmission costs, salaries, maintenance of equipment, and compensation of specialists and referring practitioners; and facilitation of collaboration among physicians and other health care providers.

The Committee would like to encourage particularly cost-effective forms of telemedicine which may not be the most technologically advanced. The full bandwidth interactive televideo demonstrations to date have shown the potential of telemedicine, but have not dealt with two important problems; the high cost per minute of use and the lack of reimbursement potential for same, and the requirement that all parties be available at the same time (although in different locations). The Committee would like to see resolutions to these problems so that telemedicine can become integrated into the practice of medicine.

Other, lower cost technologies that can solve these problems need to be tested. For example, the use of electronic mail with predetermined information forms for specialty consultations with still digital photo attachments could be implemented at modest cost, particularly if the specialty consultants were paid for their consultation, and does not require the consultant to be available at the same time as the patient and referring physician.

Federal interagency task force

The Secretary would establish an Interagency Task Force on Rural Telemedicine. The Task Force would be required to identify effective uses of telemedicine, review and coordinate evaluations of all federally funded telemedicine demonstration projects, help rural entities to conduct local needs assessments and develop consortia, and review the Health Care Financing Administration's policy for reimbursement of telemedicine services.

Insufficient amounts in the trust fund account

Funding for programs in this subtitle is limited to the amounts available in the Infrastructure Account.

Effective date

Upon enactment.

AUTOMOBILE INSURANCE COORDINATION

Persons enrolled in public or private health plans would receive treatment for injuries or illnesses suffered in an automobile accident under the usual terms and arrangements generally applicable to the provision of such services under their health plan. Automobile insurers would be responsible for reimbursing those plans for such expenses. The automobile insurers would make payments, to the extent they are obligated to do so under the policy, on the basis of fee schedules applied by the injured person's health plan. States would be required to enforce compliance by automobile insurers with these provisions.

Effective date

Upon enactment.

REMEDIES AND ENFORCEMENT

Present law

Under current law, an insured's remedies for denial of a benefit depend on whether the person is covered through an employment-based plan or through a plan purchased directly by the person. If the plan is an employee benefit plan, whether self-insured or insured, the remedies are limited to those provided under the Employee Retirement Income Security Act of 1974 (ERISA). If the plan is purchased by the individual and is not an employee benefit plan, remedies are determined under State law.

Under ERISA, plans must provide a process for reviewing claim denials within specific time periods. If the appeal fails again within that review process, the individual may file suit in State or Federal court. The court may award the person the benefits denied, as well as attorney fees and costs, may impose statutory penalties, and may grant declaratory or injunctive relief. Under ERISA, however, the court may not impose compensatory or punitive damages.

If the plan is not an employee benefit plan, and is one that the individual purchased directly, the individual may be awarded whatever damages are available under prevailing State law.

Committee provision

Individuals would have the same remedies for a denial, reduction or termination of benefits regardless of whether their plan is an employee benefit plan or an individual one.

Each health plan would be required to provide timely notice of benefit denial, reduction or termination to enrollees. The plan would be required to establish an appeals process that includes procedures for the de novo review of an initial decision and reconsideration of the initial decision. Special procedures and time limitations would apply to emergency and urgent situations.

After the plan's appeals process has rendered a final decision, individuals would be free to choose among other remedies. These would include participating in a State-run complaint review process (with the consent of the plan), taking part in a non-binding dispute resolution program established by the State, or filing suit in State or Federal court.

Each State would be required to establish a complaint review process with complaint review offices to hear complaints and render decisions with respect to benefit or payment denial or delay. The complaint review office would operate under procedures that include the use of independent medical experts, special processes in the case of emergency and urgent situations, and formal rules of evidence. If the review officer rules that a plan had acted unreasonably in denying benefits, the officer could provide equitable relief, require provision of benefits and payment of prejudgment interest and attorney's fees, and provide other appropriate relief. Decisions of the hearing officers could be appealed to a health plan review board that each State would establish.

States would also be required to establish early resolution programs with procedures to provide an opportunity for health plan enrollees to seek resolution of their claims through mediation or other forms of alternative dispute resolution established in accordance with regulations of the Secretary.

Funds from the Health Security Trust Fund would be provided to assist States with the costs of establishing complaint review systems and early resolution programs.

If the individual does not elect to pursue the complaint review process, or if the individual pursues mediation but that process does not lead to a settlement, the individual may file suit in any court of competent jurisdiction. If the court rules that a plan had acted unreasonably in denying benefits, the court could impose remedies available in such court.

Additional provisions would provide the basis for remedies and enforcement under the Health Security Act. Civil enforcement of orders by the Secretary or the Secretary of Labor would be through the district courts of the United States. Facial Constitutional challenges to the Health Security Act would be heard on a specified time schedule by a three-judge court of the United States District Court for the District of Columbia, with direct appeal to the U.S. Supreme Court.

Effective date

Upon enactment.

Subtitle B—Coordination With Other Provisions of Law

Sec. 111. McCarran-Ferguson reform

PRESENT LAW

The McCarran-Ferguson Act (15 U.S.C. §§ 1011–15) provides that the "business of insurance" is exempt from Federal antitrust laws, provided that such business is regulated by the States and that the challenged actions do not constitute a boycott or coercion or intimidation.

COMMITTEE PROVISION

Immunity from antitrust suits under the McCarran-Ferguson Act with respect to health insurance would be repealed. This would not alter immunity with respect to other forms of insurance.

Effective date

January 1, 1996.

Sec. 112. Office of Rural Health Policy

PRESENT LAW

The Office of Rural Health was established under the Social Security Act and resides within the Public Health Service's Health Resource and Services Administration.

COMMITTEE PROVISION

The position of the Director of the Office of Rural Health would be elevated to the position of the Assistant Secretary for Rural Health.

Effective date

January 1, 1996.

Sec. 113. Amendments to Employee Retirement Income Security Act

The Committee provision would permit the Secretary of Labor to issue special reporting and disclosure rules for employer group health plans and make other conforming amendments to ERISA.

Effective date

Upon enactment.

Title II—Coverage

Sec. 201. Coverage

PRESENT LAW

No provision.

COMMITTEE PROVISION

Coverage defined

An individual has health insurance "coverage" if covered by a certified standard health plan, by the Medicare or Medicaid programs, by a health care program of the Department of Defense, Department of Veterans Affairs or Indian Health Service, by a State single-payer system (approved by the Secretary under section 21031 of the Committee bill), or by any governmental health care program for institutionalized individuals.

National health care commission

An independent National Health Care Commission would be established to monitor and respond to: (1) trends in health insurance

coverage; and (2) changes in per-capita premiums and other indicators of health care inflation.

The Commission would be composed of 7 members nominated by the President and confirmed by the Senate. The Commission members would serve 6-year, staggered terms. No more than four members of the Commission may be from the same political party. The members would be compensated at a rate provided for level IV of the Executive Schedule. One member of the Commission shall be designated as Chairman by the President.

The membership of the Commission would include individuals who have gained national recognition for their expertise in health markets and have backgrounds in such disciplines as actuarial science, demography, economics, finance and health services research.

The Commission would appoint an Executive Director and such additional officers and employees as it deems necessary to carry out its responsibilities under this act.

The Commission would be advised by individuals with expertise concerning the economic, demographic and insurance markets factors that affect the cost and availability of health insurance.

Congress is authorized to appropriate such sums as are necessary for the operation of the Commission.

Assurance of universal coverage

The Commission must report to Congress biennially on the status of health insurance coverage in the nation. The report must include the structure and performance measures of every community rating area, including the following:

1. Demographics of the uninsured, and findings on why those individuals are uninsured;
2. Structure of delivery system;
3. Number and organizational form of certified standard health plans;
4. Level of enrollment in certified standard health plans;
5. State implementation of responsibilities, including establishment of community rating areas;
6. Status of insurance reforms;
7. Development of purchasing groups and other buyer reforms;
8. Success of market and other mechanisms of controlling health expenditures and premium costs in the community rating areas and nationally;
9. Status of Medicaid eligible individuals under the Medicaid program, the integration of such individuals into coverage by certified standard health plans providing standard benefits packages, and the transition of the Medicaid program toward managed care;
10. Adequacy of subsidies for individuals;
11. Status of Medicare beneficiaries under the Medicare program, the integration of such individuals into coverage by certified standard health plans providing standard benefits packages, and the transition of Medicare toward Medicare risk contracts;

12. Coverage progress among those who are employed, including status and level of voluntary employer contributions and participation rates in purchasing cooperatives and among large employers;

13. Percentage of individuals who are enrolled in certified standard health plans, separated into categories of Medicare, Medicaid, employed individuals and individuals eligible for;

14. Recommendations, specific to each community rating area, on how the area might increase coverage among the residents and further moderate growth in premiums.

The Commission is not authorized to address issues related to defining an "employee" for tax purposes, including, but not limited to, discussing these issues with the Internal Revenue Service or the Department of the Treasury.

Coverage trigger

If 95 percent of the resident population is not covered by 2002, the Commission shall submit to the Congress, by January 1, 2002, an implementing bill which contains such statutory provisions as the Commission determines are necessary or appropriate to implement the recommendations developed under this subsection. The recommendations shall include methods to reach 95 percent coverage in community rating areas that have failed to meet that target. They must address all relevant parties, including States, employers, employees, unemployed and low income individuals, and public program beneficiaries.

In addition to any other recommendations it submits, the Commission must make separate recommendations on the following:

1. A schedule of assessments or contributions to encourage employers who are not doing so to purchase coverage for their employees;

2. A method of encouraging full coverage which does not require any assessments on or contributions from employers;

3. Possible adjustments to the actuarial value of the standard and alternative standard benefits packages; (The Commission shall inform the National Health Benefits Board of any recommendations relating to the actuarial value of these benefits packages.)

4. Possible adjustments to premium and cost-sharing subsidies; and,

5. Possible adjustments to tax treatment of benefits.

The statute establishes procedures for Congressional consideration of the National Health Care Commission report.

1. Rules for the Senate

a. The Majority Leader must introduce the Report as a bill on the first day of session following the submission of the Report and legislative language. If the Majority Leader has not introduced the bill within five days of session, any Senator may do so.

b. The bill will be referred to the appropriate Senate Committee.

c. If the Committee fails to report the legislation by July 1, 2002 (or if the Senate is not in session on this date, by the first day of session after this date), it shall be automatically discharged from

further consideration of the bill; and the bill shall be placed on the appropriate Senate calendar.

d. Within 5 session days after the bill is placed on the calendar, the Majority Leader, at a time to be determined by the Majority Leader in consultation with the Minority Leader, shall proceed to the consideration of the bill.

If on the sixth day of session, the Senate has not proceeded to consideration of the bill, then the presiding officer must automatically put the bill before the Senate for consideration.

e. 30 hours of consideration—

i. Two hours for first degree relevant amendments;

ii. One hour for each relevant second degree amendment; and

iii. 30 minutes on each debatable motion, appeal, or point of order submitted by the presiding officer to the Senate and no motion to recommit shall be in order.

f. There shall be five hours of consideration of motions and amendments appropriate to resolve the differences between the Houses, at any particular stage of the proceedings.

g. There shall be 10 hours of debate on the conference report.

2. Rules for the House of Representatives

a. The Majority Leader must introduce the Report as a bill on the first day of session following the submission of the Report and legislative language. If the Majority Leader has not introduced the bill within five days of session, any Member may do so.

b. The bill will be referred to the appropriate House Committee or Committees.

c. If the committee or committees fails to report the legislation by July 1, 2002 (or if the House is not in session on this date, by the first day of session after this date), they shall be automatically discharged from further consideration of the bill.

d. On the sixth legislative day (the day on which the House is in session) after the date on which the bill has been placed on the appropriate calendar, it shall be privileged for any Member to move that the House resolve itself into the Committee of the Whole House on the State of the Union, for the consideration of the bill, and the first reading of the bill shall be dispensed with.

e. After general debate, which shall be confined to the bill and which shall not exceed four hours, to be equally divided and controlled by the Chairman and Ranking Minority Member of the Committee or Committees to which the bill had been referred, the bill shall be considered as read for amendment under the five-minute rule. The total time for considering all amendments shall be limited to 26 hours of which the total time for debating each amendment under the five minute rule shall not exceed one hour.

f. At the conclusion of the consideration of the bill for amendment, the Committee shall rise and report the bill to the House with such amendments as may have been adopted, and the previous question shall be considered as ordered on the bill and the amendments thereto to final passage without intervening motion except one motion to recommit.

Effective date

Upon enactment.

Title III—Premium and Cost-Sharing Assistance

Sec. 301. Premium and Cost-Sharing Assistance

PRESENT LAW

No provision.

COMMITTEE PROVISION

Premium assistance for individuals and families

Eligibility

The Committee bill provides premium assistance for the purchase of health insurance according to the following criteria:

(a) Individuals and families with income that does not exceed 100 percent of poverty will be eligible for premium assistance to pay for the full cost of their health insurance premiums (subject to the qualifications described below). The premium assistance eligibility level will be phased up so that by the year 2000, all those with incomes up to 200 percent of poverty will be eligible for either a full or a partial subsidy for the purchase of health insurance.

Beginning in 1997, the amount of premium assistance for which an individual or family is eligible is phased out for those with income between 100 percent and the following percentages of poverty:

Calendar year	*Percentage of poverty*
1997	125
1998	150
1999	175
2000	200

(b) No premium assistance is payable to those entitled to a subsidy of $150 or less in 1996 (indexed to changes in the medical consumer price index for years thereafter).

(c) There is no poverty adjustment for family size above a family size of 4.

States have the option of implementing the premium assistance program beginning in January 1996. All States must implement the program in January 1997.

Resident citizens and aliens permanently residing in the U. S. under color of law are eligible for premium assistance for the purchase of a certified standard health plan. Undocumented aliens are not eligible.

The poverty level that will be used in determining eligibility is the official poverty line as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

Premium assistance amount

The maximum premium assistance amount will equal the cost of the premium for a certified standard health plan (minus the amount of any contribution made or offered to be made by the indi-

vidual's employer to the premium of the certified health plan in which the individual is enrolled), but not to exceed the weighted average premium for the individual's class of enrollment for all community-rated certified standard health plans offered in the community rating area in which the individual resides. For purposes of determining premium assistance amounts, a certified standard health plan is defined to mean a certified standard health plan that offers the standard benefits package.

Definition of income

Income is defined as adjusted gross income (as determined for purposes of paying Federal income taxes), modified to include nontaxable interest income, the portion of social security benefits that are not subject to taxation, and payments under the aid to families with dependent children (AFDC) program.

Family income will be determined on the basis of the income of an individual, an individual's spouse, and the income of any dependent children or grandchildren.

Premium assistance for AFDC recipients

Recipients of AFDC who are integrated into the reformed health care system are eligible for premium assistance on the same basis as all other eligible individuals. Individuals may file an application for premium assistance at the same time that they apply for AFDC.

Eligibility determination

The Secretary of Health and Human Services is directed to promulgate regulations specifying procedural requirements that States must follow in determining eligibility for premium assistance, which shall include regulations relating to procedures for filing of applications, verification of information, timeliness of decisionmaking, appeals of adverse decisions, and such other matters as the Secretary determines to be necessary.

Applications for assistance will be available through employers and public agencies.

The Secretary is required to develop an application form that will be simple in form and understandable to the average individual.

Eligibility will be calculated on an annual basis. An individual or family that has an approved application for premium assistance must file an end-of-year income reconciliation statement at such time as is specified in regulations. If an individual fails to file the statement, the amount of the premium assistance provided in the year will be considered an overpayment to be repaid by the individual, and the individual will not be eligible for premium assistance in the following year until the statement is filed. This provision will not apply in cases where the State finds that there is good cause for failure to file a timely statement.

States may use Federal income tax return information in verifying eligibility for assistance, subject to privacy safeguards specified in the bill.

The agency administering the premium assistance program shall pay the premium assistance to which an individual or family is entitled directly to the plan in which the individual or family is en-

rolled. An employer of an employee whose application for premium assistance has been approved must, upon request of the employee, adjust any premium amount being withheld on behalf of the employee to reflect the premium assistance for which the employee is eligible.

An individual who knowingly understates income or otherwise misrepresents material information in an application for premium assistance shall be liable to the Federal government for any excess payments made based on the understatement or misrepresentation and for interest on the excess payments, and, in addition, shall be liable to the Federal government for $2,000 or, if greater, three times the excess payments made based on the understatement or misrepresentation.

Responsibility for administration

The State shall be responsible for administration, and may designate the State agency that it deems appropriate to carry out necessary functions. The Secretary of Health and Human Services must develop standards to assure consistency among States with respect to data processing systems, application forms, and such other administrative activities as the Secretary determines necessary to promote the efficient administration of the premium assistance program. A State shall be liable to the Federal government for payments made in error.

Funds required to pay the premium assistance will be transferred to the State at such time and in such form as provided in regulations. The Secretary of Health and Human Services shall provide for regular audits. A State shall be liable for payments made in error.

The Federal government will match State administrative costs at a rate of 75 percent Federal, 25 percent State.

States have the option of providing premium assistance to those who are eligible beginning with the month of January 1996, and must provide premium assistance for months after December 1996.

Premium assistance for children and pregnant women

Children under age 18 and pregnant women in families with income that does not exceed 240 percent of poverty will be eligible for premium assistance for the purchase of health insurance premiums, beginning in January 1996.

Children and pregnant women will be eligible for premium assistance as follows:

Family income and premium assistance

185% of poverty or less—100% of premium; above 185% to 200% of poverty—80% of premium; above 200% to 215% of poverty—60% of premium; above 215% to 230% of poverty—40% of premium; above 230% to 240% of poverty—20% of premium; and above 240% of poverty—no assistance.

Provisions described above relating to premium assistance for other individuals and families also apply to the premium assistance provided for these children and pregnant women. In cases where families could qualify for both regular premium subsidies and spe-

cial subsidies for children and pregnant women, the families could choose to receive the larger subsidy.

As in the Medicaid program, pregnant women will be determined presumptively eligible for assistance.

States must provide premium assistance to children and pregnant women beginning in January 1996.

Cost-sharing assistance

Cost-sharing for those up to poverty

Individuals and families with income that does not exceed 100 percent of poverty are eligible for reduced cost-sharing at point of service, as determined by the National Health Benefits Board. Health insurance plans will absorb the cost of reduced cost-sharing.

States must begin determining eligibility for cost-sharing assistance for children and pregnant women beginning in January 1996. They may begin determining eligibility for cost-sharing assistance for other individuals and families beginning in January 1996, and must do so beginning in January 1997.

Cost-sharing for those above poverty

States will have the option of providing cost-sharing assistance for individuals and families with income between 100 percent and 200 percent of poverty. The State must pay 50 percent of the cost, and will be responsible for establishing eligibility requirements and for administration. Capped entitlement funds will be allocated to the States on the basis of State population, beginning in fiscal year 1997. Two billion dollars a year will be available for this purpose.

Effective date

As noted.

Title IV—Administrative Simplification and Privacy

Sec. 401. Administrative simplification

PRESENT LAW

The Omnibus Budget Reconciliation Act of 1993 established a Medicare and Medicaid Coverage Data Bank within the Department of Health and Human Services. The Secretary was required to establish the data bank for the purposes of identifying and collecting from third parties responsible for payment of health care items and services furnished to Medicare beneficiaries, and assisting in the collection of, or collecting amounts due from third parties liable to reimburse costs incurred by any State plan under the Medicaid program. Employers are required to report certain information to the Data Bank concerning employee health coverage on an annual basis for years beginning with calendar year 1994 and ending with calendar year 1997. The first filing is to occur on February 28, 1995.

COMMITTEE PROVISION

Medicare and Medicaid coverage data bank and related identification processes

This section delays the implementation of the Medicare and Medicaid Coverage Data Bank, effective upon enactment. The Data Bank will be repealed, effective January 1, 1996, when the new health information network provided under this section is implemented.

Health Information Network

This section amends Title XI of the Social Security Act by adding at the end a new subtitle titled: Subtitle B—Administrative Simplification.

Purpose

The Committee believes that the health care system is dependent on the rapid delivery of information and that the lack of an effective health information infrastructure is responsible for much of the administrative cost and burden on health care providers, health plans, and consumers. The key to efficient health care is the rapid and efficient exchange of standardized information. Many of the reforms proposed in this Act, such as quality monitoring and risk adjustment of insurance premiums, cannot be implemented effectively without such an infrastructure. The evolution of the practice of medicine to effectively evaluate and incorporate the latest results of medical research depends on such an infrastructure to collect standardized medical record data for outcomes research and to disseminate the results into practice. All of these outcomes result, not from collecting more or duplicative information, but from the use of this infrastructure to make better use of the information we already collect to increase the efficiency and the cost effectiveness of health care. This will bring much needed control to the increasing expenditures in the Medicare and Medicaid programs. To be effective for Medicare and Medicaid programs, however, the same systems must be available for health information under all health plans.

This subtitle enables the implementation of a health information network to reduce the burden of administrative complexity, paper work, and cost on the health care system; to provide the information on cost and quality necessary for competition in health care; and to provide information tools that allow improved fraud detection, outcomes research, and quality of care.

To implement such an infrastructure responsibly, the Committee recognizes the need for national standards for the protected disclosure of potentially sensitive, individually identifiable health information. This issue of the privacy of personal health information is covered in subtitle C.

The role of the Federal government in this endeavor is to eliminate the barriers that prevent such an infrastructure from forming by establishing standards and requirements for the electronic exchange of health information and by encouraging their integration into operational systems. This subtitle does not create a government controlled data bank, but a public/private partnership which

generates only a technology-neutral blueprint for the network, to be implemented by the private sector through multiple, independent organizations responding to market forces. These organizations will achieve a cost-effective health information network through a distributed data environment using modern information technology for storing and sharing data maintained near the point of collection. The committee expects that private enterprise will implement the health information network quickly once these standards have been adopted and will continue to evolve it under competitive pressures in a manner that best serves society.

Definitions

The 'Health Information Network' is the desired result of applying the standards and requirements of this subtitle. The term 'health information' means any information, whether oral or recorded in any form or medium, that 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 relates to the physical or mental health or condition of an individual, the provision of health care to an individual, or the payment for the provision of health care to an individual. This health information is 'protected' if it identifies an individual or if there is a reasonable basis to believe that the information can be used to identify an individual. If it is not protected under this definition, then it is 'non-identifiable health information.'

Medicare definitions are used for 'health care provider.' The definition of 'Health Information Network Services' is important to the understanding of this subtitle. These private sector entities provide information processing services to plans and providers under contract and are certified by the Secretary. These entities perform functions now performed by clearinghouses, such as converting paper forms into electronic format, storing the electronic forms, and interacting with the health information network on behalf of the providers or plans. Another function of these entities is to transmit a claim for health service to the appropriate payer without burdening the provider with the job of figuring out to whom to send the bill. A standard decision making program called 'coordination of benefits' is run on each claim to determine where to send it for processing. It is worth noting that the definition of health plans used by this subtitle include ALL sources of health care and payment for health care, including workers compensation, auto insurance, Medicaid, and Medicare. Without such complete participation, the savings to Medicare and Medicaid programs will not be realized.

For those providers or plans without the capability of meeting the requirements of this subtitle, health information network services will contract to provide the necessary support. The cost of such support will be less than the present cost of preparing, processing, and submitting claims and other administrative transactions manually. Even greater savings will accrue to those providers and plans who implement these capabilities within their own organizations. Critical to the functioning of the health information network

is the requirement that all such services cooperate and work together to implement the network.

A subset of these services, called 'Health Information Protection Organizations,' perform a new and important function, that of summarizing health information to create anonymous analytic files which can be used in health research, quality improvement programs, and government monitoring programs without disclosing the identity of the individuals involved.

A 'health researcher' is a person who conducts a biomedical, public health, epidemiological, health services, or health statistics research project or a research project on social and behavioral factors relating to health, that has been approved by an institutional review board.

The term 'standard' is applied to data elements of health information, information transactions, methods of accessing information on the network, health security cards, and any other information item or process that follows strict definitions adopted by the Secretary under this subtitle.

General requirements on secretary

The Committee believes that the most effective way to implement this health information network is to set national standards for the data elements, transactions, and procedures which form the blueprint for uniform and consistent information exchange in the health care system and encourage private enterprise to develop and implement the network accordingly.

To ensure rapid adoption by such private enterprise, the Secretary is instructed to adopt standards that are in use and generally accepted or developed or modified by the standards setting organizations accredited by the American National Standard Institute (ANSI). The ANSI standards development process includes participation by government representatives from all major health agencies as well as volunteers from major industries in the health field.

The Committee recognizes that agencies within the Department of Health and Human Services have been participating actively in standards setting through ANSI and notes that it is critical for the development of the health information network that they continue to cooperate with and participate in this public/private partnership. The Committee expects the Secretary to continue to work as a member of ANSI standards development groups to develop all standards, and future modifications to standards required under this subtitle, consistent with the policy of the Office of Management and Budget as articulated in Circular A-119. If, however, after due course, this process fails to produce standards which meet the requirements of this subtitle, the Secretary is given authority to establish the necessary standards outside the ANSI process. This authority is granted as a fallback position and it is not anticipated that it will be used. The Committee expects the Secretary to work in partnership with the private sector even if this authority should be necessary, and that significant changes would be put through a defined process of testing before being adopted. Should this fallback mechanism be required, the Secretary is directed to

report the specific circumstances of the failure of the standards setting process to Congress.

The Secretary is permitted to develop an expedited procedure to adopt health information standards that already exist. The Committee assumes that standards which have proceeded through the ANSI standards setting process have already had ample opportunity for public comment and adequate participation by other public and private organizations, and therefore do not need to be put through a lengthy administrative process by the Secretary before being adopted. If, however, the establishment of the expedited process itself would take too long, the initial standards should be adopted as quickly as possible without the expedited process.

These standards form the basis for the implementation of the health information network. Although the intent is to move the processing and transmission of medical information into a completely paperless mode, the Secretary may develop paper formats for these national standards to allow their use in special situations and during the transition.

Standards for data elements of health information

The Secretary is directed to use the above general process to adopt standards for electronically representing the content and format, in a uniform and compatible manner, of the data elements used in the financial and administrative transactions of health care, the information necessary to support evaluations of plan and provider quality, and the health information in a patient medical record.

Unique identifiers for individuals, employers, providers, and plans must also be standardized. (The term 'identifier' was selected over 'identification number' to allow the use of alphanumeric characters.) The unique identifier for an individual, called the 'personal health identifier' or PHI, is a form of the individual's SSN, scrambled by an encryption method selected by the Secretary to insure privacy, accuracy, and verifiability. The intent is to give the Secretary some flexibility with this personal health identifier. There are some privacy considerations that support a mechanism to generate the personal health identifier which would allow the calculation of the SSN from the PHI, but not the reverse; although the opposite one-way calculation has been used in some situations. The PHI should include a mechanism to make sure that one can mathematically determine that a string of characters is a valid PHI and not a random string of characters. Internal checks for character transposition and other manual data entry errors should also be incorporated. Using this standard, plans may issue cards to all individuals with social security numbers. The SSN will appear on the face of the card for identification purposes, as it now appears on most driver's licenses, but will not be used to access health information. Plans may elect to update optional, encoded information on their enrollees' cards as long as they follow the standards issued by the Secretary. The intent is that all cards be used to help identify the individual for the purpose of obtaining or paying for health care, both visually and electronically, no matter what the location of the plan or provider being contacted.

There are several viable sources of identifiers for providers, plans, employers, etc. Although the Secretary is given flexibility with the selection of appropriate identifiers, the SSN of an individual provider and the tax identification number for a corporate entity are considered to be reasonable starting points in the process.

One required standard which does not fit into the above procedures is that of a code set (also called a lexicon or vocabulary) which is a table of possible values for a data element, each entry in the table having a well defined meaning. Code sets are typically used to classify medical concepts for recording and indexing purposes. The standards for the format and transmission of coded health information can be set by the process outlined above, but the development and maintenance of the set of codes, which can be entered into the format and transmitted, is a constant process, as new health care concepts which need to be coded are constantly emerging. For this reason, code sets must be maintained by defined organizations and not through the intermittent process of standards setting. The Committee believes that development and maintenance of consistent code sets are critical for the future development of computer-based patient record systems and that the Secretary should specify them and fund them accordingly.

Code sets for various areas are now maintained by different organizations, some public and some private. In general, there is no single entity that has covered enough of the biomedical field with a high quality vocabulary for clinical and research terms, but there are a large number of excellent efforts that each cover a smaller part of the biomedical domain. The best global effort to date has been to create an "umbrella" mechanism that coordinates and cross-links the best of the specialized efforts. Under congressional funding, the National Library of Medicine (NLM), part of the National Institutes of Health (NIH), has created such a compendium or thesaurus called the Unified Medical Language System (UMLS) Metathesaurus. The Metathesaurus not only cross-links different clinical code sets, but also relates them to the language used in practice guidelines and the latest scientific literature, thus supporting links between patient record systems and other information that can improve health care decisions. Further, since no Federal or private agency coordinates current health care vocabulary efforts, it is critical that one agency be designated to serve this function and to ensure that there are efficient mechanisms for updating and distributing code sets needed by computer-based patient record systems.

In particular, the NLM should be designated by the Secretary as the agency responsible for ensuring the existence, regular maintenance, and efficient distribution of code sets suitable for all elements of computer-based patient records. This will stabilize this critical component of computer-based patient record systems and encourage their development by private enterprise. In carrying out this responsibility, the NLM should establish and be advised by a scientific Clinical Language Advisory Group, composed of experts from the private sector and relevant Federal agencies within DHHS, DOD, and the VA. The NLM may also enter into agreements with private sector groups, other Federal agencies, inter-

national organizations, or foreign governments as appropriate to achieving these objectives.

Information transaction standards

The Secretary is directed to use the general process described above to adopt standards for conducting electronically over the network the usual financial and administrative transactions of health care. Special attention is paid to developing standards for electronic coordination of benefits, because it involves several parts which must be coordinated to operate correctly. Standards for the transmission and authentication of electronic signatures are also required to cover legal requirements on transactions required by this Act as well as for prescriptions and electronic medical records.

Timetables for adoption of standards

The Secretary is expected to adopt existing standards for data elements within 9 months of enactment. The Secretary is expected to adopt additional standards that are currently under development within 2 years. Standards for the electronic medical record are complex and difficult to achieve, but are an extremely important step toward encouraging the development of these systems. The Secretary is instructed to adopt an initial set of such standards after 2 years but within 7 years.

The Committee expects that the system of standards will evolve over time to keep pace with technology and the sophistication of the health information network. On the other hand, if standards are changed too often, it becomes inefficient for network participants who must comply with each new standard. Therefore, the Secretary is instructed to review and make changes to the standards (other than code sets) no more frequently than every 6 months, after the first year. Ideally, changes should not be required any more often than annually, but the Committee felt that the Secretary needed some flexibility in this area. The intent is to limit changes which would typically require program or format changes but not to limit additions to code sets, which typically only require updates to tables to describe new or more precise concepts. Code set additions would be allowed anytime they are deemed helpful. Major structural changes in code sets would have to follow the above timetable for other standards. Modifications to code sets must include instructions on how to preserve the meaning of previously encoded information. The Secretary is permitted to conduct demonstration projects and cost analysis in evaluating the consistency of adopted standards.

Requirements with respect to certain transactions and information

All health plans, including Federal and State plans, and all health care providers are required to participate in the health information network either directly or through a contract with a certified health information network service. Providers may also get plans to satisfy the requirements on their behalf. Plans and providers are responsible for conducting claims transactions (including coordination of benefits and eventually claims attachments), or for providing encounter information in the case of providers who do

not submit claims, and for responding to authorized inquiries for information standardized under this subtitle.

In addition, plans are required to conduct transactions electronically over the health information network for enrollment; eligibility determination; claims status; payment and remittance advice; premium payments; first report of injury; and referrals, certification, and authorization. Submissions of quality information in standard formats are also required. Co-ops are required to accept electronic enrollments and premium payments.

The intent here is not to force employers or co-ops to submit enrollments or payments electronically, but to make sure that all plans and co-ops will accept electronic enrollments and premium payments from those who want to take advantage of the capability. Likewise, providers would have the option to make electronic eligibility determinations, claims status inquiries, electronic payments, and electronic referral authorizations with any plan. It is expected that when offered by all plans, the savings and convenience will quickly convince all providers to participate voluntarily.

Coordination of benefits presents a special situation which, to be effective, requires four elements. Electronic eligibility determination must be available for all enrollees in all plans, first reports of injury must be submitted by all employers when workers are injured on the job (these serve as retrospective enrollments for worker's compensation cases), a standard algorithm for determining the hierarchy of obligors for claims must be established by the Secretary and, all claims must be submitted electronically for processing against this algorithm and thus routed to appropriate payers. It is the intent of the Committee to require all four elements.

The Medicare and Medicaid Coverage Data Bank enacted by OBRA 93 is delayed and then repealed at the beginning of this subtitle. Its function is replaced through the above requirement on all health plans to ensure the electronic availability on the health information network of standardized enrollment and eligibility information on every covered individual. In addition, certified health information network access services would be capable of performing automated electronic coordination of benefits and responding to queries from health care providers and health plans, in standardized transactions as defined by the Secretary, regarding the enrollment and coverage for any individual under any health plan. The required coordination of benefits described above implements, in an automated way, the intention of the original language.

Timetables for compliance with requirements

All health care providers and plans are required to participate in the health information network within 12 months after the Secretary adopts standards for doing so. The Secretary will determine the grace period for modifications to standards in the range of 90 days to 12 months, depending on the nature and extent of the modifications and the amount of time needed to comply.

Accessing health information for authorized purposes

Plans and providers are required to make certain standard data available electronically on the health information network to authorized inquiries, such as those for research, quality evaluation,

and public health. The Secretary is directed to adopt technical standards for requests for standard health information which assure that the request is authorized under the privacy law (subtitle C) or that it is a request for health information that is not protected under the privacy law (subtitle C) because individuals cannot be identified.

Health information protection organizations are expected to provide non-identifiable health information to government agencies under standard government procurement rules. Health plans and providers are required to provide to such a health information protection organization the information necessary to respond to a government inquiry at a cost not to exceed the cost of accessing and transmitting the information. This requirement is reciprocated so that a health information protection organization that gets a government contract does not have unfair advantage over its competitors in using the information for other purposes.

Responding to access requests

The Secretary, through the general standards setting process, will adopt a mechanism for responding to requests made of the distributed database of health information made available by health care providers and health plans. These standards only apply to the access of data elements for which the Secretary has adopted standards under this subtitle. Providers and plans are required to respond in a timely manner. If the provider or plan has predetermined that they will not answer requests for information of the type being requested, they must respond in a timely manner with an explanation, in a standard form, of the specific reason for being unable to respond with the requested data. The intent here is to preserve the denominator in research and other inquiries by distinguishing between information requests that have not been received, responses that have not been sent or received, and failures to provide health information because of some considered reason.

Length of time information should be accessible

There is no practical limit on the amount of textual information that can be kept on-line. A private practitioner can preserve the complete electronic medical record in textual form for every patient in the practice on a single disk drive. Larger installations would be expected to use a hierarchical storage architecture which allows preserving older materials on-line but on slower, less expensive devices. Visual information, for example, takes much more digital storage space to preserve, so the Secretary is directed to adopt standards with respect to the length of time each type of health information should be kept accessible (on-line) through the health information network.

Timetables for adoption of standards and compliance

The Secretary is required to adopt initial standards for health information access within 9 months of enactment. Modifications are limited to once every 6 months, after the first year, and will be effective on adoption.

Standards and certification for health information network services

The Secretary is instructed to establish standards and procedures for certifying State operated or private entities called health information network services to perform the intermediary functions which implement the network. Health information trustees may not disclose protected health information to such entities if they are not certified. Certified entities are required to follow all the standards and requirements adopted by the Secretary, to coordinate their services and facilitate the health information network, to make public disclosure of measures their performance, to maintain the highest practicable security procedures for handling health information, and to have policies and procedures in place which isolate their activities and information processing to prevent access by any larger organization of which they may be part.

While the Committee was reluctant to impose a regulatory burden on these entities, it was believed to be necessary primarily to ensure that any entity that processes sensitive, individually identifiable health information meet necessary requirements to ensure that patient privacy is protected. The certification serves three additional purposes. First, certification allows a plan or provider to contract with such services with the understanding that they have been judged to possess the competence to do what they claim they can do, a judgment most providers are in no position to make. Second, such a plan or provider would not be held liable under the privacy law (subtitle C) if a certified service violated those provisions. And third, revocation of certification or conditional certification would ensure compliance, since entities which are not certified cannot have access to the health information network.

It is expected that health information network services will not typically perform all of the functions listed and that some appropriate new functions may arise over time. Certification is intended to specify exactly which functions a health information network service is certified to perform and such certified functions may be added and dropped over time.

Within 12 months of enactment, the Secretary will establish this certification procedure, but it is expected that one or more private sector groups will emerge to perform this function for a fee imposed on applicants and that the Secretary will designate them to conduct the certification. Certification would not be lost unless willful neglect or refusal to correct problems was evident. Although the entities are required to get recertified every 3 years, the Committee fully expects the Secretary to devise a certification process that imposes as little burden as practical. The process is expected to be one of providing a standard set of information on qualifications and past performance and not of site visits or inspections unless an audit is justified by complaints, evidence of poor performance, or other routine investigations.

Ensuring availability of information

When a health plan or health care provider does not have the ability to transmit standard data elements directly or does not have access to health information network services, the Secretary is instructed to help make their health information available for disclosure electronically. Since access to a health information net-

work service is not restricted by geography, the intent here is not to have the Secretary perform these functions but to establish procedures for providing assistance to the plan or provider in meeting their obligations under this subtitle. This may include technical assistance, helping the plan or provider make contact with a willing service organization, or temporary financial assistance.

General penalty for failure to comply with requirements and standards

All participants are expected to comply with standards and submissions of required transactions within a reasonable time unless specifically waived or excluded. The Secretary shall impose a penalty of not more than $1,000 for each violation of health information network standards and requirements. There is sufficient flexibility that penalties are not expected to be imposed unless willful neglect is evident. The Secretary may provide technical assistance as necessary to those unable to comply. Additional penalties are imposed for violations of the privacy law under subtitle C.

Imposition of additional requirements

Health plans and providers may not impose additional data transmission requirements or standards beyond those adopted by the Secretary unless they are mutually agreeable by all parties or a waiver is granted. The intent is to prevent haphazard requirements which add significantly to the administrative cost of doing business without a justifiable reason. The waiver procedure is intended to allow valuable additions that are justifiable. An anonymous reporting mechanism allows a party experiencing a violation of this process to file a report without being subject to retaliation.

Effect on State law

Requirements of this Act would preempt contrary or more stringent State laws, including provisions that require health records to be maintained in written, rather than electronic, form. The Secretary may exempt provisions, including those necessary to prevent fraud and abuse related to controlled substances.

Health information continuity

States are required to obtain and secure any standard data that may be abandoned by a health care provider or plan when such an entity ceases to exist or is unable to make data available as required. In cases where the information is maintained under contract by a health information network service, and that service is decertified, ceases to exist, or is unable to make such data available, the information will be transferred to another certified health information network service as designated by the Secretary.

Protection of commercial information

The Committee understands that requirements which cause disclosure of trade secrets would be anti-competitive, which is not the intent of this subtitle.

Payment for health care services or health plan premiums

This statement assures that this subtitle does not prevent individuals from paying their medical bills or premiums by credit card if they choose to do so. It is not intended to apply to other situations, such as payments to providers by plans, or premium payments to plans or co-ops from employers.

Health security cards

Through the general standards setting process, the Secretary is directed to adopt a standard format for a health security card and for the information which may be encoded on it electronically. The card must be durable with a useful life of at least 5 years, resistant to counterfeiting, able to store some information electronically, and cost-effective to produce and use in any health care location.

The electronically encoded information to be required by the Secretary will be the minimum to help identify the individual, but the Secretary may set standards for other types of information that could help with the main purpose of the card, easing access to health care and paying for it. Although the card described in this provision is technology neutral, the committee has in mind something like a credit card or driver's license. It is not in any way intended to imply the use of an expensive device with the capacity to store significant amounts of information. Since this subtitle requires every provider and every plan to be connected to an electronic network, the network should be the only source of personal or health information that may change over time for an individual.

The individual's normal SSN is required to appear on the face of the card as part of the identification information, but their health information would be stored under an encrypted form of the SSN called the "personal health identifier" or PHI. The PHI is required to be included in the information encoded electronically on the card but would not appear in human readable form on the card. Using this standard, plans will be responsible for issuing cards. Plans may elect to add their own encoded information on their enrollees' cards as long as they follow the standards issued by the Secretary. On request, plans are require to print out the encoded information on an individual's card and give them a copy.

Misuse of health security card or personal health identifier

A person who requires the display or use of the health security card for purposes other than obtaining or paying for health care or who counterfeits a health security card faces a fine of up to $25,000 and a prison term of up to 2 years. The same is true of a person who requires disclosure of or use of a personal health identifier for a purpose not authorized by the Secretary.

Direct billing for clinical laboratory services

Claims for clinical laboratory services must be submitted directly to a plan.

Authorization of appropriations

The standards setting process, which forms the critical part of Federal participation in the health information network requires continuous support. Improving the SSA enumeration system to

handle the increased demand for accuracy and speed of issue of health identifiers must be funded. The additional effort by NLM to coordinate code set development and integration will require about $20 million per year. These sums and any other sums which may be necessary to carry out the purposes of this subtitle are authorized to be appropriated.

General requirement on Secretary

The Secretary is required to rely on the work of the Health Information Advisory Committee in complying with this subtitle. Consultation with other Federal agencies involved in standards setting in the health field, such as the VA, is also required.

Health Information Advisory Committee

In carrying out her duties under this part, the Secretary will consult with an Advisory Committee consisting of 15 members from the private sector including providers, consumers, and experts with practical experience in developing and applying health information and networking standards. The members and the chair would be appointed by the President and serve staggered, 5 year terms with some initial appointments made for less than 5 years. Procedures and requirements are included for vacancies, conflicts of interest, meetings, and quorum determination.

The Committee expects members to represent different professions and geographic areas, including urban and rural areas, and have the experience, expertise, and ability to represent all elements of the healthcare industry to appropriately assist the Secretary to meet the requirements of this subtitle. Members of the committee are expected to be nominated from the following groups: national organizations representing health care providers, manufacturers of healthcare products, healthcare financial managers, medical record managers, health informatics professionals, State health departments and public health officials, health information system vendors, government healthcare programs, healthcare fiscal intermediaries, health insurance industry, the business community, healthcare coalitions, consumer groups, labor, and the elderly.

The Committee is empowered to hold hearings, take testimony, and receive evidence to allow it to function as required. It will function in a manner similar to the Prospective Payment Assessment Commission.

The Committee will submit an annual report to Congress and the Secretary detailing the status of the health information network, the savings and costs of the network, the activities of those using the network and the extent to which they are using standards to work together to meet their needs, the extent to which privacy and security protections are being met, the number and types of penalties assessed, the quality of information being received by governments, problems with implementation or timing of standards adoptions, and any legislative recommendations related to the health information network. The Committee will be funded and act until otherwise provided by law.

Grants for demonstration projects

The Secretary may make grants for demonstrations projects to promote the development and use of electronically integrated, community-based clinical information systems and computerized patient record systems. An Institute of Medicine study cautioned that "merely automating the form, content, and procedures of current patient records will perpetuate their deficiencies and will be insufficient to meet emerging user needs." It is not enough that the Secretary set standards for health information and that the private sector automate the health information using those standards. The goal of being able to build linkages of longitudinal, lifetime patient data across the continuum of care in an operational system from which, simultaneously, providers can practice, administrators can administer, and researchers can conduct research, cannot be reached without creating and testing new conceptual models. Demonstration projects will provide the laboratory setting in which process models and global data models for the computer-based patient record can be integrated with operational clinical decision support and new methods for expressing and encoding medical concepts. If these things can be integrated and used to express medical concepts and processes well enough to support the paperless practice of medicine, then the administrative and monitoring requirements will be automated with little additional cost.

The Secretary is given broad authority to determine which appropriate demonstrations to fund, concentrating not on the development of new technologies, but on the practical integration, testing, and use of existing technologies in the real-world practice of healthcare in the community.

Effective date

Upon enactment.

Sec. 402. Privacy of Health Information

PRESENT LAW

Present Federal law provides protection for the medical records held by federally funded drug and alcohol abuse treatment programs.

COMMITTEE PROVISION

Findings and purposes

The improper disclosure of personally identifiable health information can cause harm to the individual and the possibilities for improper disclosure are aggravated by increasing broad access to health information from automated data banks, particularly the federally funded health care systems, Medicare, and Medicaid. The intent of this subtitle is to protect the privacy of persons with respect to individually identifiable health information, whether oral or recorded in any form or medium.

Definitions

'Protected health information' is any information that relates to the physical or mental health of an individual, the provision of

health care to the individual, or the payment for such health care. Someone who holds such protected information is called a 'health information trustee.' Health information trustees include health care providers, health plans, life insurers, schools and universities, health oversight agencies, and employers. A health information network service that is certified by the Secretary is also a trustee, although it cannot disclose any protected health information except when acting as an agent of another trustee.

An 'institutional review board' is a board established in accordance with regulations of the Secretary in a private research institution or a government agency to review proposed research projects for the protection of human subjects.

General limitations on disclosure

The general rule is that a trustee, including officers, employees and agents of the trustee, cannot disclose protected health information unless specifically allowed by this subtitle. All health information that could reasonably be related to a specific individual would be protected from disclosure. These protections would apply, regardless of form or medium, whether kept in paper files or in electronic databases, whether retained in doctors' offices or insurance company files, or available from an information system or over a computer network.

Every disclosure of protected health information allowed by this subtitle is limited to the minimum necessary to accomplish the purpose for which the disclosure is made. The Secretary may issue regulations to implement this restriction.

All disclosed protected health information must be identified as protected and subject to this subtitle. Protected health information about an individual cannot be redisclosed or used for another purpose and cannot be used against the individual unless specifically permitted by this subtitle. The Secretary may issue regulations to protect information in which the health care provider is identified to promote the availability of health care services.

In allowing trustees to charge a reasonable fee for the disclosure and reproduction of health information, the Committee intends this to mean that the costs of labor, materials, and duplication should be paid for by the requester, but that the trustee should make no profit from this activity.

Authorizations for disclosure of protected health information

The subject of protected health information may authorize disclosure of the information under circumstances that ensure the authorization is a knowing and meaningful choice, that circumscribe the uses of the disclosure, and that allow for time limitation and revocation of permission. This means that the individual must sign an authorization form which says that they have read a separate form on which the person who will receive the protected health information has described the disclosures they intend to make, naming or describing the person who will disclose the information, the information to be disclosed, and the person who will receive the information. The authorization must specify an expiration date of 2 years or less. The authorization may be revoked or amended at any time. The limitation on authorizations requested in connection with

the provision of health care are to prevent any coercion on the part of the provider. Note that with this law, there is no longer a need for routine authorizations for health care because the normal business of health care and payment for health care is permitted without authorization.

The Secretary is required to develop model requests for authorization for disclosure and model statements of intended disclosures which are structured to serve these purposes. A copy of the authorization must be maintained as part of the information disclosed.

The Secretary is required to establish a procedure for obtaining protected health information on a deceased individual when there is no individual representative such as a next of kin.

Certified health information network services

A health information trustee may disclose protected health information to a certified health information network service acting as an agent of the trustee for any purpose permitted by this provision. The health information network service, acting as an agent of a trustee, may redisclose the information to another person, as permitted under this provision to facilitate the completion of the purpose for which the information was disclosed to the service.

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.

Disclosures for treatment and financial and administrative transactions

Disclosures of protected health information to a provider for the purpose of rendering care to the individual are not limited unless the individual has previously objected in writing. This is necessary to permit health care providers to share relevant information in the process of diagnosis and treatment. A provider or employer may disclose protected health information to a plan for the purpose of paying for, or reviewing the payment for, health care. A plan may likewise disclose such information to providers or other plans for the same purpose.

Next of kin and directory information

A provider may disclose protected health information to the next of kin, the individual's representative, or an individual with whom the individual has a close personal relationship if the individual has not objected and the information is about health care currently being provided to that individual. A provider may disclose the location and general health status of a named individual if the person has not objected. Health trustees may disclose protected health information to assist in the identification of a deceased individual.

Emergency circumstances

A trustee may disclose protected health information in an emergency to protect the health or safety of an individual from imminent harm, but the disclosure can only be make to people who need it to take action to protect the individual at risk.

Oversight

A trustee may disclose protected health information to a health oversight agency to deter, uncover, and remedy health care fraud and other abuses of the health care system. Except for an action or investigation arising out of receipt of health care or payment for health care, no information about an individual disclosed for oversight purposes can be used in an action against the individual.

Public health

A trustee may disclose protected health information to meet the requirements of public health authorities and the need for disease and injury reporting, public health surveillance, and public health investigations or interventions.

Health research

A trustee may disclose protected health information to a health researcher if the research project is judged by an appropriate institutional review board to require the information and to be of sufficient importance as to outweigh the intrusion into the privacy of the individual. If the research project requires direct contact with the individuals identified in the information, the institutional review board must also judge that the contact is necessary and that it will involve the minimum of risk to the individual. If the information is to be disclosed using the health information network, the approving review board must be one certified by the Secretary to do so. The Secretary will issue regulations for certifying such institutional review boards which have the qualifications to protect the confidentiality of research subjects. The researcher is obliged to destroy the individual identification information as soon as possible and to take appropriate precautions to keep it confidential until then.

Judicial and administrative purposes

If an individual places their physical or mental condition in issue in a judicial or administrative proceeding or undergoes a court-ordered physical or mental examination, a trustee is permitted to disclose such health information to the court.

Law enforcement

A trustee may disclose protected health information to a law enforcement agency with written certification as to the need for such information for use in an investigation of a trustee, in the identification of a victim or witness, or in an investigation of criminal activity against the trustee or on premises controlled by the trustee. The disclosed information cannot be used against the identified individual unless the action is directly related to the purpose for which the information was obtained.

Government subpoenas and warrants

A trustee may disclose protected health information in response to a government subpoena or warrant. The disclosed information cannot be used against the identified individual unless the action is directly related to the purpose for which the information was obtained.

Access procedures for law enforcement subpoenas and warrants

A government authority cannot obtain protected health information unless there is probable cause to believe that the information is relevant to a legitimate inquiry. Within 30 days of when a warrant is served, an individual must be notified of any protected health information so obtained. A copy of a subpoena must be served on the individual, together with a notice of the individual's right to challenge, 15 days before the government can obtain protected health information. The government may apply to the court for delay of notification in special cases.

Challenge procedures for law enforcement subpoenas

A protocol is specified under which an individual may challenge a government subpoena or warrant for protected health information within 15 days of notice, including the requirement that the need for the information outweighs the intrusion into the individual's privacy.

Private party subpoenas

A trustee may disclose protected health information in response to a private party subpoena.

Access procedures for private party subpoenas

A copy of a subpoena must be served on the individual, together with a notice of the individual's right to challenge, 15 days before the private party can obtain protected health information.

Challenge procedures for private party subpoenas

A protocol is specified under which an individual may challenge a private party subpoena for protected health information within 15 days of notice, including the requirement that the need for the information outweighs the intrusion into privacy.

Establishment of safeguards

The Committee expects health information trustees to take all reasonable precautions to ensure the integrity and confidentiality of protected health information. The Secretary is directed to promulgate regulations regarding the type and level of security measures trustees are expected to adopt.

Accounting for disclosures

Ideally, the Committee would prefer that every disclosure of protected health information be documented as outlined in this provision, but the additional burden of recording and storing such documentation is considered to be prohibitive. Therefore, the Committee has taken the tack of requiring all trustees to record disclosures by exception, that is, those disclosures which are not routinely part of that trustee's business. Understanding that each type of trustee has a different definition of what is routinely part of doing business, the Committee has instructed the Secretary to issue guidelines to help trustees determine the exceptional circumstances in which they are required to record disclosures.

Inspection of protected health information

Within 30 days of a written request, a health care provider or health plan must permit the subject of protected health information or their representative to inspect and get a copy of records of such information through their health care providers. The plan or provider may offer to explain or interpret these records. The plan or provider must determine the identity of previous providers or obtain previous records on behalf of the individual if requested in writing. There are specific exceptions and procedures to follow in cases of mental health treatment notes, information about others, expected endangerment to life or safety, confidential sources, or unrelated administrative information. Plans and providers may require a cost reimbursement for providing such services.

Individuals also have the right to prohibit the disclosure of sensitive and personal information so that it would not be included in the health information that providers are otherwise permitted to share

Amendment of protected health information

Within 45 days of a written request, a health care provider or health plan must respond to a request by an individual to correct or amend a record of health information by either making the correction or amendment or following a prescribed process for dealing with disagreements.

Notice of information practices

A health care provider or health plan must prepare and disseminate a notice regarding the personal rights of an individual, as described above, and the provider or plan's procedures for the exercise of those rights. The Secretary is required to develop a model for such a notice.

Standards for electronic documents and communications

Most of this legislation about privacy of health information was written assuming that the protected health information and the documents involved in disclosing it were all done in writing on paper. The intent of the Committee, however, is that as much as possible of the storage and disclosure of protected health information will be done electronically, so the Secretary is instructed to adopt and promulgate standards by which all the situations described in this may be executed totally electronically.

No liability for permissible disclosures

A disclosure permitted by this subtitle will not be cause for liability under common law.

No liability for institutional review board determinations

Review board members and their institutions will not be liable for the good faith decisions of the board.

Good faith reliance on certification

If a health information trustee legally discloses protected health information to a certified health information network service which

subsequently violates this subtitle, the originating trustee will not be held liable.

Civil penalty

A trustee who substantially fails to comply with this subtitle will be subject to a civil penalty of up to $10,000 per violation.

Civil action

An individual aggrieved by conduct in violation of this subtitle may bring civil action commencing no more than 3 years after the violation was, or should have been, discovered.

Wrongful disclosure of protected health information

Penalties for knowingly violating this subtitle range from fines of up to $50,000 and prison terms of up to one year for wrongful disclosure or obtaining of protected health information, to fines of up to $100,000 and prison terms of up to five years for violations committed under false pretenses, to fines of up to $250,000 and prison terms of up to ten years for offenses committed with intent to sell protected health information for commercial advantage or personal gain.

Relationship to other laws

This subtitle preempts State law, except for laws relating to public health or mental health or the reporting of vital statistics, abuse or neglect, or infectious diseases.

Rights of incompetents

The rights of individuals declared incompetent by a court are exercised by their representative. A health care provider may also make such a determination.

Rights of minors

All the rights of individuals under the age of 14 years of age are exercised by their parent or legal guardian. The rights of individuals of from 14 through 17 years of age may be exercised by either themselves or their parent or legal guardian. Persons 18 years of age and older, and those who have the legal right under State law to apply for and obtain medical care, shall exercise their own rights.

Effective date

Upon enactment.

Title V—Malpractice and Fraud

Subtitle A—Federal Tort Reform

Sec. 501. Federal Tort Reform

PRESENT LAW

Under current law, malpractice claims are generally resolved under State law.

COMMITTEE PROVISION

Federal malpractice reforms would preempt inconsistent State laws except to the extent such laws permitted additional defenses to malpractice actions, imposed greater limitations on attorney fees, or imposed greater restrictions on non-economic or punitive damages. The Federal malpractice provisions would govern actions in State or Federal courts but would not establish any new basis for bringing malpractice actions in Federal court.

Participating States would be required to establish alternative dispute resolution (ADR) procedures and malpractice claims could not be brought in court until the claims had gone through and reached a final resolution under the plan's procedures. After the ADR procedure was completed, either party dissatisfied with the result could contest the ADR decision in court to the extent permitted under State law. That party could bring a lawsuit to seek damages or other redress permitted under State law. If such a person receives a worse result or damages one-third below what had been awarded in the ADR proceeding, that party would be required to pay the costs and attorney fees of the other party for the court action.

Contingency fees paid to attorneys would be limited to a sliding-scale schedule, with the proportion to the attorney declining from 33 ⅓ percent of the first $150,000 to 25 percent of awards beyond $150,000.

The total amount of damages for noneconomic losses from an injury would be capped at $250,000, indexed annually by the CPI. Traditional rules of joint and several liability would be modified to limit the liability of each defendant for punitive or noneconomic damages to a proportion equal to that person's level of responsibility, to be determined by the trier of fact. Seventy-five percent of punitive damage awards would be paid to the State for licensure, certification, and other activities to improve the safety and quality of care.

The Secretary of HHS would be authorized to conduct demonstration projects on no-fault approaches to medical liability.

Effective date

Causes of action arising after January 1, 1995.

Subtitle B—Expanded Efforts to Combat Health Care Fraud and Abuse Affecting Federal Outlay Programs

PRESENT LAW

Health care anti-fraud trust fund

No provision.

Sanctions for fraud that affects Federal outlays

Title XI of the Social Security Act provides penalties for health care fraud and abuse within the Medicare and Medicaid programs. These penalties include exclusion from participation in the programs and the imposition of civil monetary penalties and criminal penalties. The Office of the Inspector General of HHS and the Attorney General are responsible for investigating and prosecuting

such violations. State agencies also provide health care fraud control programs to restrict fraud and abuse within the Medicaid program.

COMMITTEE PROVISION

Part I (secs. 511–514)—Improved enforcement and creation of health care anti-fraud trust fund

A Federal Outlay Program Fraud and Abuse Control Account would be created in the Health Security Trust Fund to contain a portion of administrative penalties and assessments imposed under the Social Security Act, civil monetary penalties imposed under this Act, and other penalties paid for related violations and actions. In any year, the account would receive the first $75,000,000 in collections plus 50 percent of any additional amounts. Amounts in the account would be available without appropriation and could be used by the Secretary and the Attorney General to cover the costs of prosecutions, investigations, audits, inspections, provider and consumer education and advisory opinions, and other activities to control fraud affecting Federal outlays. Such funds are intended to be supplementary to appropriated operating budgets of the agencies. The Secretary and Attorney General would submit an annual report to Congress on the revenue generated and disbursed by the account. The Inspector General would be authorized to retain and use any funds paid to reimburse for the costs of conducting investigations. An "HHS Office of Inspector General Asset Forfeiture Proceeds Fund," to be administered by and continually available to the Inspector General for investigations, would be established in the Treasury. Funds transferred from the Department of Justice from forfeitures would be deposited in the fund. A program of rewards for information leading to prosecution and conviction of a person for a Federal health care offense would be established.

Part II (sec. 521–523)—Civil penalties and rights of action

The Secretary of Health and Human Services and the Attorney General would be required to establish a joint program to coordinate efforts and take actions to control fraud and abuse affecting Federal outlay programs.

The Secretary of HHS would be authorized to impose civil monetary penalties for actions affecting Federal outlays, including ones that are similar to those that would subject a person to a penalty under specific provisions of section 1128A of the Social Security Act. The Secretary would generally follow procedures and provide for appeals as would be required for similar proceedings under section 1128A of the Social Security Act, or the State in which the plan is located could initiate such a proceeding.

The Secretary of HHS would be required to exclude from participation in a health plan for not less than five years an individual or entity convicted of violations described in section 1128(a) of the Social Security Act, as amended to include actions affecting Federal outlays under this Act. The Secretary would be authorized to exclude from participation in a health plan for periods of different duration an individual or entity convicted of violations described in specified subsections of section 1128(b) of the Social Security Act,

as amended. The Secretary would be required to provide notice of exclusions to health plans, State health care administrative agencies, and State licensing agencies. Provision would be made for providing notice, hearings, and judicial review of exclusions.

Part III (secs. 531–541)—Additional amendments

A number of related amendments to conform and strengthen the anti-fraud and abuse provisions under the Social Security Act would also be made. A "health care offense" would be defined as a violation of specified sections of title 18 of the United States Code, of the Social Security Act, of ERISA, and of the Food Drug and Cosmetic Act, including certain sections as amended in the Health Security Act. Title 18 of the United States Code would be amended to define health care fraud and other offenses related to health care. Section 3729 of title 31 of the United States Code would be amended to provide that false claims for payments by health plans shall be considered false claims subject to the provisions of the False Claims Act.

Effective date

January 1, 1996.

Title VI—Medicare, Medical Education, and Medicaid

Subtitle A—Medicare

PART I—RISK CONTRACTING ENTITIES

Sec. 601. Improvements in risk contracts

PRESENT LAW

Approximately 5 percent of beneficiaries are enrolled in health maintenance organizations (HMOs) under risk contracts with Medicare. In order to enter into Medicare risk contracts, health plans are required to meet standards established in Section 1876 of the Social Security Act. Included among those standards is a requirement that a health plan be a federally qualified health maintenance organization or provide members with at least the following health care services: physicians' services, inpatient hospital services, laboratory, X-ray, emergency and preventive services, and out-of-area coverage. Under risk contracts, Medicare pays HMOs 95 percent of the estimated amount it would have cost to provide Medicare benefits to demographically comparable beneficiaries in the same county who had not enrolled in an HMO. The payment amount is the average adjusted per capita cost (AAPCC).

COMMITTEE PROVISION

Standards for contracts

Certified standard health plans, as defined in Sec. 21004 of the Social Security Act, would be permitted to enter into Medicare risk and cost contracts if they meet revised standards established in Sec. 1876 of the Social Security Act. The requirement that plans be federally qualified health maintenance organizations would be repealed. The existing requirement that a plan have at least 5,000

enrollees would be retained, as would the Secretary's authority to enter into contracts with a plan serving fewer enrollees if the plan primarily serves members residing outside of urbanized areas (found in current Section 1876(g)(1)).

The existing standards for entering into a cost-based contract (found in current Section 1876(h)) would be retained.

Individuals eligible to enroll

All Medicare beneficiaries entitled to benefits under Part A and enrolled in Part B would be eligible to participate in a risk or cost contract with a certified health plan that serves the area in which the individual resides. Employer-based plans would be permitted to restrict enrollment to certain classes of individuals designated by the Secretary in regulations. Medicare beneficiaries with end stage renal disease would be permitted to enroll in a certified standard health plan with a risk or cost contract.

Enrollment

Eligible individuals would be permitted to enroll with a certified standard health plan that has a contract under Section 1876 as provided for in regulations (including enrollment through a third party). Individuals would be permitted to terminate enrollment during an annual enrollment period specified by the Secretary, if the individual moves from the plan's service area, or if other special circumstances exist, as prescribed by the Secretary.

Requirements regarding marketing and enrollment

The existing provisions regarding marketing and enrollment (found in current Section 1876(c)(3)(C)) would be retained. The Secretary would also be required to develop and distribute comparative materials regarding all certified standard health plans to individuals eligible to enroll in a contract under Section 1876.

Sources of payment from Medicare trust funds

The existing provisions regarding sources of payments to health plans with contracts under this section (found in current Section 1876(a)(5)) would be retained.

Payment rules under risk contracts

Certified standard health plans entering into Medicare risk contracts would receive a payment for each enrolled Medicare beneficiary for each month of enrollment equal to the average Medicare per capita rate for the plan's service area, adjusted by the rate factor determined for each class of individual. The Secretary would be required to define appropriate classes of individuals, based on age, disability status, and other factors the Secretary determines to be appropriate. The Secretary would also be required to determine rate factors for each class of individuals to reflect differences in the average per capita spending for benefits under Medicare Parts A and B. The Secretary would be required to announce the rate factors to interested parties (in a manner designed to provide notice to interested parties) not later than July 1 before the calendar year concerned.

Budget neutrality

The Secretary would be required to proportionately reduce the amount of payments for risk contracts by an the Secretary determines necessary to assure that payments do not exceed those that would otherwise have been paid if Section 601 of the Health Security Act had not been enacted. In making such adjustments, the committee intends that the Secretary take into account for costs in a service area as compared to national costs.

Determination of average Medicare per capita rate

The Secretary would be required to annually determine the average Medicare per capita rate and announce this rate for each service area by October 1 before the calendar year involved. The monthly average Medicare per capita rate for a service area would be equal to the sum of the plan component and the fee-for-service component.

The plan component is defined as the sum of the following amounts for each certified standard health plan: the amount of the uniform monthly premium submitted by the plan to the Secretary, adjusted by a factor the Secretary determines necessary to normalize the difference in the distribution of individuals projected to be enrolled in that certified standard health plan among the various classes of individuals compared with the national distribution of all classes of Medicare beneficiaries multiplied by a fraction (expressed as a percentage). The numerator of the fraction is the number of all individuals enrolled in the plan (projected by the plan, using either historical experience or some other methodology developed by the Secretary). The denominator is the number of all Medicare eligible individuals in the service area.

The fee-for-service component is defined as the projected average monthly per capita fee-for-service costs for the service area for Medicare beneficiaries not enrolled in certified standard health plans with contracts under Section 1876, adjusted by a factor the Secretary determines necessary to normalize the difference in the distribution of individuals projected to be enrolled in that certified standard health plan among the various classes of individuals compared with the national distribution of all classes of Medicare beneficiaries, multiplied by a fraction (expressed as a percentage). The numerator of the fraction is equal to the number of all Medicare eligible individuals in the service area minus the number of individuals who are enrolled in certified standard health plans with Medicare risk contracts. The denominator is equal to the number of all Medicare eligible individuals in the service area.

Projected average monthly per capita fee-for-service costs are defined as the amount (prorated to be expressed as a monthly amount) that the Secretary prospectively estimates would be payable for services covered under Parts A and B and other expenses (including administrative expenses) if the services were provided by other than a certified standard health plan with a Medicare risk contract.

The Secretary would be required to base these estimates on actual experience of the service area. However, if the Secretary determines that the data in the service area are inadequate to make an accurate estimate, the Secretary would be authorized to use the ac-

tual experience of a similar area, with appropriate adjustments to assure actuarial equivalence, including adjustments for demographics, health status, and the presence of specific medical conditions.

Uniform monthly premiums and premiums for additional services

Each certified standard plan with a Medicare risk contract would be required to submit a bid to the Secretary for the next calendar year for each service area for which the plan has a risk contract. The bid would be required to include the following: (1) the monthly premium amount the plan intends to charge for Medicare beneficiaries enrolled in the plan and a projection of the plan's enrollment by class of individual; (2) the premium amount the plan intends to charge for each class of individuals for the mandatory additional services (described below); and (3) the premium amount the plan intends to charge for each package of additional health care services offered by the plan.

At least 45 days before the date for submitting bids, the Secretary would be required to provide for notice to certified standard health plans with risk contracts of proposed changes in the methodology or benefits coverage assumptions. The Secretary would also be required to provide plans with an opportunity to comment on the proposed changes.

Payment rules for risk contracts

Each certified standard health plan with a Medicare risk contract would be required to charge individuals enrolled in the plan, for the duration of the individual's enrollment, a fixed monthly premium equal to the uniform monthly premium amount and the premium amount for the additional mandatory services. An enrolled individual would be responsible for paying the plan the difference between the fixed monthly premium amount and the average Medicare per capita payment made to the plan.

The Secretary would be required to make monthly payments in advance equal to the average Medicare per capita payment on behalf of each enrollee. This payment amount may be retroactively adjusted to take into account the difference between the actual number of individuals enrolled in the plan and the number of individuals estimated to be enrolled at the time the amount of the advance payment was estimated.

The Secretary would also be authorized to make retroactive adjustments to take into account individuals enrolled in a health plan operated, sponsored or contributed to by an individual's employer, former employer (or the employer or former employer of the individual's spouse.

Rebates or contributions to supplemental health services

If the average Medicare per capita rate paid to a health plan exceeds the fixed monthly premium charged by the plan, the plan would be required to either pay the excess amount to the individual in the form of a rebate or contribute the excess to the premium charged for additional health care services elected by the plan. The determination of whether to receive a rebate or a contribution to a supplemental health premium would be made by the plan. The

committee intends that information about rebates or contributions to supplemental health plans be supplied to Medicare beneficiaries in written marketing materials so that the Secretary would have an opportunity to review the materials. The committee further intends that rebates given to individuals be treated as non-taxable income.

Payment rules for cost contracts

The existing payment rules for cost contracts (found in current Section 1876(h)) would remain unchanged.

Coverage of benefits under risk contracts

Certified standard health plans with Medicare risk contracts would be required to provide enrolled Medicare beneficiaries with services covered under Medicare Parts A and B for the uniform monthly premium amount. They would also be required to provide Medicare beneficiaries with three additional mandatory services: (1) preventive health services as defined by the Secretary; (2) unlimited inpatient hospitalization; and (3) waiver of the current Medicare rule which stipulates that Medicare beneficiaries have an inpatient hospital stay of 3 days before becoming eligible for post-hospital extended care services under Section 1861(i). Plans would be required to charge a separate premium for these services. Plans would be permitted to offer Medicare beneficiaries additional services for another separate, additional premium.

The existing rules regarding the provision of medically necessary care (found in current Section 1876(c)(3)(4) (A) and (B)) remain unchanged.

Exception for national coverage decisions

The existing provision excluding the effects of a national coverage decision on rates for the year in which the coverage decision is made (found in current Section 1876(c)(2)(B)) remains unchanged.

Cost-sharing requirements

Each certified standard health plan with Medicare enrolled individuals would be required to establish cost-sharing requirements for Medicare beneficiaries that are not greater than the cost-sharing requirements established for non-Medicare individuals enrolled in the plan.

Enrollment periods

The existing provisions regarding enrollment periods (found in current Section 1876(c)) would remain unchanged. A coordinated open enrollment period would be authorized under Section 655 of the Health Security Act.

Modification of the 50/50 rule

Each certified standard plan with a contract under Section 1876 would be required to have an enrolled membership, 50 percent of which does not consist of Medicare or Medicaid enrollees. The Secretary would be permitted to modify or waive this requirement if the plan demonstrates that it provides for an adequate quality of

care for beneficiaries by (1) meeting the quality standard for certified standard health plans imposed by the Health Security Act; (2) meeting the fiscal soundness requirements under Title XIII of the Public Health Service Act and any such requirements necessary to remain a certified standard health plan for at least the 3 years immediately preceding an application for a waiver under this section; (3) demonstrating successful operational experience as a certified standard health plan with a Medicare contract under Section 1876 for at least the 3 years immediately preceding an application for a waiver under Section 1876; (4) demonstrating that the number of individuals enrolled in the plan is at least 50,000 at the time of application for a waiver.

The Secretary would be permitted to accept quality performance standards measured by private organizations acceptable to the Secretary or organizations designated by the Secretary, including peer review organizations.

The Secretary's existing authority to suspend enrollment of Medicare beneficiaries in a plan (found in current Section 1876(f)(3)) would be retained. The Secretary would be permitted to terminate the 50/50 requirement when the Secretary has determined that certified standard health plans have established alternative quality assurance mechanisms that effectively provide sufficient quality safeguards.

Prompt payment requirement

The existing requirement that health plans provide for prompt payment of claims (found in current Section 1876(g)(6)(A)) would be retained, as would the existing provision permitting the Secretary to provide for direct payment of claim in such cases (found in current Section 1876(g)(6)(B).

Duration and termination of contracts; effective dates and terms of contracts; powers and duties of the Secretary; and remedies

The existing provisions regarding duration and termination of contracts; effective dates and terms of contracts; powers and duties of the Secretary; and remedies (found in current Section 1876(i)(1) through (6) would be retained. Additional remedies available under Subtitle H of Title I of the Health Security Act would also be available to Medicare beneficiaries enrolled in Medicare risk or cost contracts.

Agreement with utilization and quality control peer review organizations

The existing requirement that health plans with contracts under Section 1876 enter into contracts with a utilization and quality control peer review organization (found in current Section 1876(i)(7)) would be retained.

Grievance procedures and appeals

The existing provisions regarding beneficiary grievances and appeals (found in current Section 1876(c)(5)) would be retained.

Advance directives

The existing requirement that plans provide Medicare beneficiaries with information regarding advance directives (found in current Section 1876(c)(8)) would be retained.

Special requirement regarding certain hospitals

The existing requirement regarding payments by a health plan with a contract under Section 1876 on behalf of an enrolled individual receiving services from a hospital defined in Section 1886(d)(1)(B) of the Social Security Act (found in current Section 1876(c)(7)) would be retained.

Limit on charges for certain services

The existing provision limiting certain charges for services rendered to Medicare beneficiaries enrolled in contracts under Section 1876 (found in current Section 1876(j)) would be retained.

Study on certified standard health plans with risk contracts

The Prospective Payment Assessment Commission and the Physician Payment Review Commission would each be required to study and make recommendations to Congress on the following: (1) ways in which enrollment in certified standard health plans with Medicare risk contracts could be increased; (2) alternatives to the current payment methodology that might encourage more organizations and beneficiaries to enroll in certified standard health plans with Medicare risk contracts; (3) whether the demographic characteristics and health status of beneficiaries enrolled in certified standard health plans with Medicare risk contracts differs from other individuals entitled to benefits under Medicare Part A and enrolled in Part B; and (4) whether the volume and quality of care rendered to Medicare beneficiaries enrolled in risk contracts with certified standard health plans differs from that rendered to other individuals entitled to benefits under Medicare Part A and enrolled in Part B.

Effective date

January 1, 1996.

PART II—PROVISIONS RELATED TO PART A

Sec. 611. Inpatient hospital services update for PPS hospitals

PRESENT LAW

Under the prospective payment system, there are different standardized amounts for hospitals located in large urban (metropolitan statistical areas with a population over 1 million or 970,000 in New England), "other urban" areas, and rural areas. Different update factors apply to the urban and rural standardized amounts. Medicare dependent and sole community hospitals are paid based on the higher of the applicable standardized amount or a hospital-specific rate updated annually. The update factors are based on the projected increase in the hospital market basket, an index that measures changes in the prices of goods and services purchased by hospitals. The update factors are as follows:

Fiscal year 1995: For urban hospitals, the estimated percentage increase in the hospital market basket minus 2.5 percentage points; for rural hospitals, the amount necessary to equalize the rural and "other urban" standardized amounts. The update factors for the hospital-specific rates applicable to a sole community hospital or a Medicare-dependent, small rural hospital are set equal to the percentage increase in the hospital market basket minus 2.2 percentage points.

Fiscal year 1996: For all hospitals, the percentage increase in the hospital market basket minus 2.0 percentage points.

Fiscal year 1997: For all hospitals, the percentage increase in the hospital market basket minus .5 percentage points.

For fiscal years 1998 and thereafter, the update factor for all hospitals is set equal to the percentage increase in the hospital market basket.

COMMITTEE PROVISION

For fiscal years 1997 through 2000, the update factor for all hospitals (urban, rural, sole community, and Medicare-dependent) would be set equal to the percentage increase in the hospital market basket minus 2.0 percentage points.

Effective date

Upon enactment.

Sec. 612. Reduction in Payments for Capital-Related Costs for Inpatient Hospital Services

PRESENT LAW

Medicare pays hospitals for inpatient capital expenses under a prospective payment system. During a ten-year transition that began in fiscal year 1992, hospitals are paid based on a blend of Federal rates and hospital-specific capital rates. The initial Federal rate was computed based on unaudited 1989 cost-report data, trended forward to 1992. The hospital-specific rates were based on data from the hospital's 1990 cost report, trended forward to 1992. The Federal and hospital-specific rates are updated annually for inflation.

The Omnibus Budget Reconciliation Act of 1993 reduced the Federal capital rate by 7.4 percent to correct errors in the inflation forecasts used to establish the Federal rates.

Hospitals excluded from the prospective payment system (psychiatric, rehabilitation, children's, cancer, and long-term hospitals and psychiatric and rehabilitation distinct part units) are paid on a reasonable cost basis for the capital-related costs of inpatient services.

COMMITTEE PROVISION

Adjustments would be made to the Federal and hospital-specific capital payment rates. For discharges occurring after September 30, 1995 the Secretary would reduce by 7.31 percent the unadjusted standard Federal capital rate in effect as of the date of enactment, and would reduce by 10.4 percent the unadjusted hospital specific rate in effect on that date.

Payment for capital-related costs shall be reduced by 15 percent for cost reporting periods occurring during each of fiscal years 1996 through 2003.

Effective date

Effective for discharges occurring on or after October 1, 1995.

Sec. 613. Reductions in Disproportionate Share Payments

PRESENT LAW

Under the prospective payment system, Medicare provides additional payments to hospitals serving a disproportionate share of low-income patients. The adjustment amount is determined using formulas based on the disproportionate share patient percentage. The disproportionate share patient percentage is defined as the sum of the percentage of total patient days that are attributed to non-Medicare-eligible Medicaid beneficiaries and the percentage of Medicare patient days that are attributed to Medicare beneficiaries that are also eligible for Supplemental Security Income benefits. Separate formulas are provided for various categories of urban and rural hospitals.

COMMITTEE PROVISION

The Secretary would be required to reduce payments that would otherwise be made under the disproportionate share adjustment by 25 percent.

The Secretary and the Prospective Payment Assessment Commission would submit to the Congress by July 1, 1996 a recommendation for a methodology to measure and allocate funds for hospitals that receive a Medicare disproportionate share payment.

Effective date

Effective for discharges occurring on or after October 1, 1997.

Sec. 614. Revised payment methodology for rehabilitation and long-term care hospitals

PRESENT LAW

Hospitals excluded from the prospective payment system (psychiatric, rehabilitation, children's, cancer, and long-term hospitals and psychiatric and rehabilitation distinct part units) are paid on a reasonable cost basis subject to a rate of increase limit on operating costs per discharge. The per discharge limit, or target amount, is updated annually.

COMMITTEE PROVISION

Rehabilitation hospitals and distinct part units would be assigned their 1990 and 1991 Medicare cost reporting periods as a new base year. Limits for subsequent periods would be determined based on per-discharge Medicare operating cost averaged over the two year period. The rebasing would:

Hold harmless those hospitals and units under their limits by paying them their costs plus incentive payments.

Provide a floor of 70% of the national average for each type of facility for those facilities with very low limits.

Provide a ceiling of 110% of the national average for each type of facility for new facilities.

The Secretary would be required to complete development of a prospective payment system for rehabilitation hospitals and distinct part units, including a patient classification system, and present recommendations to Congress by October 1, 1996.

Conditions for exclusion of rehabilitation hospitals and distinct part units from the PPS would be expanded to account for the impact of new technologies and survival rates and the changes in the practice of rehabilitation medicine over the past decade.

Any Long Term Hospital meeting a two year financial loss test and a low-income patient load test, would be assigned an average of their 1990 and 1991 Medicare cost reporting periods as a new base year. In any subsequent two-year period in which both tests were met, the Secretary would be required to assign the hospital a new base year averaging the costs of the two years. A hospital meets the financial loss test if it has had two consecutive years of losses where its costs exceed its limit. A hospital satisfies the low-income patient load test if it has a Medicare disproportionate share patient percentage of greater than 25 percent.

Effective date

October 1, 1994

Sec. 615. Moratorium on designation of new long-term hospitals

PRESENT LAW

Long-term hospitals excluded from the prospective payment system are paid on a reasonable cost basis subject to a rate of increase limit on operating costs per discharge.

COMMITTEE PROVISION

Hospitals with an average inpatient length of stay of greater than 25 days would not be treated as a long term hospital unless the hospital held this status as of the date of the enactment of the Health Security Act.

Effective date

October 1, 1994

Sec. 616. Extension of freeze on updates to routine service costs for skilled nursing facilities

PRESENT LAW

Medicare payment for skilled nursing facility services is made on a reasonable cost basis subject to a limit on routine costs per diem. The limit is based on 112 percent of the mean per diem routine service costs for freestanding facilities. There is an add-on to the limit for hospital-based facilities equal to 50 percent of the difference between 112 percent of the mean per diem routine costs for freestanding facilities and 112 percent of the mean per diem routine costs for hospital-based facilities. OBRA 1993 prohibited the

Secretary from applying an update factor to the cost limits for skilled nursing facility cost reporting periods beginning in fiscal years 1994 and 1995.

COMMITTEE PROVISION

The Secretary would limit to 100 percent (or the amount necessary to preserve the effects of the OBRA '93 freeze on updates) the upper limit on payment for reasonable routine service costs for services in skilled nursing facilities.

Effective date

This provision is effective on October 1, 1995.

Sec. 617. Payments for sole community hospitals with teaching programs and multi-hospital campuses.

PRESENT LAW

The Secretary is required to determine DRG specific rates for hospitals in different areas. Requirements to reimburse multi-campus facilities based on the location of the discharge applies only to hospitals not exempt from PPS and to hospitals reimbursed on the basis of DRGS and not to hospitals reimbursed on a cost basis.

COMMITTEE PROVISION

The Secretary would establish separate rates of payment for each facility of a sole community hospital with multi-hospital campuses when at least one of the hospitals of the multi-hospital campus is eligible to receive indirect medical education payments.

Effective date

Effective date is October 1, 1993 for hospitals that merged after October 1, 1987.

Sec. 618. Medicare Dependent, Small Rural Hospitals

PRESENT LAW

To quality for Medicare Dependent Hospital (MDH) status, a hospital must be located in a rural area, have no more than 100 beds, and gave had at least 60 percent of its inpatient days or discharges attributed to Medicare patients during the cost reporting period beginning during fiscal year 1987. MDHs are eligible for payment under the same rules as sole community hospitals for cost reporting periods beginning on or after April 1, 1990 and ending before April 1, 1993. For discharges occurring during any cost reporting period beginning on or after April 1, 1993, through September 30, 1994, and MDH would receive 50 percent of the difference between their payment under the existing MDH rules and the payment regularly provided under the prospective payment system.

COMMITTEE PROVISION

A technical correction to clarify that payment amounts are determined by using a 36 month cost reporting period. The target

amount definitions needed to make the calculations for MDHs would be extended to September 30, 1998.

MDHs would receive 50 percent of the difference between their payment under the current MDH rules and the payment regularly provided under the prospective payment system through September 30, 1998.

Effective date

Effective beginning with discharges occurring on or after October 1, 1994.

Sec. 619. Provisions Related to the Rural Health Transition Grant Program

PRESENT LAW

OBRA 87 instituted a program of grants to assist rural hospitals with fewer that 100 beds in developing and implementing projects to modify the type and extent of services they provide. Grants may be used to develop health systems with other providers, diversify services, recruit physicians, improve management systems, and provide instruction and consultation via telecommunications to physicians in manpower shortage areas. The program is authorized at $25 million per year for fiscal years 1990 through 1992.

COMMITTEE PROVISION

Appropriations for the rural health transition grant program would be authorized at $30 million per year for fiscal years 1993 through 1997. Rural primary care hospitals would be eligible for grants.

Effective date

Effective upon the date of enactment.

Sec. 620. Limited Service Hospital Program

PRESENT LAW

Under the Essential Access Community Hospitals/Rural Primary Care Hospital (EACH/RPCH) program, up to 7 States may be designated by the Secretary to receive grants to develop rural health networks consisting of EACHs and RPCHs.

The Medical Assistance Facility (MAF) program currently operates a demonstration project in Montana that exempts small rural hospitals from certain licensure laws, expands the role of mid-level practitioners and improves Medicare payment.

There is no provision for limited service hospital programs or for rural emergency medical services programs.

COMMITTEE PROVISION

The Secretary would be required to establish a limited service hospital program to coordinate rural hospital payment methodologies and delivery systems, including MAF, EACH/RPCH, and rural emergency medical services. The goals of the Limited Service Hospital Program are to:

Make available alternative hospital models to small rural or isolated rural communities in which facilities are relieved of the burden of selected regulatory requirements by limiting the scope of inpatient acute services offered.

Alter Medicare reimbursement policy to support the financial viability of alternative facilities by limiting the financial risk faced by such small hospitals through the use of reasonable cost reimbursement.

Promote linkages between facilities designated by the State and broader programs supporting the development of and transition to integrated provider networks in rural areas.

The Rural Primary Care Hospital (RPCH) component of the Limited Service Hospital program would be extended to all States. The existing criteria for designation of a RPCH remain except the requirement that RPCHs not have a length of stay exceeding 72 hours would be changed to allow an average length of stay not exceeding 96 hours, and the requirement that RPCHs not have more than 6 inpatient beds would be changed to allow 15 inpatient beds for providing acute inpatient care (including swing beds).

The requirement that hospitals be designated as EACHs would be discontinued. RPCHs, however, would be required to establish linkages with other providers through rural health networks. The requirement that the Secretary develop a prospective payment system for RPCHs would be repealed. Instead, RPCHs would be reimbursed using the MAF reimbursement methodology, including costs of contracts for services with other providers in a rural health network. Hospitals currently certified as EACHs would be permitted to retain Sole Community Hospital status.

The MAF demonstration program would be made a permanent component of the Limited Service Hospital Program, and all States would be permitted to participate. Criteria for designation as a MAF would parallel those for an RPCH except for the following:

(A) The location criteria would be that a MAF is located in a county with fewer than 6 residents per square mile or is in a rural area that is located more than a 35 mile or 45 minute drive from a hospital, MAF or RPCH.

(B) A MAF would not have to be an existing hospital.

(C) A MAF would not have to be part of a rural health network.

(D) A MAF would not have a bed size limitation.

(E) The only criteria of a rural health clinic that a MAF would have to meet is for appropriate procedures for review of utilization of clinic services.

A rural emergency medical services program would be established to improve emergency medical services (EMS) operating in rural and frontier communities.

There would be authorized to be appropriated from the Federal Hospital Insurance Trust Fund for the purpose of making grants to States under the Limited Service Hospital Program:

(A) $15,000,000 for States that have established a RPCH program for each of fiscal years 1993 through 1995.

(B) $25,000,000 for all States who qualify for grants under the Limited Service Hospital Program for each of fiscal years 1996 through 1999.

The Committee intends that the rural emergency medical services program would also include trauma care as a component of emergency care. The Committee also intends that States may use grants to fund non-profit State designated agencies to help formulate plans, implement rural health networks, and recommend designation of facilities as RPCHs or MAFs.

Effective date

Effective for discharges on or after October 1, 1994.

Sec. 621. Termination of Indirect Medical Education Payments

PRESENT LAW

Indirect medical education payments are made to hospitals under the Medicare Prospective Payment System.

COMMITTEE PROVISION

Medicare indirect medical education payments made directly to hospitals would be terminated. The amount of payments that would have been made for indirect medical education would be transfered to the Graduate Medical Education and Academic Health Centers Trust Fund.

Effective date

January 1, 1996.

Sec. 622. Subacute Care Study

PRESENT LAW

No provision.

COMMITTEE PROVISION

The Secretary would conduct a study by October 1, 1996 to:

(A) Define the level and type of care that should constitute subacute care.

(B) Determine the appropriateness of furnishing subacute care in different settings by evaluating the quality of care and patient outcomes.

(C) Determine the cost and effectiveness of providing subacute care to individuals eligible for the Medicare program.

(D) Determine the extent to which hospital DRG prospective payment rates are appropriate for the less restrictive institutional settings that provide subacute care.

(E) Study the relationships between institutions and their payment methodologies in order to develop ways in which to maximize the continuity of care for each patient episode in which subacute care is furnished.

Effective date

Upon enactment.

PART III—PROVISIONS RELATED TO PART B

Sec. 631. Updates for Physicians' Services

PRESENT LAW

Under current law, payments for some services covered under Part B are updated each year by an inflation index. Prior to 1984, physician fees were updated annually by the Medicare Economic Index (MEI). The MEI measures inflation in the cost of providing physician services. From 1984 through 1991, the MEI update was often set in reconciliation legislation. The MEI is currently estimated to be 2.2 percent for 1995.

Beginning in 1992, Medicare physician fees are updated annually by a default formula, unless Congress acts. This update is based on two things: (1) the MEI; and (2) a comparison of actual physician spending in a base period compared to an expenditure goal known as the Medicare Volume Performance Standard (MVPS). Separate goals are set for surgical, primary care, and non-surgical services (excluding primary care).

If the MVPS was exceeded in the base period, the update for services within the category is equal to the MEI reduced by the percentage by which the target was exceeded. If expenditures were less than the MVPS, the update is the MEI increased by the percentage by which expenditures in the category were below the target.

The Omnibus Budget Reconciliation Act of 1993 (OBRA 93) reduced the default updates for 1994 by 3.6 percentage points for surgical services, and 2.6 percentage points for all other services (including anesthesia services), except for primary care, which received the full default update. The 1994 updates are 10.0 percentage points for surgical services, 5.3 percentage points for non-surgical service (including anesthesia services), except for primary care services, which received a 7.9 percent update.

OBRA 93 also reduced the default updates for 1995. The default update is reduced by 2.7 percentage points for surgical services and all other services (including anesthesia services), except primary care services, which receive the full update.

Under the default formula, the Secretary of HHS has estimated that the 1995 updates will be as follows: 13.2 percentage points for surgical services; 6.7 percentage points for non-surgical services (excluding primary care services); and 9.4 percentage points for primary care services.

COMMITTEE PROVISION

The committee provision would reduce the 1995 default update by 4.0 percentage points for surgical services, 4.0 percentage points for non-surgical services, and 1.0 percentage point for primary care services.

Effective date

Upon enactment.

Sec. 632. Substitution of Real Gross Domestic Product (GDP) for Volume and Intensity in the Volume Performance Standard

PRESENT LAW

The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) established a system of Medicare volume performance standards (MVPS) which is used to calculate the annual update in fees (conversion factor) for physician and certain other Part B services after January 1, 1992. Under this system, Congress would enact a specific level of increase in expenditures for a subsequent calendar year. In the absence of Congressional action, the rate of increase in expenditures is determined by a formula set in law. The MVPS is based on an estimate of: (1) the percentage increase in Medicare fees; (2) the increase in the number of Part B enrollees, excluding enrollees in HMO risk-contracts; (3) an estimate of the historical rate of increase in the volume and intensity of services delivered; and (4) any change in payment due to legislation or regulation. This is reduced by a performance standard factor, which equals 3.5 percentage points in 1994 and 4.0 percentage points in each subsequent year.

Under current law, there is a lower limit on the default updates to the physician fee schedule. The annual update to the fee schedule can be no lower than the MEI minus 3.0 percentage points in calendar 1994 and minus 5.0 percentage points in 1995 and succeeding years.

COMMITTEE PROVISION

The committee provision would specify that the historical rate of increase in the volume and intensity of services delivered would be deleted from the MVPS. Substituted in its place would be the average per capita growth in real (inflation-adjusted) GDP for the 5-year period beginning with the previous fiscal year (1994). The performance standard factor would be repealed. In addition, the lower limit on the default update would be repealed.

Effective date

The provision substituting real GDP for volume and intensity and the provision repealing the performance standard factor take effect with respect to volume performance standards established beginning with FY 95. The provision regarding the repeal of the maximum reduction to the update takes effect for services furnished on or after January 1, 1997.

Sec. 633. Payments for Physician Services Relating to Inpatient Stays in Certain Hospitals

PRESENT LAW

There generally are no adjustments to amounts payable to physicians when covered services are provided to inpatients of hospitals. Each physician submits claims for services rendered, and the amounts paid are determined in accordance with the Medicare physician fee schedule. The only exceptions to this general rule are when physicians provide services as part of a surgical team or

when they supervise services provided by certified registered nurse anesthetists.

COMMITTEE PROVISION

The Secretary would be directed to develop for all hospitals paid under the prospective payment system, annual, hospital-specific case-mix adjusted relative value units per admission and determine whether a hospital exceeds the allowable average per admission relative value units applicable to the medical staff for the year. If the Secretary determines that the rate for the hospital exceeds the allowable average per admission, the Secretary would reduce payments for physician services to hospital inpatients. By October 1 of each year, the Secretary would notify each hospital of its specific relative values.

In the case of urban hospitals, the allowable average per admission relative value units would be equal to 125 percent for admissions in 1998 and 1999, and 120 percent thereafter of the median 1996 hospital-specific relative value units per admission for all hospital medical staffs.

In the case of rural hospitals for each year beginning with 1998, the allowable per admission relative value units would be equal to 140 percent of the median 1996 hospital-specific relative value units per admission for all hospital medical staffs.

The hospital specific projected relative value units for a hospital would be equal to the average relative value units per admission for physician services furnished to inpatients during 1996 by the hospital's medical staff and billed to Medicare, adjusted for variations in case mix, the disproportionate share adjustment, and indirect teaching adjustment, if applicable.

The projected excess relative value units for a year would mean the number of percentage points (as determined by the Secretary) by which a medical staff's hospital specific per admission relative value units exceed the allowable average per admission relative value units.

The amount of payments otherwise due would be reduced by 15 percent for each service furnished for hospitals whose relative value units per admission exceed the allowable average per admission.

Not later than October 1 each year, beginning in 1999, the Secretary would be required to determine each hospital's actual average per admission relative value units using claims forms submitted not later than 90 days after the last day of the previous year, adjusted for case mix, and the disproportionate share and indirect teaching adjustments.

In cases in which a hospital's actual average per admission relative value units were reduced and were also below the allowable average rate, the Secretary would reimburse the hospital medical staff's fiduciary agent the amount that was withheld plus accrued interest. In cases where the actual average relative value units were less than 15 percentage points above the allowable average, the Secretary would reimburse the hospital medical staff's fiduciary agent an amount equal to the difference between 15 percentage points and the actual number of percentage points by which the

staff exceeded the allowable average per admission relative value units plus accrued interest.

Hospital medical executive committees would be given a one-year advance notice of projected excessive relative values and would designate a fiduciary agent to receive and disburse amounts withheld by the Secretary that are subsequently returned. Alternatively, the Secretary could distribute such amounts directly to physicians who treated patients in the hospital on a pro-rata basis based on the proportion of services provided by each physician during the year.

Effective date

Effective for services furnished on or after January 1, 1998.

Sec. 634. Changes in Underserved Bonus Payments

PRESENT LAW

Physicians providing services in health professional shortage areas, as defined in Sec. 332 of the Public Health Services Act, currently receive a bonus equal to 10 percent of the Medicare payment amount for each physician service delivered.

COMMITTEE PROVISION

The committee provision would increase the bonus payment for primary care services, as defined in Sec. 1842(i)(a) of the Social Security Act, to 20 percent for each physician service. The bonus payment for other physician services (excluding primary care) would be set at 10 percent for services delivered in health professional shortage areas located in rural areas. The 10 percent bonus payment for non-primary care services delivered in health professional shortage areas located in urban areas would be eliminated.

Effective date

Upon enactment.

Sec. 635. Development and Implementation of Resource-Based Methodology for Practice Expenses

PRESENT LAW

From 1992 to 1996, Medicare is phasing in a fee schedule with separate components for physician work, practice expense and malpractice expense. Practice expense includes office rents, employees wages, physician compensation, and physician fringe benefits. Payment for the physician work component of the fee schedule is based on a resource-based relative value scale (RBRVS), but payment for practice expense and malpractice expense are based on historical charges.

COMMITTEE PROVISION

The Secretary would be required to develop a methodology for implementing in 1997 a resource-based system for determining practice expense relative value units for each physician service. In developing the methodology, the Secretary would consider the staff, equipment and supplies used in the provision of various medical and surgical services in various settings. The Secretary would be

required to report to Congress on the methodology by January 1, 1996. The existing payment methodology would be repealed when the new payment methodology takes effect in 1997.

Effective date

Upon enactment.

Sec. 636. Demonstration Projects for Medicare State-Based Performance Standard Rates of Increase

PRESENT LAW

Medicare currently sets volume performance standard for three categories of physician services: (1) surgical services; (2) non-surgical services (excluding primary care services); and (3) primary care services. These volume performance standards are calculated on a national basis; there are no State-based volume performance standards.

COMMITTEE PROVISION

The Secretary would be required to establish demonstration projects in not more than three States under which a State elects State-based volume performance standard rates of increase to substitute for national performance standard rates of increase. The Secretary would be required to establish budget-neutrality requirements for the demonstration projects.

Sec. 637. Elimination of Formula-Driven Overpayment for Certain Hospital Outpatient Services

PRESENT LAW

The aggregate amount of Medicare payments made for hospital outpatient services (or rural primary care hospital services) furnished in connection with ambulatory surgery, radiology and diagnostic tests equals the lesser of: (1) the lower of a hospital's reasonable costs or its customary charges, net of deductible or co-insurance amounts, and (2) a blended amount comprised of a cost portion and a charge portion. The cost portion of the blend is based on the lower of a hospital's costs or charges net of beneficiary cost-sharing. The cost portion of the blend is 42 percent for ambulatory surgery and radiology services and 50 percent for diagnostic tests. The charge portion of the blend is 58 percent of the ambulatory surgery center (ASC) payment rates net of beneficiary co-insurance, and 58 percent of the physician fee schedule amount for radiology services net of co-insurance, and 50 percent of the physician fee schedule for diagnostic tests net of co-insurance.

A hospital may bill a beneficiary for co-insurance equal to twenty percent of its charge for an outpatient service. However, the blended amounts are calculated after application of beneficiary cost-sharing (e.g. lower of hospital cost or charges net of cost-sharing and 80 percent of the ASC rate). This inconsistency in application of cost-sharing results in an anomaly whereby the amount a beneficiary pays in co-insurance does not result in a dollar for dollar decrease in Medicare program payment.

COMMITTEE PROVISION

Using the current blend percentages, the payment formula would be changed to determine the blended payment limit prior to the application of beneficiary cost-sharing provisions. Medicare's payment amount would be determined based on the lesser of (1) the lower of the hospital's reasonable costs or customary charges, or (2) the blended payment limit. Medicare would then pay the lesser of (1) 80 percent of the lowest amount, or (2) the lowest amount less the beneficiary cost-sharing amounts.

Effective date

Effective for services furnished during portions of cost-reporting periods occurring on or after January 1, 1995.

Sec. 638. Payments to Eye and to Eye and Ear Specialty Hospitals

PRESENT LAW

Hospitals designated as eye, or as eye and ear hospitals receive a blended payment rate for ambulatory surgery for which 75 percent is based on the hospital's costs and 25 percent is based on the rate paid to freestanding ASCs. In general, the blended payment rate to hospitals for outpatient surgery is based 42 percent on costs and 58 percent on the ASC rate. This rule applies for cost reporting periods beginning on or after October 1, 1988, and before January 1, 1995.

COMMITTEE PROVISION

The use of the 75/25 blend for eye hospitals, and eye and ear hospitals would be extended to services provided until September 30, 1997.

Effective date

January 1, 1995.

Sec 639. Imposition of Co-insurance for Laboratory Services

PRESENT LAW

Medicare beneficiaries are required to make co-insurance payments equal to 20 percent of Medicare's approved payment amount for certain services. Since 1987, payment of co-insurance has not been required for clinical laboratory services.

COMMITTEE PROVISION

The committee provision would require Medicare beneficiaries to pay co-insurance equal to 20 percent of the approved Medicare payment amount for clinical laboratory services.

Effective date

January 1, 1995.

Sec. 640. Application of Competitive Acquisition Process for Part B Items and Services

PRESENT LAW

Medicare pays for computer axial tomography (CT) scans and magnetic resonance imaging (MRI) tests on the basis of the Medicare physician fee schedule. The fee schedule has two parts: a technical component for performing the test and a professional component for interpreting the test. Either part of the test can be billed separately.

Payments for oxygen and oxygen equipment are made on the basis of a fee schedule for durable medical equipment.

COMMITTEE PROVISION

The committee provision would direct the Secretary to establish competitive acquisition areas for procurement of CT scans, MRI tests and oxygen and oxygen equipment.

The Secretary would be permitted to establish different competitive acquisition areas for different items and services. The competitive acquisition areas would be required to be, or be within, metropolitan statistical areas (MSAs). They would be chosen by the Secretary based on the availability and accessibility of suppliers and the probable savings to be realized from the use of competitive bidding.

The Secretary would be required to conduct a competition among individuals and entities supplying items and services for each competitive acquisition area. The Secretary would only be permitted to award a contract if the individual or entity meets quality standards specified by the Secretary.

A competitive acquisition contract would specify: (1) the quantity of items and services to be provided; and (2) other terms and conditions specified by the Secretary.

If competitive acquisition failed to result in at least a 10 percent reduction in the payment amount for these services, the Secretary would be required to make reductions in payment levels for these services to achieve a 10 percent reduction.

Effective date

January 1, 1995.

Sec. 641. Application of Competitive Acquisition Process for Clinical Laboratory Services

PRESENT LAW

Medicare payments for clinical diagnostic laboratory tests are made on the basis of local fees in payment areas designated by the Secretary. Each fee schedule payment is limited by a national cap. The cap is set at 84 percent of the median of all fee schedule payments for a particular test in 1994, 80 percent in 1995, and 76 percent in 1996 and thereafter.

COMMITTEE PROVISION

The committee provision would direct the Secretary to establish competitive acquisition areas for procurement of clinical diagnostic laboratory tests.

The Secretary would be permitted to establish different competitive acquisition areas for different items and services. The competitive acquisition areas would be required to be, or be within, metropolitan statistical areas (MSAs). They would be chosen by the Secretary based on the availability and accessibility of suppliers and the probable savings to be realized from the use of competitive bidding.

The Secretary would be required to conduct a competition among individuals and entities supplying items and services for each competitive acquisition area. The Secretary would only be permitted to award a contract if the individual or entity meets quality standards specified by the Secretary.

A competitive acquisition contract would specify: (1) the quantity of items and services to be provided; and (2) other terms and conditions specified by the Secretary.

If competitive acquisition failed to result in at least a 10 percent reduction in the payment amount for laboratory services, the Secretary would be required to make reductions in payment levels for these services to achieve a 10 percent reduction.

Effective date

January 1, 1995.

Sec. 642. Expanded Coverage for Physicians Assistants and Nurse Practitioners

PRESENT LAW

Direct payment may be made for certain services furnished by nurse practitioners, clinical nurse specialists, and physicians' assistants. Where payment is made, it must be made on an assignment-related basis, subject to Part B coinsurance and deductible requirements.

Payment may not be made directly to physicians' assistants; it must be made to their employers. Nurse practitioners and clinical nurse specialists may bill Medicare Part B directly for services performed in a rural area, including hospitals.

Reimbursement varies with the setting in which services are performed. For services provided by physician assistants serving as assistants at surgery, reimbursement is limited to the lesser of the actual charge or 65 percent of the amount that would be paid to a physician serving as an assistant at surgery. For services rendered by physician assistants in a hospital, other than as assistants at surgery, and for services rendered by nurse practitioners and clinical nurse specialists in hospitals in rural areas, payment is limited to the lesser of the actual charge or 75 percent of the amount paid to physicians for performing that service. In all other covered settings, payment for services rendered by physicians' assistants, nurse practitioners and clinical nurse specialists is limited

to the lesser of the actual charge or 85 percent of the amount that would be paid to physicians for performing that service.

COMMITTEE PROVISION

Reimbursement for services provided by physicians' assistants and nurse practitioners in outpatient settings would be set at the lesser of the actual charge or 85 percent of the amount paid to physicians for performing that service. Reimbursement for nurse practitioners who practice in rural settings, but who refer one of the patients to an urban setting for a surgery and subsequently act as an assistant at surgery in that case would be reimbursed at the lesser of the actual charge or 65 percent of the amount paid to physicians for assisting at surgery.

Effective date

January 1, 1997.

Sec. 643. Part B Premium

PRESENT LAW

From 1984 through 1990, the Part B premium was set to cover 25 percent of Part B spending for aged beneficiaries. The remaining 75 percent was funded from general revenues. The Omnibus Budget Reconciliation Act of 1990 established the monthly Part B premium in statute through 1995 to cover 25 percent of Part B spending as follows: $29.90 in 1991, $31.80 in 1992, $36.60 in 1993, $41.10 in 1994 and $46.10 in 1995. The Omnibus Budget Reconciliation Act of 1993 extended the 25 percent Part B premium policy through 1998, but did not specify actual premiums in law.

COMMITTEE PROVISION

The committee provision would permanently set Part B premiums at 25 percent of Part B spending for aged beneficiaries.

Effective date

Upon enactment.

PART IV—PROVISIONS RELATED TO MEDICARE PARTS A AND B

Sec. 651. Medicare Secondary Payer

PRESENT LAW

(a) Extension of Transfer of Data.—OBRA 89 authorized the establishment of a database to identify working beneficiaries and their spouses to improve identification of cases in which Medicare is secondary to third-party payers. The data match links Internal Revenue Service (IRS) tax records with data from the Health Care Financing Administration (HCFA). The Omnibus Budget Reconciliation Act of 1993 authorized an extension of the transfer of data through September 30, 1998.

(b) Extension of Medicare Secondary Payer for Disabled Beneficiaries.—Medicare is the secondary payer to certain group health plans offered by employers of 100 or more employees for disabled

beneficiaries. The authority for this provision expires September 30, 1998.

(c) Extension of 18-Month Rule for ESRD Beneficiaries.—Medicare is the secondary payer to certain employer group health plans covering beneficiaries with end stage renal disease (ESRD) during the first 18 months of a beneficiary's entitlement to Medicare on the basis of ESRD. The authority for this provision expires September 30, 1998.

COMMITTEE PROVISION

(a) Extension of Transfer of Data.—The authority for the transfer of data would be made permanent.

(b) Extension of Medicare Secondary Payer for Disabled Beneficiaries.—The Medicare secondary payer requirements for disabled beneficiaries would be made permanent.

(c) Extension of 18-Month Rule for ESRD Beneficiaries.—The Medicare secondary payer requirements for beneficiaries with end stage renal disease would be made permanent.

Effective date

Upon enactment.

Sec. 652. Modification to Physician Referral Exception

PRESENT LAW

Physicians (or immediate family members of such physicians) with a financial relationship with clinical laboratories, physical therapy services; occupational therapy services; radiology or other diagnostic services; radiation therapy services; durable medical equipment; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics, and prosthetic devices; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services are prohibited from referring Medicare patients to those entities. There are a series of general and specific exceptions to the prohibition. A specific exception is provided to the ban on ownership or investment for services furnished in rural areas if substantially all of the services provided are furnished to individuals residing in the rural area.

COMMITTEE PROVISION

The proposal would expand the ownership and investment exception to include services provided in an urban area if (1) the entity providing the service is located more than 100 miles from other like entities; (2) no less than 50 percent of the patient-users in the entity's service area utilize the entity; and (3) because of the area's local topography or periods of prolonged severe weather conditions, other entities providing the services are not readily accessible for at least 30 days in 2 out of 3 years.

Effective date

Upon enactment.

Sec. 653. Expand Centers of Excellence

PRESENT LAW

Medicare currently has two demonstration projects that involve competitive contracts with "centers of excellence" to perform coronary artery bypass graft surgery and cataract surgery for one payment that includes all services provided in connection with these procedures. The bypass surgery demonstration is currently being conducted in seven cities and the cataract surgery demonstration is being conducted in three cities.

COMMITTEE PROVISION

The committee provision would direct the Secretary to expand the demonstration projects for coronary artery bypass and cataract surgery in urban areas. Payment would be made on the basis of a negotiated or all-inclusive rate, beginning with fiscal year 1995.

The amount of payment would be required to be less than the aggregate amounts of payments the Secretary would have made if the demonstrations were not conducted. Payment for coronary artery bypass surgery would include the bypass procedure and related services.

The Secretary would be required to make a payment to each beneficiary to whom services are provided under this demonstration equal to 10 percent of the difference between what the Secretary would have paid for these services in the absence of this provision and what the Secretary actually paid for the services under this provision.

Effective date

Upon enactment.

Sec. 654. Medicare Select

PRESENT LAW

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) requires that all Medigap policies conform to one of ten standard benefit packages, including a core benefit package that must be made available by all Medigap insurers, and nine other packages that an insurer has the option of offering. In general, Medigap policies may not be canceled and must be guaranteed renewable as long as premiums are paid. OBRA 90 also permitted the offering of a new Medicare supplement policy, known as Medicare Select, in 15 States. The only difference between standard Medigap and Medicare Select is that Select policies will only pay full benefits if covered services are obtained through selected health professionals.

COMMITTEE PROVISION

The committee provision would permit Medicare Select policies to be offered in all States. The three year limitation would be eliminated. A health maintenance organization could offer a Medicare supplemental policy that does not conform to at least one of the ten standard benefit packages if: (1) the benefits include at least the core benefits package, although the plan could charge nominal

copayments, and (2) the benefit package including any copayments, when combined with Medicare benefits, is substantially similar to benefits provided to non-Medicare enrollees of the health maintenance organization. A Medicare Select policy may be canceled or not renewed in the case of an individual who leaves the service area of the policy, except that if the individual moves to an area for which the issuer of the Medicare Select policy (or an affiliate) offers a Medigap policy, the alternative must be made available to the individual.

Effective date

The National Association of Insurance Commissioners (NAIC) would have nine months after the date of enactment to revise the current model regulations to reflect this provision and to make other changes of a technical nature. If the NAIC does not revise its model regulations within the stated time frame, the Secretary would be required to develop a regulation and would have 9 months to do so.

The revised model regulations or Federal regulations would apply in each State on the date the State adopts such regulations or one year after the regulations are developed, whichever is earlier. Special provisions are included for States whose legislatures will not meet during the one year period following the development of the regulations.

Sec. 655. Medicare Supplemental Insurance Polices (Medigap)

PRESENT LAW

Medical underwriting and certain other practices are prohibited with respect to Medicare supplemental policies for which an individual age 65 or older applies during the six-month period beginning with the first month which an individual is first enrolled for benefits under Medicare Part B.

COMMITTEE PROVISION

The committee provision would require Medicare supplemental policies (Medigap) to have a coordinated annual open enrollment period of 30 days.

Effective date

January 1, 1996.

Sec. 656. Reduction in Routine Cost Limits for Home Health Care Services

PRESENT LAW

Home health care services are reimbursed on a reasonable cost basis, subject to aggregate cost limits which are updated annually. The Omnibus Budget Reconciliation Act of 1987 limited payment for home health agency costs to 112 percent of the mean labor-related and non-labor per visit costs for freestanding home health agencies (HHAs). OBRA 1993 prohibited the Secretary from applying an update factor to the cost limits for home health services for cost reporting periods beginning in fiscal years 1994 and 1995.

OBRA 1993 also eliminated additional payments for administrative and general costs of hospital-based HHAs.

COMMITTEE PROVISION

The upper limit on payment for allowable visit-related costs for home health services would be limited to 100 percent. The cost limits are changed from a percentage of the mean cost to a percentage of the median cost.

Effective date

October 1, 1995.

Sec. 657. Termination of Graduate Medical Education Payments

PRESENT LAW

Graduate medical education payments are made to hospitals under Medicare.

COMMITTEE PROVISION

Medicare graduate medical education payments made directly to hospitals would be terminated. The amount of payments that would have been made for graduate medical education would be transferred to the Graduate Medical Education and Academic Health Centers Trust Fund.

Effective date

January 1, 1996.

Sec. 658. Extension of Social Health Maintenance Organizations

PRESENT LAW

The Deficit Reduction Act of 1984 required the Secretary to grant three-year waivers for demonstrations of social health maintenance organizations (SHMOs). These demonstrations integrated health and long-term care services on a prepaid capitated basis. These demonstrations have been extended several times, most recently in OBRA 93, which extended the waivers through December 31, 1997.

COMMITTEE PROVISION

The waivers would be extended for an additional two years to December 31, 1999.

Effective date

Upon enactment.

Sec. 659. Study on Medicare Spending

PRESENT LAW

No provision.

COMMITTEE PROVISION

The Prospective Payment Assessment Commission and the Physician Payment Review Commission would each be directed to con-

duct a study of the rate of increase in Medicare spending and to make recommendations to Congress on strategies to slow the rate of growth. The studies would be required to include: (1) an examination of ways to slow both the national rate and the rate of growth in community rating areas; and (2) an assessment of whether setting local expenditure targets or local volume performance standards would be successful as part of this effort.

Effective date

Upon enactment.

Sec. 660. Streamlined Processing Systems

PRESENT LAW

No provision.

COMMITTEE PROVISION

The Secretary of Health and Human Services would be authorized: (1) to develop a streamlined, standardized and paperless process for handling all claims for Medicare benefits, excluding beneficiaries enrolled in Medicare risk contracts; and (2) a process to ensure that claims for Medicare services are filed with Medicare, Medicare supplemental policies, and other supplemental policies before providers would be permitted to bill Medicare beneficiaries.

Effective date

Upon enactment.

End stage renal disease

The Committee urges the Secretary to examine the appropriateness of the current 18 month secondary payer period for individuals entitled to Medicare because they have end stage renal disease and to determine whether a longer secondary payer period might be appropriate.

Subtitle B—Medical Education

Sec. 665. Medical Education

GRADUATE MEDICAL EDUCATION TRUST FUND

Present law

Graduate medical and nursing education trust fund

No provision.

Payments for graduate medical education

Under Medicare's payments to hospitals, the direct costs of graduate medical education are paid separately from the DRG-based payments. Payments are made on a formula based on each hospital's historical costs per resident. Each hospital's costs per resident are calculated for the hospital's cost reports for fiscal year 1984, generally updated to the present. The number of residents is the weighted average number of residents who are within the minimum number of years required for board eligibility plus 1, not to

exceed 5 years, and one-half the number of residents in additional years of training. Payments include resident and faculty salaries and other related direct costs.

Graduate nursing education payments

No provision (the direct costs of training for nurses working toward the RN degree in provider-operated programs are paid by Medicare on a reasonable cost basis, but not those in graduate education programs).

Medical school account

No provision.

Committee provision

Graduate medical and nursing education trust fund

A trust fund for payments for Graduate Medical and Nursing Education and Medical School payments is established (see Sec. 761, creating a new Sec. 9552 of the Internal Revenue Code of 1986). Payments into the trust fund consist of payments that would have been made for Medicare direct medical education under current law, plus a portion of revenues from the 1.75% assessment on premiums for insured and self-insured health plans and policies.

Payments for graduate medical education

The Secretary of HHS would make payments from the Trust Fund for the operation of approved graduate physician and dental training programs, beginning in calendar year 1996. Payments would total $3,200,000,000 in 1996; $3,550,000,000 in 1997; $5,800,000,000 in 1998; and in subsequent years, $5,800,000,000 increased by the change in the medical care component of the Consumer Price Index each year.

Payments to each eligible applicant would equal the full-time-equivalent number of residents in the program (generally as calculated under current Medicare law) multiplied by the institution's costs of training residents as determined under current law for the most recent two-year period for which data are available. Payments in any year would be pro-rated if necessary on the basis of available funds.

Graduate nursing education payments

A program to pay for the costs of graduate nurse education would be established. Eligible applicants would be defined as programs for advanced nurse education and for training nurse practitioners, nurse midwives, nurse anesthetists, and other training in clinical nurse specialties determined by the Secretary to require advanced education. The amount available for graduate nurse training programs from the Trust Fund would be $200,000,000 in 1996, increased annually thereafter by the change in the medical care component of the Consumer Price Index.

Medical school payments

Payments would be made to medical schools to assist in meeting additional teaching and research costs associated with the transi-

tion to managed competition and expanded ambulatory teaching. Payments would total $200 million in 1996, $300 million in 1997, $400 million in 1998, $500 million in 1999, and $600 million in 2000, increased annually thereafter by changes in the medical care component of the Consumer Price Index.

Effective date

Upon enactment.

ACADEMIC HEALTH CENTERS TRUST FUND

Present law

The Indirect Medical Education (IME) adjustment factor under Medicare's prospective payment system for inpatient hospital services increases payments to teaching hospitals compared with nonteaching hospitals. The IME payments are intended to reflect differences in patient care costs due to the indirect costs associated with graduate medical education, the severity of illness treated, and the complexity of highly specialized care. Payments to major teaching hospitals based on diagnosis-related groups (DRGs) are increased on average by about one-third, under a statutory formula that increases payments for each discharge by about 7.65 percent for each 0.1 increase in the ratio of residents to beds (section 1886(d)(5)(B)(ii) of the Social Security Act). The formula is calculated on a curvilinear basis, so that the increase in the payment tapers off somewhat in hospitals with very high resident-to-bed ratios.

Committee provision

A trust fund to make payments to teaching hospitals and to academic health centers that operate teaching hospitals, to schools of dentistry, and to high intensity nonteaching rural hospitals would be established (see Sec. 761, creating a new Sec. 9552 of the Internal Revenue Code of 1986). Payments into the trust fund would consist of payments that would have been made for Medicare indirect medical education under current law, plus a portion of revenues from the 1.75% assessment on premiums for insured and self-insured health plans and policies.

The payments to the teaching hospitals and academic health centers are to assist with specialized costs they incur that are not routinely incurred by other entities in providing health services and that are unlikely to be covered by payments for hospital services under managed competition.

An "academic health center" is a teaching hospital or a school of medicine or osteopathy that operates a teaching hospital. A teaching hospital is a hospital that operates a residency training program that is accredited by a specialty or subspecialty.

Distribution of funds among teaching hospitals and academic health centers would be according to a formula modeled after the current Medicare IME adjustment factor. The current IME payment formula, which is based on DRGs, would be modified to reflect the varying methods of hospital payment in the private sector. It would also be adjusted to compensate for the higher costs of research-intensive academic centers.

The Secretary of HHS would be required to report to the Committee on Finance and the Committee on Ways and Means by July 1, 1996, with any recommendations for further modifications of the formula.

Payments to schools of dentistry are to assist with the costs of training dentists and with unreimbursed oral health care costs. Seventy-five percent of the payments would be made on the basis of the number of full-time training equivalents at the school, and twenty-five percent on the basis of the amount of unreimbursed oral health care costs. Total payments would equal $50,000,000 in 1996, increased annually thereafter by changes in the medical care component of the Consumer Price Index.

High intensity nonteaching rural hospitals would be nonteaching hospitals in rural areas that have a high number of seriously ill patients, based on a case-mix index of greater than 120 percent of the national average for such hospitals. Payments to such hospitals would be equal to 5 percent of the inpatient costs of all patients of the hospital.

Annual payments for academic health centers, schools of dentistry and high intensity nonteaching rural hospitals would total $6,280,000,000 in 1996; $7,250,000,000 in 1997; $8,220,000,000 in 1998; $9,400,000,000 in 1999; $10,640,000,000 in 2000; and in each subsequent year, $10,640,000,000 increased annually thereafter by changes in the medical care component of the Consumer Price Index.

Effective date

Upon enactment.

GRADUATE MEDICAL EDUCATION AND ACADEMIC HEALTH CENTERS AND BIOMEDICAL RESEARCH TRUST FUND ADVISORY COMMITTEE

A Graduate Medical Education and Academic Health Centers and Biomedical Research Trust Fund Advisory Committee would be established. The Committee would conduct a study of the operation of the trust funds established above and on whether the funding levels were appropriate and would report to the Committees on Finance and Ways and Means and the Secretary by January 1, 1999. The Committee would be made up of 7 persons with relevant expertise, and would serve for the lesser of 5 years or the life of the Committee, which is scheduled to expire 90 days after filing its report.

Effective date

Upon enactment.

BIOMEDICAL AND BEHAVIORAL RESEARCH TRUST FUND

For provisions related to the Biomedical and Behavioral Research Trust Fund, see section 761, creating a new section 9553 of the Internal Revenue Code of 1986.

Effective date

Upon enactment.

Subtitle C—Home and Community Based Service

Sec. 667. State Programs for Home and Community Based Care for Individuals with Disabilities

Present law

The Medicaid program currently covers home and community based long term care services for low income people who are physically disabled, mentally ill, and developmentally disabled or mentally retarded. Home and community based long term care services can be provided through waiver authority under Sec. 1915. These waivers permit States to provide a broad range of services, including homemaker/home health aide services, personal care, adult day care, and other non-institutional services needed by disabled persons to remain in the community. Waiver programs also permit States to apply institutional care eligibility rules (which are typically more generous) to the non-institutional long term care population. Other than waiver programs, States can provide discrete community based long term care services, such as personal care, clinic services for mental health care, and home health. For these services, however, States cannot use the more generous eligibility standards that apply to persons needing institutional care. For this reason, the Medicaid program is generally considered to have an institutional bias insofar as long term care services are concerned.

Committee provision

In General: States would have the option of establishing a new program for home and community based long term care for individuals with disabilities under Part C of the Medicaid program. The Secretary would be required to designate an agency responsible for program administration within six months of enactment. States could implement programs on or after January 1, 1998.

State Plan Requirements: States would be required to obtain the Secretary's approval of their State plan prior to implementing the program. The Secretary could not approve a State plan unless it was developed after a public comment period of at least 30 days and met the following requirements:

Eligibility: The State plan must specify a system for conducting an initial screening to determine if an individual has a qualifying level of disability. A State could not limit eligibility for services based on: income, age, geography, nature or category of disability, residential setting (other than an institutional setting), or on other grounds specified by the Secretary except that a State would be permitted to limit eligibility for services based on the level of disability. The State plan would have to assure that an individual receiving Medicaid home and community based services would continue to receive an appropriate level of services either under Parts A or C of Medicaid.

Services: The State plan must specify the services to be covered under the program, the method of equitably allocating resources and services among individuals with a variety of disabilities, the manner in which the plan services are to be coordinated within the program and with health and long term care services available outside the program. The State plan would be required to ensure that

low-income individuals are represented in the program in the same proportion as they are represented in the State population. The State plan could take into account the availability of informal care when determining the amount and array of services to be provided to a disabled individual. The State plan would be required to provide consumer choice in selecting program services and program providers. Within two years of implementing the program, a State must conduct a statewide assessment of the needs of individuals with disabilities using a format specified by the Secretary.

Cost-Sharing: The State plan would be required to provide for beneficiary cost-sharing in accordance with the specifications below.

Provider Participation: The State plan would be required to specify the types of providers eligible to provide services under the plan, including consumer-directed services, and could not limit providers to registered nurses, licensed practical nurses, or Medicare-certified agencies or providers. The State plan would be required to specify the provider payment methodology. The State plan would be required to limit participating providers to those that accept program payment as payment in full.

Quality Assurance: The State plan would be required to provide for quality assurance according to the specifications listed below.

Advisory Group: The State plan shall assure the creation and maintenance of an advisory group in accordance with specifications listed below.

Administration: The State plan shall designate an agency or agencies with responsibility for program administration. The State plan will assure that administrative costs do not exceed 10 percent of program expenditures beginning in 2003. The State plan shall comply with requirements for addressing any adverse effects on health care workers redeployment resulting from implementation of a program under this Part.

State Compliance with Requirements: The State shall provide to the Secretary such reports as the Secretary may specify and cooperate with audits. The Secretary shall monitor State programs on an annual basis. States that fail to comply with the requirements of this Part are subject to the withholding of Federal funds for services or administration.

Eligibility: Individuals with disabilities eligible for services under this program include:

> An individual of any age who requires hands-on assistance, supervision, or cueing to perform three or more activities of daily living and who is expected to require such assistance, supervision, or cueing over a period of at least 90 days;
>
> An individual of any age whose score on a standard mental status protocal indicates severe cognitive impairment or severe mental impairment or both, who requires hands-on or standby assistance, supervision, or cueing with one or more activities of daily living, requires assistance with one or more instrumental activities of daily living related to cognitive or mental impairment as the Secretary shall specify, or who displays symptoms of one or more serious behavioral problems (as specified by the Secretary) which creates a need for supervision to prevent

harm to self or others, and whose condition is expected to last at least 90 days;

An individual of any age who has severe or profound mental retardation (as determined according to a protocol specified by the Secretary); and

An individual under age six who has a severe disability or chronic medical condition that limits functioning in a manner comparable to standards established for other categories of individuals eligible for services under this program, and whose disability is expected to last at least 90 days.

Activities of daily living include: eating, toileting, dressing, bathing, and transferring.

The Secretary shall establish criteria for determining the functional level of disability among all categories of individuals that are comparable in severity, regardless of age or the nature of the disabling condition. The Secretary shall specify a uniform protocol for use in the initial screening and determination of disability. States may not assess a fee for determinations of disability.

Eligibility determinations shall be conducted by public or nonprofit entities specified in the State plan. Redeterminations shall be conducted at least every six months or more frequently if there is a significant change in an individual's condition.

Program services

Care Management.—The State program must make available care management services which include a (1) comprehensive assessment of the individual's need for home and community based services, (2) an individualized plan of care based on the assessment, (3) arrangements for the provision of services specified in the plan of care, and (4) monitoring the delivery of services.

Care management services cannot be provided by an individual or agency that also provides home and community based services except in circumstances where a State determines that program enrollment cannot support a diversity of providers and care managers and the State specifies procedures to avoid conflict of interest of an entity that is both care manager and a provider of home and community based services.

The comprehensive assessment shall include an assessment of the need for services whether or not the services are provided under this program. The assessment shall be conducted using an assessment tool developed by the Secretary.

The individualized plan of care shall specify the services to be provided under this program and identify arrangements for necessary services not provided under this program. The plan of care will specify how services will be coordinated with other health care services. Such plan of care will be reviewed and updated every six months. The care plan shall be developed with the involvement of the individual or the individual's representative and shall be approved by the individual or individual's representative.

Personal Care.—The program shall include personal care in the array of services covered by the State. Available personal care services shall include both agency-administered and consumer-directed. States shall act as the employer of persons providing consumer-directed personal care services and assume responsibility for provid-

ing billing, provider payment, tax withholding, unemployment insurance and workers' compensation coverage. Beneficiaries shall retain the right to select, hire, terminate, and direct the services of a consumer-directed provider.

Additional Services.—States may provide a range of services in addition to care management and personal care including: homemaker and chore assistance, home modifications, respite services, assistive devices, adult day services, habilitation and rehabilitation, supported employment, home health services, transportation, and any other care or assistive services specified by the State and approved by the Secretary.

Exclusions and Limitations.—The program may not provide coverage for room and board, or services furnished in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other institutional setting specified by the Secretary. Services may not be provided to the extent that an individual is eligible for the same service covered by a health plan, the Medicare program, or the Medicaid program. States operating a program under this part would be required to continue to make available under Part A of Medicaid certain specified home and community based long term care services to categories of individuals eligible to receive such services during the year immediately preceding the year in which the State submitted a State plan for approval under this Part.

Cost-sharing: The levels of beneficiary coinsurance under the program shall be as follows: no coinsurance for individuals with family incomes below 125 percent of the Federal poverty level; 10 percent coinsurance for individuals with family incomes of at least 125 percent of poverty but below 175 percent of poverty; 15 percent coinsurance for individuals with family incomes of at least 175 percent of poverty but below 225 percent of poverty; 25 percent for individuals with family incomes of at least 225 percent of poverty but below 275 percent of poverty; 30 percent for individuals with family incomes of at least 275 percent of poverty but below 325 percent of poverty; and 35 percent coinsurance for individuals with family incomes of at least 325 percent of poverty.

A schedule of annual deductibles shall be as follows: no deductible for individuals with family incomes below 125 percent of the Federal poverty level; $100 for individuals with family incomes of at least 125 percent of poverty but below 175 percent of poverty; $200 for individuals with family incomes of at least 175 percent of poverty but below 225 percent of poverty; $300 for individuals with family incomes of at least 225 percent of poverty but below 275 percent of poverty; $400 for individuals with family incomes of at least 275 percent of poverty but below 325 percent of poverty; and $500 for individuals with family incomes of at least 325 percent of poverty.

The Secretary would be required to develop a methodology to reduce the cost-sharing burden for individuals with exceptionally high out-of-pocket costs for whom such costs could jeopardize their ability to take advantage of services offered under this program.

Quality Assurance: The State plan would be required to specify how the State will ensure and monitor the quality of services including: safeguarding the health, safety and confidentiality of records of individuals with disabilities receiving services; setting

and enforcing minimum standards for agency providers; setting minimum competency requirements for consumer-directed providers of personal care services and how such competency will be demonstrated; obtaining meaningful consumer input including measuring satisfaction and receipt of services; establishing a process to receive, investigate and resolve allegations of neglect and/or abuse; establishing optional training programs for program beneficiaries in use and direction of consumer-directed providers of personal assistance services; establishing an appeals procedure for eligibility denials and a grievance procedure for disagreements concerning a plan of care; providing for consumer participation in quality assurance activities; specifying the role of the long term care ombudsman in assuring service quality and beneficiary rights.

The State plan would be required to comply with Federal standards in the following areas: sample review of client records; mandatory reporting of abuse, neglect, and exploitation; development of a provider registry to be made available to the public; and optional training programs for informal care givers.

Program beneficiaries would be required to have the following rights: to be fully informed in advance orally and in writing, of the care to be provided (or changes in that care); to participate in care planning; to voice grievances with respect to services without reprisal; to be informed concerning how to lodge a complaint with the State; to prompt resolution of any complaint or grievance; to privacy as well as confidentiality of personal and clinical records; to access personal and clinical records; to refuse care; to training on the management of care; to be free from physical or mental abuse, corporal punishments, and physical or chemical restraints; to free choice of providers; and to direct care.

Advisory Groups: The Secretary would be required to establish an advisory group composed of a majority of individuals with disabilities, their representatives, as well as Federal and State officials, providers, and local agencies. The group shall advise the Secretary and the States on all aspects of the program.

Each State would be required to establish an advisory group to advise it on all aspects of the program. Members shall be appointed by the Governor. A majority of the group shall consist of individuals with disabilities and their representatives. In addition, the group shall include State officials and local agency representatives, and providers. The group shall advise the State prior to development of the State plan and provide ongoing input concerning the program.

Payments to States

Services.—Federal matching rate shall be the Federal Medical Assistance Matching Percentage plus 15 percentage points, except that the Federal percentage under this part shall not exceed 90 percent.

Quality Assurance.—The Federal share shall be 90 percent of amounts expended for quality assurance activities.

Eligibility Determinations and Needs Assessments.—The Federal share of amounts expended for eligibility and assessments shall be 90 percent.

Claims Processing: Until 2003, the Federal share shall be 90 percent for amounts expended for design, development and installation of claims processing and information systems. Beginning in 2003, the Federal share for such activity shall be 75 percent of amounts expended.

General Administration.—The Federal share shall be 50 percent for amounts expended for general administration of the State plan.

Federal Budget Amount and Allotment to States: State allotments in any year after 1997 shall be based on the amount of funds available for the year in the Long Term Care Account of the Health Security Trust Fund plus any funds in the Account that were not expended in a preceding fiscal year.

The Secretary shall allot funds to each State based on: the State's share of individuals with disabilities in the Nation; State wages for service personnel relative to the national average; a State's Federal matching rate percentage under the program; and the proportion of State's population that is low-income relative to the national proportion.

Evaluations: Beginning in 2003 and annually thereafter, the Secretary would be required to report to Congress concerning: the extent to which low-income individuals with disabilities are equitably served by the program; the adequacy and equity of services provided to individuals with comparable disabilities in different States; the comparability of State participation in the program; and the ability of providers to meet service demand.

Effective date

Upon enactment.

Subtitle D—Medicaid Program

PRESENT LAW

Title XIX of the Social Security Act (Medicaid) provides for mandatory coverage by all participating States of acute care services for individuals and families receiving either Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) income support payments. These groups are referred to as the "cash population" within Medicaid. In addition, participating States must extend coverage to pregnant women and children up to age six with family incomes up to 133 percent of the Federal poverty level and children born after September 1983 up to 100 percent of the Federal poverty level. The Medicaid program provides States the option to extend coverage of pregnant women and children up to age one up to 185 percent of poverty. There are many other optional and mandatory coverage groups for acute care Medicaid services, one of which is Medically Needy eligibility under which families with significant medical care expenses can "spend down" into Medicaid eligibility.

Federal law establishes a basic set of mandatory services that States must provide including: inpatient and outpatient hospital services; laboratory and x-ray services; rural health clinic and federally qualified health center services; nursing facility services; family planning services; early and periodic screening, diagnostic and treatment (EPSDT) services for children under 21 years old;

home health services; and physician, nurse midwife and certain certified nurse practitioner services. There are many other services a State may choose to offer including: prescription drugs, case management, personal attendant care, physical therapy, rehabilitation, and mental health services.

COMMITTEE PROVISION

PART I—INTEGRATION OF CERTAIN ELIGIBLES

Sec. 671. Limiting Coverage under Medicaid of Items and Services Covered under Standard Benefit Package

AFDC and Non-Cash: Individuals receiving Aid to Families with Dependent Children (AFDC) payments and individuals eligible for Medicaid acute care services who do not receive any Federal income support (referred to as 'non-cash') would be integrated into the general health care reform program. These individuals would move into the community-rated, private sector health care system as they become eligible for Federal premium subsidies. For purposes of premiums and cost-sharing, these individuals would be treated like other low-income people eligible for Federal subsidies and enrollment in certified health plans.

Current Medicaid rules governing covered services and eligibility would be retained to cover services not otherwise provided through certified health plans. Because Medicaid is a secondary payer when a recipient has private coverage, the program would provide supplemental services for low-income groups currently entitled to Medicaid. The current flexibility provided to States to determine the optional services and groups it will cover would be retained.

SSI Recipients: Medicaid beneficiaries who receive Supplementary Security Income payments would remain in the full Medicaid program and would not be included in the community rated market.

Dual Eligibles: Medicaid beneficiaries who are eligible for Medicare would also not be included in the community rates market. This group would remain under Medicaid.

Maintenance of Effort: States would be required to make a general maintenance of effort (MOE) payment for services covered under the standard benefits package for that portion of the Medicaid population that moves from Medicaid onto the Federal premium subsidy program. The State MOE would be indexed to the per capita growth in national health expenditures and growth in the State's population. Quarterly Federal Medical Assistance grants to the States would be reduced by the maintenance of effort amount.

Effective date

January 1, 1996 for States that implement the premium subsidy program in that year. January 1, 1997 for States that do not implement the premium subsidy program early.

PART II—COORDINATED CARE SERVICES OR DISABLED MEDICAID ELIGIBLES

Sec. 672. Coordinated Care Services for Disabled Medicaid Eligibles

Current law regarding Medicaid managed care would remain intact except that States could only contract with certified standard health plans. Further, no certified health plan with a Medicaid contract could have more than 50 percent of its enrollment composed of SSI/Medicaid recipients.

Effective date

January 1, 1996.

PART III—PAYMENTS TO HOSPITALS SERVING VULNERABLE POPULATIONS

Sec. 673. Replacement of DSH Payments with Payments to Hospitals Serving Vulnerable Populations

The current Medicaid Disproportionate Share Hospital (DSH) payment program would be phased down during the period of time in which the Federal premium subsidy program is implemented. Beginning in 1997, the State DSH allotments would be recalculated to account for reduced State medical assistance payments resulting from the conversion of some of the program to a maintenance of effort payment. When the premium subsidy eligibility level (for individuals other than children and pregnant women) reaches 125% of the Federal poverty level, the Federal and State DSH spending caps would be reduced to 10% of medical assistance expenditures. The Federal and State spending limits would be reduced another 2 percentage points for each increase of 25% in the level of premium subsidy eligibility. The concept of "high DSH States" and "low DSH States" would be eliminated. The year after the subsidy eligibility level reaches 200% of poverty, the DSH program would be eliminated and replaced with a Vulnerable Populations Adjustment program.

Hospitals eligible for payments under this program would have had a low-income utilization rate (as defined under Sec. 1923(b)(3)) of at least 25% in 1994. Payments to hospitals will be allocated based on the amount of hospital-specific low-income days relative to low-income days inpatient days nationally. Total funding available under this program is $2.5 billion per year.

Effective date

October 1, 1997.

PART IV—MEDICAID LONG TERM CARE PROVISIONS

Sec. 674. Payments for Home or Community-Based Care, Personal Care Services, and Frail Elderly Services

The Federal Medical Assistance Percentage would be increased by 10 percentage points for: personal care attendant services, Sec.

1915 home and community based long term care waiver services, and the frail elderly home care option under Sec. 1929.

Sec. 675. Increased Resource Disregard for Individuals Receiving Certain Services

States would have the option to expand eligibility for single individuals by increasing the asset limit from $2,000 to $4,000 for services including personal care attendant services, the Sec. 1915 waiver programs, and the frail elderly home care option under Sec. 1929.

Sec. 676. Frail Elderly Demonstration Project Waivers

The number of authorized Program of All-Inclusive Care for the Elderly (PACE) demonstration sites would be increased from 15 to 40. The Secretary of HHS would be required to develop minimum standard requirements that an organization must meet to receive a demonstration waiver. The Secretary would also be required to develop and make available to States, model guidelines for unified licensure or certification of PACE providers for use by States choosing to develop unified licensure or certification requirements for these integrated provider/service delivery models. The Secretary would be required to develop evaluation protocols for PACE projects in operation on the date of enactment and report to Congress by January 1, 1998 on the desirability of granting permanent provider status to this sites. The Secretary would also be required to develop evaluation protocols for demonstration projects established after the date of enactment and report to Congress by January 1, 2003 on the desirability of granting permanent provider status to these entities.

Sec. 677. Elimination of Prior Institutionalization Requirement

The requirement that individuals need to have been institutionalized as a condition of eligibility for habilitation services under a home and community based care waiver would be eliminated.

Sec. 678. Elimination of Rule Regarding Availability of Beds in Certain Institutions

As a condition of approval for a Sec. 1915 waiver, HCFA currently requires States to demonstrate the availability of an institutional bed in order to have an equivalent slot in a home and community based waiver program. This requirement would be eliminated.

Effective date

January 1, 1995, except that Sec. 676 shall become effective upon enactment.

PART V—MISCELLANEOUS

Sec. 679. Coverage of All Certified Nurse Practitioner and Clinical Nurse Specialist Services

State Medicaid programs would be required to reimburse directly for the services provided by all certified nurse practitioners or clinical nurse specialists which they are legally authorized under State law or regulation to perform, whether or not they operate under the supervision of a physician or other health care provider.

TITLE VII. REVENUE PROVISIONS

Subtitle A—Financing Provisions

1. Increase in Excise Taxes on Tobacco Products (secs. 701–703 of the bill and sec. 5701 of the Code)

PRESENT LAW

Tax rates

Excise taxes are imposed on the manufacture or importation of cigarettes, cigarette papers and tubes, snuff, chewing tobacco, and pipe tobacco. The present-law tax rates are as follows:

Cigarettes:	
Small cigarettes (weighing no more than 3 pounds per thousand)[1].	$12 per thousand (i.e., 24 cents per pack of 20 cigarettes).
Large cigarettes (weighing more than 3 pounds per thousand)[2].	$25.20 per thousand.
Cigars:	
Small cigars (weighing no more than 3 pounds per thousand).	$1.125 per thousand.
Large cigars (weighing more than 3 pounds per thousand)	12.75 percent of manufacturer's price (but not more than $30 per thousand).
Cigarette papers and tubes:	
Cigarette papers[3]	0.75 cent per 50 papers.
Cigarette tubes[4]	1.5 cents per 50 tubes.
Snuff, chewing tobacco, pipe tobacco:	
Snuff	36 cents per pound.
Chewing tobacco	12 cents per pound.
Pipe tobacco	67.5 cents per pound.

[1] Most taxable cigarettes are classified as small cirgarettes.
[2] Large cigarettes measuring more than 6½ inches in length are taxed at the rate prescribed for small cigarettes, counting each 2¾ inches (or fraction thereof) as one cigarette.
[3] Cigarette papers measuring more than 6½ inches in length are taxed at the rate prescribed, counting each 2¾ inches (or fraction thereof) as one cigarette paper. No tax is imposed on a book or set of cigarette papers containing 25 or fewer papers.
[4] Cigarette tubes measuring more than 6½ inches in length are taxed at the rate prescribed, counting each 2¾ inches (or fraction thereof) as one cigarette tube.

Exemptions; use of revenues

No tax is imposed on tobacco products exported from the United States. Exemptions also are allowed for (1) tobacco products furnished by manufacturers for employee use or experimental purposes; and (2) tobacco products to be used by the United States. In addition, no tax is imposed on tobacco to be used in "roll-your-own" cigarettes.

Revenues from the tobacco products excise taxes are retained in the general fund of the Treasury. Revenues from taxes on tobacco products brought into the United States from Puerto Rico are transferred ("covered over") to Puerto Rico if the products satisfy

a domestic content requirement.[5] No Federal excise tax is imposed on tobacco products sold in Puerto Rico.

REASONS FOR CHANGE

Medical research has linked the use of tobacco products to a number of diseases—including cancer of the lungs, mouth and throat, emphysema, chronic bronchitis, and heart disease. Smoking also is believed to be a contributing factor to low birth weight babies. In addition, medical research has suggested that "second-hand smoke," that is, smoke inhaled by nonsmokers, increases health risks and costs for nonsmokers. Thus, all Americans, both smokers and nonsmokers bear the detrimental health effects from smoking.

Research has concluded that smokers of all ages require more medical care than those who have never smoked. As a major provider of health care, the Federal Government has an interest in controlling health costs. Therefore, the Committee concluded that it is appropriate to increase tobacco taxes to provide a market incentive to individuals to reduce their consumption, or never commence the consumption, of products that can harm one's health and increase the health care expenditures of the Federal Government.

EXPLANATION OF PROVISION

Rate increases; extension of coverage

The bill increases the excise tax rate on small cigarettes by $50.00 per thousand (one dollar per pack of 20 cigarettes) and on large cigarettes by $105.00 per thousand. The tax on other currently taxable tobacco products (except snuff and chewing tobacco) is increased proportionately and a $17.35 per pound tax is imposed on "roll-your-own" tobacco. The tax on snuff is increased by $1.00 per 1.2 ounce tin, and the tax on chewing tobacco is increased by $1.00 per 3 ounce pouch.

The new tax rates on all tobacco products will be—

Cigarettes:	
Small cigarettes (weighing no more than 3 pounds per thousand).	$62.00 per thousand (i.e., $1.24 per pack of 20 cigarettes).
Large cigarettes (weighing more than 3 pounds per thousand.	$130.20 per thousand.
Cigars:	
Small cigars (weighing no more than 3 pounds per thousand.	$51.13 per thousand.
Large cigars (weighing more than 3 pounds per thousand .	66 percent of manufacturer's price (but not more than $155.00 per thousand).
Cigarettes papers and tubes:	
Cigarette papers	3.88 cents per 50 papers.
Cigarette tubes	7.76 cents per 50 tubes.
Snuff, chewing tobacco, pipe tobacco, "roll-your-own" tobacco:	
Snuff	$13.69 per pound.
Chewing tobacco	$5.45 per pound.
Pipe tobacco	$17.35 per pound.
"Roll-your-own" tobacco	$17.35 per pound.

[5] Code section 7652(d) provides that an article, other than an article containing distilled spirits, shall not be treated as produced in Puerto Rico unless the sum of (a) the cost or value of the materials produced in Puerto Rico plus (b) the direct costs of process operations performed in Puerto Rico equals or exceeds 50 percent of the vlaue of the article as of the time it is brought into the United States.

Revenues from the increase in excise tax rates on tobacco products will be paid into the Health Security Trust Fund.

The bill also imposes the increase in excise tax rates on tobacco products manufactured and sold in Puerto Rico. Revenues from these taxes will be paid into the Health Security Trust Fund.

To provide full subsidies to children and pregnant women under part B of title XIX of the Social Security Act, the excise tax rate on small cigarettes set forth above shall be increased by 30 cents per pack of 20 cigarettes in the case of articles removed after June 30, 1996, and before January 1, 2002. The excise tax on other taxable products will be increased by comparable amounts during that period.

Exemptions and administrative provisions

The bill repeals the present-law exemptions for tobacco products provided to employees of the manufacturer or used by the United States, and includes the following administrative and compliance provisions:

(1) The exemption for exports is limited to products that are marked or labelled under Treasury Department rules designed to prevent the diversion of such products into the domestic market.

(2) Re-importation of tobacco products previously exported without payment of tax (other than for return to the manufacturer) is prohibited and a new penalty, equal to the greater of $1,000 or five times the amount of tax, is imposed on all parties involved in any prohibited re-importation. (All tobacco products and cigarette papers and tubes, as well as all vessels, vehicles, and aircraft used in such re-importations, are subject to seizure by the United States.)

(3) The current manufacturer inventory maintenance and reporting requirements, criminal penalties, and forfeiture rules are extended to importers of tobacco products.

(4) The present-law exemption for books or sets of cigarette papers containing 25 or fewer papers is repealed.

(5) Cover over of tobacco product revenues to Puerto Rico and the Virgin Islands is limited to present-law tax levels.

EFFECTIVE DATE

The provision generally is effective for tobacco products removed after December 31, 1994. A floor stocks tax is imposed on taxable tobacco products held on January 1, 1995, and on each subsequent rate increase date.

2. Assessments on Insured and Self-Insured Health Plans (sec. 705 of the bill and new secs. 4501-4503 of the Code)

PRESENT LAW

There is no excise tax or other special Federal tax on domestic health insurance policy premiums. A one-percent excise tax is imposed on premiums for certain foreign-issued sickness and accident insurance and reinsurance policies (sec. 4371).

REASONS FOR CHANGE

The purpose of the assessment on accident or health coverage is to raise revenues to fund the Graduate Medical Education and Academic Health Centers Trust Fund and the Biomedical and Behavioral Research Trust Fund, established under subtitle F of title VII of the bill.

EXPLANATION OF PROVISION

In general

The bill imposes an assessment on accident or health coverage provided (whether through insurance policies or otherwise) with respect to residents of the United States[6], as well as on certain related administrative services. No assessment is imposed on accident or health coverage if substantially all of the coverage relates to liabilities incurred under workers' compensation laws, tort liabilities, liabilities relating to ownership or use of property, credit insurance, or such other similar liabilities as may be specified by the Secretary of Treasury in regulations. Accident or health coverage includes, but is not be limited to, coverage for sickness, accident, dental, preventive care, payments as a result of a medical condition, or payment of a fixed amount for specific diseases or hospitalization or other specific types of care.

In general, with respect to health insurance, the assessment is imposed on premiums. With respect to prepaid health care arrangements, the assessment is imposed on the fixed payments or premiums paid by members. With respect to self-insured plans, the assessment is imposed on the accident and health coverage expenditures and the administrative expenses of the plan.

Assessment on accident and health insurance policy premiums

The bill imposes a 1.75-percent assessment on the premium for any insurance policy providing accident or health insurance. The issuer of the policy is liable for the assessment.[7] The assessment is imposed regardless of who pays the premium.

If a policy subject to the assessment provides both accident or health coverage and non-accident or health coverage, no assessment is imposed on the portion of the premium attributable to the non-accident or health coverage if the charge for such other coverage is separately stated or furnished to the policyholder in a separate statement, and is reasonable in relation to the total charges under the policy.

Arrangements under which (1) a person receives fixed payments or premiums in exchange for an agreement to provide or arrange for the provision of accident or health coverage, and (2) substantially all of the risk of utilization of health care services is assumed by such person or the provider of such services (i.e., prepaid health care arrangements) are treated as insurance policies subject to the

[6] The bill generally defines the "United States" to include possessions of the United States. Amounts collected pursuant to this assessment on accident and health coverage will not be transferred ("covered over") to any possession.

[7] For purposes of the assessment, a cost-plus contract is treated as an insurance contract.

assessment.[8] In such a case, the assessment is imposed on such payments or premiums. The person receiving the payments or premiums is treated as the issuer of the policy and is liable for the assessment.

Assessment on health-related administrative services

The bill also imposes a 1.75-percent assessment on amounts paid for certain health-related administrative services not included in the premium for a policy. The assessment is imposed on the provider of the services. If the health-related administrative services are performed pursuant to a contract providing for administrative services for both accident or health coverage and non-accident or health coverage, no assessment is imposed on amounts paid for administrative services attributable to the non-accident or health coverage if the charge for such other services is separately stated or furnished to the policyholder in a separate statement, and is reasonable in relation to the total charges under the contract.

Services subject to the assessment include claims processing or other administrative services performed in connection with accident or health coverage (if the charge for such services is not included in the premiums for such policy), and claims processing, arranging for the provision of accident or health coverage, or other administrative services performed in connection with a self-insured plan established or maintained by another person.

Treatment of self-insured plans

Self-insured plans are subject to a monthly assessment equal to 1.75 percent of the sum of the plan's expenditures for accident and health coverage (as defined above) and direct administrative expenses for the month. The assessment is paid by the plan sponsor.

Plans subject to the assessment are plans that provide any accident or health coverage other than through an insurance policy, and that are established or maintained by (1) one or more employers for the benefit of their current or former employees; (2) one or more employee organizations for the benefit of their current or former members; (3) one or more employers and employee organizations jointly for the benefit of current or former employees; (4) a voluntary employees' beneficiary association described in Code section 501(c)(9); and (5) qualified association plans defined in section 21433 of the bill (i.e., certain multiple employer welfare arrangements, plans maintained by rural electric cooperatives or by rural telephone cooperative associations, and certain plans maintained by trade, industry, or professional associations, chambers of commerce, religious organizations, or public entity associations).

The accident and health coverage expenditures of a plan for any month do not include expenditures subject to the assessment on accident and health insurance policy premiums or expenditures subject to the excise tax on health-related administrative services, described above. In addition, any reimbursements received by the

[8] This provision is not intended to limit the types of arrangements that are treated as insurance policies subject to the assessment. For example, arrangements under which substantially all of the risk of utilization of health care services is not assumed by the person arranging for the provision of such services or the provider of such services (e.g., "fee-for-service" health care arrangements) are insurance policies subject to the assessment.

plan sponsor (through insurance or otherwise) are subtracted from accident and health coverage expenditures.

Depreciation expenses allowable for property to be used in connection with the provision of accident or health coverage under Code section 167 are treated as accident and health coverage expenditures. Accident and health coverage expenditures do not include any other expenditure for the acquisition or improvement of land or for the acquisition or improvement of any property to be used in connection with the provision of accident or health coverage which is subject to depreciation allowance.

The following examples illustrate the operation of the assessment with respect to self-insured plans:

Example 1.—Employer A maintains a self-insured plan and has a contract with Insurance Company X to provide administrative services only with respect to the plan. Employer A is liable for the assessment with respect to accident and health coverage expenditures under the plan. Insurance Company X is liable for the assessment with respect to amounts received from Employer A for administrative services.

Example 2.—Employer B maintains a plan that is self-insured, and purchases stop-loss coverage from Insurance Company Y. Employer B is liable for the assessment with respect to accident and health coverage expenditures under the plan. In applying the assessment, the amount of any reimbursements received from Insurance Company Y under the stop-loss policy are subtracted from total accident and health coverage expenditures. Insurance Company Y is liable for the assessment with respect to the premiums paid for the stop-loss policy by Employer B.

Exemption applicable to certain governmental programs

Certain direct governmental insurance programs are exempt from the assessment. Exempt governmental programs are Medicare Parts A and B, Medicaid, any program that provides health coverage (other than through an insurance policy) to members of the Armed Forces or veterans or to their spouses or dependents, and any program established by Federal law for providing medical care (other than through an insurance policy) to members of Indian tribes. Other government programs are subject to the assessment.

Graduate Medical Education and Academic Health Centers Trust Fund and Biomedical and Behavioral Research Trust Fund

The net revenues collected from the assessment will be used to fund the Graduate Medical Education and Academic Health Centers Trust Fund and the Biomedical and Behavioral Research Trust Fund, established under the bill.

EFFECTIVE DATE

The assessment is effective for payments and premiums received and expenses incurred with respect to coverage for periods after December 31, 1995.

3. Excise Tax on High Cost Health Plans (sec. 706 of the bill and secs. 4511–4512 of the Code)

PRESENT LAW

No excise tax or other special Federal assessment is imposed on domestic health insurance policy premiums.

REASONS FOR CHANGE

The Committee believes that an excise tax on high cost health plans will help contain nationwide health insurance costs.

EXPLANATION OF PROVISION

In general

The bill imposes a nondeductible excise tax on the issuer[9] of any applicable health plan[10] that is determined to be a high cost health plan for any taxable period.[11] The tax imposed equals 25 percent of the taxable amount with respect to the high cost health plan for the taxable period. For purposes of the provision, the taxable period is generally the period immediately following the close of the plan's annual open enrollment period for which coverage is provided to persons insured under the plan.[12]

The Secretary of the Treasury will establish reporting and recordkeeping requirements, and the times for making any deposits with respect to the tax imposed under this provision. Treasury is also granted authority to issue other regulations necessary to carry out this provision.

Status as a high cost health plan

General rule

An applicable health plan is a high cost plan for any taxable period in which the premiums received under the plan[13] exceed the sum of the target amounts for each class of enrollment.

The premiums received under the plan will be adjusted in a manner and only to the extent prescribed by the Secretary of the Treasury to disregard certain actuarial factors taken into account in establishing the premiums charged to insureds. With respect to community-rated plans, the premiums received will be the pre-

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[9] With respect to a self-insured plan, the tax will be imposed on the plan sponsor.

[10] An applicable health plan is any "certified standard health plan" and any "certified nonstandard health plan." A certified standard health plan is generally defined in section 21011(a)(2) of the Social Security Act, but, for this purpose, does not include a plan providing the alternative standard benefit package described in subtitle C of such Act. A certified nonstandard health plan is defined in section 21011(a)(3) of the Social Security Act.

An applicable health plan that covers individuals residing in more than one community-rated area will be treated as a separate plan with respect to each area.

[11] Amounts collected pursuant to this excise tax on high cost health plans will not be transferred (i.e., "covered over") to any possession.

[12] Every plan in a community-rated area will have the same open enrollment period, except for self-insured plans maintained by multistate employers. The taxable period for a multistate self-insured plan with respect to a particular area would be the plan's first full coverage period that begins on or after the end of the applicable community-rated area's coverage period. For example, assume that a multistate self-insured plan's coverage period runs from May 1 to April 30 of each year. If the plan operates in a community-rated area that has a coverage period that begins on January 1, 1995, the plan's taxable period for that year would begin on May 1, 1995 and end on April 30, 1996.

[13] The premimums received by a community-rated plan do not include any risk adjustment payment received by the plan.

miums that would have been received by the plan had any age adjustment factor been disregarded. For example, if a community-rated plan charged an individual an additional $100 above its standard premium as a result of the individual's age, the additional $100 is not treated as a premium received for purposes of determining whether the plan is a high cost plan.

With respect to experience-rated plans, the premiums received will be the premiums that would have been received by the plan had any risk adjustment factor been disregarded. The Committee intends that the risk adjustment factors to be disregarded will be similar to those factors used by the Department of Health and Human Services (HHS) to determine the risk adjustment for community-rated plans. For example, if gender is a factor that is taken into account in determining the risk adjustment for community-rated plans, then any amounts received by an experience-rated plan attributable to gender will be disregarded in the manner prescribed by the Secretary of the Treasury.

The premiums received under the plan include any premium received by the insurer with respect to a certified supplemental health plan [14] that covers an insured also covered by the certified standard health plan.

For a given class of enrollment for any taxable period, the target amount will be the target premium (established by the Treasury, as discussed below) for that class of enrollment multiplied by the number of primary insured people covered by the plan in that class of enrollment.[15]

Exception

An applicable health plan will not be treated as a high cost plan if the Treasury determines that the adjusted average premium for the plan falls below the adjusted average premium for three fourths of all plans in the United States for the calendar year. The adjusted average premium is the weighted average premium for all classes of enrollment under the plan, adjusted to account for (1) the same actuarial factors discussed above (i.e., in the case of community-rated plans, age adjustments, and in the case of experience-rated plans, risk adjustments), and (2) cost-of-living [16] and other differences among community-rated areas which affect premium costs. The adjusted average premium takes into account any premium received by the insurer with respect to a certified supplemental health plan that covers an insured also covered by the certified standard health plan.

Determination of taxable amount

Under the bill, the taxable amount is the amount by which the total premiums received under the plan exceed the sum of the "reference premium amounts" for each class of enrollment. For this purpose, the total premiums received is determined in the same manner as the general rule for determining whether a plan is a

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[14] A certified supplemental health plan is defined in section 21011(a)(4) of the Social Security Act.

[15] In the event a primary insured person is covered only for a portion of the taxable period, the target premium with respect to such person must be proportionately reduced.

[16] If cost-of-living data is not available by area, the Treasury Department is authorized to use such other information relating to cost-of-living as it deems relevant.

high cost plan. The reference premium amount, for a given class of enrollment, will be the reference premium for that class of enrollment for the taxable period multiplied by the number of primary insured people covered by the plan in that class of enrollment.

Establishment of target and reference premiums

The Secretary of the Treasury is required annually to establish target premiums and reference premiums for each community-rated area as soon as practicable after the close of the area's open enrollment period. A target premium and a reference premium would be separately established for community-rated and experience-rated plans with respect to each class of enrollment. The Secretary is required to establish target premiums at levels it estimates will cause the tax to apply to (1) community-rated standard health plans covering 40 percent of the total primary insured people covered by community-rated standard health plans in the area, and (2) experience-rated standard health plans covering 40 percent of the total primary insured people covered by experience-rated standard health plans in the area. The reference premium for an area will equal the average premium for the class of enrollment for all certified standard health plans offered in the area.

Treatment of self-insured plans

For purposes of determining a self-insured plan's status as a high cost plan and its taxable amount, the premiums received by the self-insured plan will include (1) a reasonable estimate of the plan's expenditures for accident or health coverage and for direct administrative expenses in the community-rated area during the taxable period, and (2) any premiums paid by the plan sponsor for accident or health coverage under an insurance policy.

Temporary increase in tax rate to fund subsidies

The excise tax rate under this provision is increased to 29 percent for taxable periods beginning after December 31, 1996 and before January 1, 2002, to provide full subsidies for children and pregnant women under part B of title XIX of the Social Security Act.

Effective date

The provision is effective after December 31, 1995.

4. Recapture of Certain Health Care Subsidies Received by High-Income Individuals (sec. 711 of the bill and sec. 59B of the Code)

PRESENT LAW

Medicare, authorized under Title XVIII of the Social Security Act, is a nationwide health insurance program for the aged and certain disabled persons. It consists of two parts: the hospital insurance (Part A) program and the supplementary medical insurance (Part B) program.

Most Americans age 65 or older are automatically entitled to coverage under Part A of Medicare. Part B of Medicare is voluntary. For 1994, each individual who enrolls in Medicare Part B pays the

same flat-rate premium of $41.10 per month regardless of his or her income level. This premium rate is equal to 25 percent of estimated program costs for the coming year. Benefits received under Part A and Part B of Medicare are excludable from the gross income of the recipient.

REASONS FOR CHANGE

Under present law, the Federal Government subsidizes 75 percent of the cost of coverage under Part B of Medicare. The subsidy applies to all Medicare Part B enrollees regardless of their income levels. The Committee believes that premium subsidies should be based on each taxpayer's ability to pay and, thus, that higher-income taxpayers should pay a greater share of the premiums for coverage under Medicare Part B.

EXPLANATION OF PROVISION

Under the bill, taxpayers with modified adjusted gross income (AGI) above a threshold amount are required to pay additional premiums for each month of coverage under Part B of Medicare. The maximum Medicare Part B premium for high-income Medicare Part B enrollees would cover approximately 75 percent of estimated program costs, up from the current level of 25 percent.

For purposes of computing the additional premium, modified AGI is AGI plus tax-exempt interest, certain foreign source income, and income from tax-exempt higher education U.S. savings bonds. The threshold amount is $90,000 for unmarried taxpayers, $115,000 for married taxpayers filing joint returns, and $0 for married taxpayers filing separate returns. The amount of additional premiums is phased in for taxpayers with modified AGI which exceeds the threshold amount by less than $15,000 ($30,000 for married taxpayers filing joint returns if each spouse is required to pay additional premiums).

Any additional Medicare Part B premiums imposed under the bill are treated as income taxes for purposes of subtitle F of the Code (relating to income tax procedure and administration) but are not treated as income taxes for alternative minimum tax purposes (Code sec. 55), or for the purpose of determining the amount of other tax credits under the Code. Additional premiums imposed under the bill are deductible to the extent the premiums, when added to other medical expenses not otherwise deductible, exceed 7.5 percent of AGI.

Under the bill, penalties for failure to pay estimated income tax will not be imposed on a taxpayer for any period prior to April 16, 1997, to the extent that the underpayment results from the failure to pay additional Medicare Part B premiums.

Proceeds from the collection of additional Medicare Part B premiums are to be credited at least quarterly to the Supplementary Medical Insurance Trust Fund.

Under present law, the Medicare system is applicable in U.S. possessions. In order to ensure that the additional Part B premium is collected with respect to Medicare participants who are residents of a U.S. possession, the bill provides that a U.S. possession is not a participating State for purposes of the bill unless, under an agreement with the United States, the laws of the possession im-

pose an additional Medicare Part B premium that is the same as that imposed in the United States and the possession pays over the proceeds from the premium to the Supplementary Medical Insurance Trust Fund.

Effective date

The provision is effective for taxable years beginning after December 31, 1995.

5. Increase in Excise Tax on Certain Hollow Point and Large Caliber Handgun Ammunition (sec. 715 of the bill and sec. 4181 of the Code)

PRESENT LAW

A 10-percent excise tax is imposed on the sale of pistols and revolvers by a manufacturer, producer or importer thereof. Other firearms and shells and cartridges are subject to an 11-percent excise tax.

Amounts equivalent to revenues from these excise taxes fund the Federal Aid to Wildlife Program for use in making grants to support State wildlife programs.

REASONS FOR CHANGE

The Committee believes that certain ammunition has been designed, not for sporting purposes, but rather with the sole intent to inflict severe, massive, physical injury to the human body. For example, some ammunition has been designed to produce, upon impact, sharp barb-like projections that extend beyond the diameter of the unfired cartridge, producing extraordinary tissue damage in a victim. In the United States, such ammunition can be purchased readily over the counter. The availability of such ammunition presents a grave danger to ordinary citizens, to law enforcement officers, and even to emergency room physicians who must remove barbed projectiles by hand from the wounds of gunshot victims.

The Committee believes that such ammunition should be removed from the market place. Accordingly, the Committee believes it is appropriate to impose a rate of tax of sufficient magnitude on such ammunition to eliminate its manufacture.

EXPLANATION OF PROVISION

The provision increases the ad valorem excise tax rate on certain handgun ammunition. A 10,000-percent rate applies to (1) jacketed, hollow point projectiles which may be used in a handgun and are designed to produce, upon impact, sharp-tipped, barb-like projections that extend beyond the diameter of the unfired projectile; and (2) cartridges with a projectile measuring 0.500 inch or greater in diameter which may be used in a handgun.

"Jacketed" means the projectile or bullet is encased in a thin metal cover or jacket. "Hollow point" means there is a cavity in the nose of the projectile. A hollow point projectile expands somewhat on impact. Examples of jacketed, hollow point projectiles that produce, upon impact, sharp-tipped, barb-like projections, are ammunition currently known as "Starfire," "Hydro Shok," "Golden Saber," and "Lawman."

Amounts equivalent to revenues from this increased excise tax will be added to the General Fund and will not be used to fund the Federal Aid to Wildlife Program.

Effective date

The provision is effective for sales made after December 31, 1994. A floor stocks tax generally is imposed on taxed ammunition products held on January 1, 1995. However, no floor stocks tax is imposed on taxed ammunition that is destroyed (in a manner prescribed by the Secretary of Treasury) before April 1, 1995.

6. Modification to Self-Employment Tax Treatment of Certain S Corporation Shareholders and Partners (sec. 716 of the bill and sec. 1402 of the Code)

PRESENT LAW

Employment taxes, in general

As part of the Federal Insurance Contributions Act (FICA), a tax is imposed on employees and employers. One-half of the tax is imposed on the employer and one-half is imposed on the employee. The tax is composed of two parts: old-age, survivor, and disability insurance (OASDI) and Medicare hospital insurance (HI). For wages paid in 1994 to covered employees, the total OASDI portion of the tax is 12.4 percent of the first $60,600 of wages. The total HI portion of the tax is 2.9 percent of total wages. The cap on wages subject to the OASDI portion of FICA tax is indexed to changes in the average wages in the economy. The cap on wages subject to the HI portion of the tax was repealed for wages and income received after December 31, 1993. For 1993, the HI wage cap was $135,000.

Similarly, under the Self-Employment Contributions Act (SECA), a tax is imposed on an individual's net earnings from self-employment (NESE). The SECA tax rate is the same as the total FICA rates for employers and employees (i.e., 12.4 percent for OASDI and 2.9 percent for HI) and the SECA base is capped and indexed in the same manner as is the FICA base. In general, the SECA tax is reduced to the extent the individual had wages for which FICA taxes were withheld during the year.

Treatment of partners and S corporation shareholders

The NESE of a partner in a partnership generally is the partner's distributive share from any trade or business of the partnership, adjusted for certain items of income that are passive in nature (for example, rentals of real estate, dividends, and interest are excluded from NESE unless such amounts are received in the course of a trade or business of a dealer in the related property). However, the distributive share of a limited partner generally is excluded from NESE except to the extent the distributive share is a guaranteed payment for services actually rendered to or on behalf of the partnership.

Similar rules are not provided for shareholders in S corporations.[17] Thus shareholders are not required to include as NESE their pro rata share of the income of an S corporation.[18] Rather, shareholders who perform services for the S corporation are subject to FICA taxes on the wages paid to them.[19]

REASONS FOR CHANGE

The SECA wage base is intended to parallel the FICA wage base in that both SECA and FICA are intended to subject to tax remuneration from the taxpayer's own labor. The Committee believes that the current SECA base is under-inclusive in some cases (because certain labor income is not subject to tax) and over-inclusive in others (because certain capital income is subject to tax). These under- and over-inclusions often result merely because of the form of entity through which the individual taxpayer conducts his or her trade or business. The bill modifies the SECA base to more accurately measure the "wage" element of self-employment income and to provide similar treatment for similar income earned through different types of entities.

EXPLANATION OF PROVISION

In general

The provision amends the definition of NESE to: (1) Include 80 percent of the pro rata share of S corporation income derived from service-related businesses for shareholders who own more than two percent of the stock and provide significant services to the corporation; (2) provide similar rules for limited partners who provide significant services to partnerships; and (3) provide a special exclusion for certain income derived from inventory for all taxpayers.

S corporation shareholders

Under the provision, in the case of a "2-percent shareholder" of an S corporation for any taxable year who provides significant services to or on behalf of the corporation during the year, the NESE of the shareholder includes 80 percent of the shareholder's pro rata share of taxable income or loss from "service-related businesses" carried on by the S corporation. A "2-percent shareholder" means any shareholder that owns more than 2 percent of the stock of an S corporation at any time during the year (sec. 1372(b)). The shareholder's pro rata share of the income or loss of an S corporation is determined pursuant to the general rules of subchapter S (sec. 1366). A "service-related business" is any trade or business involving the performance of services in the fields of health (other than with respect to in-patient personal care facilities), law, engineering,

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[17] For some purposes, a shareholder that owns more than 2 percent of the stock of an S corporation is treated as a partner in a partnership (sec. 1372(a)). However, this rule does not apply for employment tax purposes.

[18] See, Rev. Rul. 59–221, 1959–1 C.B. 225.

[19] Furthermore, a shareholder of an S corporation may be subject to FICA tax even if the shareholder is not paid amounts denominated as "wages" by the corporation. In Rev. Rul. 74–44, 1974–1 C.B. 287, the IRS held that two shareholders who performed services for an S corporation but did not draw salaries were subject to FICA tax on dividend distributions from the corporation because the dividends represented reasonable compensation for the services performed. See, also, *Spicer Accounting, Inc.* v. *U.S.*, 918 F2d 90 (9th Cir. 1990) and *Dunn & Clark, P.A.* v. *U.S.*, No. CV 93–0108–E–EJL, (DC Idaho, 3/25/94) for similar results.

architecture, accounting, actuarial services, performing arts, consulting, athletics, financial services (other than lending[20] or brokerage services), or any trade or business with respect to which the Secretary of the Treasury determines that capital is an insignificant income-producing factor.

The present-law exclusions from NESE that apply to certain types of income also apply to S corporations. If any portion of a shareholder's pro rata share of the income or loss of an S corporation from a trade or business carried on by the corporation is community property income or loss under the community property laws applicable to such share, all of such income or loss is included in computing the NESE of the shareholder and no part of such income or loss is taken into account by the shareholder's spouse.

Amounts that an S corporation shareholder must treat as NESE under this provision are treated as compensation received by the taxpayer as an employee of the corporation for purposes of subchapter D of the Internal Revenue Code (relating to deferred compensation).

Limited partners

In the case of a limited partner of a partnership who provides significant services to or on behalf of the partnership during the year, the NESE of the partner for the year includes 80 percent of the partner's distributive share (other than guaranteed payments for services) of taxable income or loss from service-related businesses (as defined above) carried on by the partnership.[21] The provision retains the present-law guaranteed payment rule for limited partners who provide services to or on behalf of the partnership. Thus, for example, a limited partner who provides significant services to or on behalf of the partnership during the year would include in NESE: (1) 100 percent of any guaranteed payments received for services, plus (2) 80 percent of any remaining distributive share of taxable income or loss from service-related businesses carried on by the partnership. The present-law exclusions from NESE that apply to certain types of income also apply to limited partners.

Inventory income

In general, the provision allows a taxpayer with NESE in excess of $135,000 and income from inventory to exclude 40 percent of such inventory income from NESE. No exclusion is allowed with respect to the first $135,000 of NESE, even if all of such income is from inventory. Specifically, the provision allows a taxpayer to reduce his or her NESE for the taxable year by 40 percent of the

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[20] For this purpose, lending services generally means the lending services of a type similar to those normally provided by a bank or similar institution.

[21] In some instances, a limited partner may provide significant services to or on behalf of a partnership in one taxable year that will generate taxable income to the partnership (and be reported in the distributive share of the limited partner) in another taxable year during which the limited partner may not provide significant services. To the extent provided in regulations promulgated by the Secretary of the Treasury, a limited partner will include in NESE a portion of the partner's distributive share of taxable income or loss from service-related businesses from a taxable year if such share is attributable to services performed in another taxable year. Such regulations shall not apply to income attributable to services rendered in taxable years prior to the effective date of this provision. Similar rules will apply to 2-percent shareholders of S corporations.

lesser of: (1) the amount of the taxpayer's allocable share of net inventory income or (2) the amount by which the taxpayer's NESE (determined without respect to this inventory exclusion) for the year exceeds $135,000. The $135,000 amount is reduced by the amount of the taxpayer's wages that are subject to FICA and is indexed to changes in the average wages in the economy.

For this purpose, "net inventory income" generally is net income from the sale of property described in section 1221(1) (i.e., stock in trade of the taxpayer or other property of a kind which would properly be included in the inventory of the taxpayer if on hand at the close of the taxable year, or property held by the taxpayer primarily for sale to customers in the ordinary course of his trade or business). For this purpose, net income is the gross profit from inventory sales reduced by the items of deduction or loss properly allocable to such sales.[22] In the case of a dealer in securities (as defined in sec. 475(c)(1)), net inventory income generally includes all net income otherwise includible in NESE related to securities[23] (generally as defined in sec. 475(c)(2), but including section 1256 contracts) held in the taxpayer's capacity as a dealer in securities. Thus, net inventory income of a dealer in securities includes interest, dividends, and other income or gain with respect to securities held as inventory.

Other

The provision makes conforming amendments to the Social Security Act.

The provision is not intended to change the present-law authority of the Internal Revenue Service to ascertain the proper amount to be treated as wages derived by a shareholder-employee of an S corporation.

Effective date

The provision applies to taxable years of individuals beginning after December 31, 1995, and to taxable years of S corporations and partnerships ending with or within such taxable years of individuals.

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[22] For a trade or business the sole activity of which is the sale of inventory, net inventory income is the net income of the trade or business. For a trade or business that involves the sale of inventory and other activities, net inventory income is the gross profit from the inventory sales (i.e., gross sales less cost of goods sold) less the items of loss and deduction properly allocable to such sales.

[23] A self-employed individual includes a NESE gross income from any trade or business carried on by the individual less the deductions allocable to such income. Present-law sec. 1402(a)(2) provides that NESE does not include interest and dividend income unless the interest and dividends are received in the course of a trade or business as a dealer in stocks or securities. Similarly, sec. 1402(a)(3) provides that gains from the sales of property are excluded from NESE if such property is a capital asset or is of a kind which is not includible in inventory or held primarily for the sale of customers. Thus, under present law, a dealer in securities described by sec. 475(c)(1) generally includes in NESE the dividends, interest, gains, or other income derived from securities described by sec. 475(c)(2) held by the dealer. A dealer in securities generally excludes from NESE any income derived from a security held as an investment (e.g., those securities described by sec. 475(b)(1)(A)).

7. Extending Medicare Coverage of, and Application of Hospital Insurance Tax to, All State and Local Government Employees (sec. 717 of the bill, sec. 3121(u) of the Code, and secs. 210(p) and 226(g) of the Social Security Act)

PRESENT LAW

Under present law, State and local government employees hired before April 1, 1986, are not covered under Medicare unless a voluntary agreement is in effect. Although the hospital insurance payroll tax does not apply to such employees, they may receive Medicare benefits, for example, through their spouse. Medicare coverage and the hospital insurance payroll tax are mandatory for State and local government employees hired on or after April 1, 1986, and Federal employees.

For wages paid in 1994 to Medicare-covered employees, the total hospital insurance tax rate is 2.9 percent of total wages. One-half of the hospital insurance tax (1.45 percent) is imposed on the employee and one-half on the employer.

REASONS FOR CHANGE

The Committee believes that it is appropriate, as part of fundamental health care reform, to require that all State and local government employees be entitled to coverage under Medicare. The Committee believes that such coverage will ensure that no elderly individuals will be denied adequate health care.

In addition, many State and local government employees already qualify for Medicare coverage by virtue of other employment. The Committee believes that it is unfair to relieve such employees of an obligation to contribute to the solvency of the Medicare system when all other employees are required to contribute to Medicare even after they have sufficient quarters of coverage to qualify for Medicare benefits.

EXPLANATION OF PROVISION

The provision extends Medicare coverage on a mandatory basis to all employees of State and local governments not otherwise covered under present law, without regard to their dates of hire. These employees and their employers would be liable for the hospital insurance tax, and the employees will earn credit toward Medicare eligibility.

In addition, service prior to October 1, 1995, of State and local government employees whose wages are subject to the hospital insurance tax solely because of the bill will be considered covered employment for purposes of determining eligibility for Medicare coverage. The Department of the Treasury will be required to reimburse the Federal Hospital Insurance Trust Fund for additional payments made, administrative expenses incurred, and any interest losses which occur as a result of the recognition of the prior service of State and local government employees for Medicare eligibility purposes.

The provision requires that the Secretary of the Treasury, in consultation with State and local governments, provide procedures designed to ensure that individuals who perform Medicare-qualified

government employment are informed of (1) their eligibility or potential eligibility for benefits under Medicare Part A, (2) the requirements for, and conditions of, eligibility for benefits under Medicare Part A, and (3) the necessity of filing a timely application as a condition of becoming entitled to benefits. These procedures are required to give particular attention to individuals who apply for an annuity or retirement benefit based on a disability.

Effective date

The provision applies to services performed by State and local government employees after September 30, 1995.

Subtitle B—Tax Treatment of Employer-Provided Health Care

1. Tax Treatment of Voluntary Employer Health Care Contributions (sec. 721 of the bill and new secs. 4521–4524 of the Code)

PRESENT LAW

Employers generally can deduct the full cost of employer-provided health care as an ordinary and necessary business expense. In addition, employer-provided health coverage generally is fully excludable from the gross income of employees. However, if an employer provides its employees with health benefits under a self-insured medical reimbursement plan, reimbursements under such plan are excludable with respect to a highly compensated individual only to the extent that the plan does not discriminate in favor of highly compensated individuals either as to eligibility to participate or as to benefits (sec. 105(h)). Under the requirements for nondiscrimination in benefits, a self-insured plan may establish a limit for the amount of reimbursement which may be paid for any single benefit or combination of benefits under the plan. However, any maximum limit on the amount of reimbursement for health expenses attributable to employer contributions under a self-insured medical expense plan must be uniform for all participants and for all dependents of employees who are participants and may not be modified by reason of a participant's age or years of service (Treas. Reg. § 1.105–11(c)(3)(i)).

REASONS FOR CHANGE

The Committee believes that employer-provided health coverage that does not meet the requirements of the bill, that discriminates against individuals based on health status, or that is not made available on the same terms to all employees should not receive favorable tax treatment. Moreover, requiring any employer contributions to be made available on the same terms to all employees prevents employers from providing coverage for higher-income employees while shifting the cost of coverage of lower-income employees to the Federal Government.

The Committee believes it appropriate to deny the deduction for noncomplying employer contributions. However, because a deduction denial has no effect on some employers (e.g., tax-exempt and government employers are not affected by a deduction denial), the Committee has decided to impose an excise tax as a proxy for denial of the employer deduction.

EXPLANATION OF PROVISION

In general

Under the bill, employer-provided health care continues to be excludable from the gross income of employees. However, employer contributions for accident or health care that do not meet certain requirements are subject to a nondeductible excise tax designed to approximate the effect of denying the employer deduction for certain health expenses. In general, the excise tax applies to employer contributions for coverage other than permitted coverage and to employer contributions for discriminatory coverage. Permitted coverage generally includes coverage that satisfies the requirements of Title I of the bill and certain other specified types of coverage. Coverage is discriminatory if it is provided on a basis that discriminates against individuals based on health status or if the employer contributions are not available on an equal basis to employees.

Employer contributions for health coverage other than permitted coverage

Under the bill, employer-provided accident or health coverage is subject to the excise tax if it is not permitted coverage. Permitted coverage is (1) coverage under a certified standard health plan,[24] (2) coverage under a certified supplemental health plan[25] unless such coverage supplements the coverage or benefits provided under a certified standard health plan that provides the alternative standard benefits package,[26] (3) coverage under a qualified long-term care insurance policy,[27] (4) 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, (5) accidental death or dismemberment coverage, (6) coverage under a medicare supplemental policy[28] and (7) coverage under an equivalent health care program.[29]

The provision does not affect the present-law rules regarding taxation of employer contributions for coverage or the taxation of any payments received by an employee. Whether or not accident or health coverage is permitted coverage for purposes of the excise tax is independent of income or employment tax treatment.

Discriminatory coverage

Employer contributions cannot vary based on health status

Any employer that contributes towards the cost of coverage for employees under a certified standard health plan or a certified supplemental health plan that constitutes permitted coverage cannot

[24] The term "certified standard health plan" is defined in sec. 21011(a)(2) of the Social Security Act.

[25] The term "certified supplemental health benefit plan" is defined in sec. 21011(a)(4) of the Social Security Act.

[26] The alternative standard benefits package is described in sec. 21201(b) of the Social Security Act.

[27] The term "qualified long-term care insurance policy" is defined in new sec. 7702B(b) of the Code.

[28] The term "medicare supplemental policy" is defined in sec. 1882(g)(1) of the Social Security Act.

[29] The term "equivalent health care program" is defined in sec. 21100(6) of the Social Security Act. Equivalent health care programs include certain government programs such as Medicare, Medicaid, programs for the military, and similar programs.

impose a waiting period, deny coverage, or vary the amount of the contribution solely by reason of any employee's health status, claims experience, medical history, receipt of health care, or lack of evidence of insurability.

Equal employer contribution

General rules.—Any employer that contributes towards the cost of coverage for any employee under a certified standard health plan or a certified supplemental health plan that constitutes permitted coverage is required to contribute one of the following amounts towards the cost of the coverage selected by any other employee: (1) The same dollar amount, (2) the same percentage of the cost of the coverage (with or without a dollar cap),[30] or (3) the same percentage of the weighted average premium for the class of enrollment[31] for the community rating area in which the employee works (with or without a dollar cap).

An employer can elect to apply the equal contribution rule separately with respect to full-time employees and part-time employees. Employers that contribute to the purchase of any part-time employee's coverage can elect to make a contribution to all part-time employees proportionate to the number of hours worked by the part-time employee.

A full-time employee is an employee who is normally employed at least 24 hours in a week. A part-time employee is an employee who is normally employed at least 10 hours per week and less than 24 hours per week. The following employees (whether full-time or part-time) are excluded for purposes of the equal contribution rule: (1) Employees who have not completed 6 months of service; (2) employees who normally work not more than 6 months during any year; (3) employees who are included in a unit of employees covered by a collective bargaining agreement if health coverage was the subject of good faith bargaining; (4) employees who have not attained age 18; (5) former employees; and (6) employees who are non-resident aliens and who receive no U.S. source earned income.

Aggregation rules.—For purposes of the equal contribution rule, certain aggregation rules apply. All employees of corporations that are members of a controlled group of corporations, or all employees of trades and businesses (whether or not incorporated) that are under common control, are aggregated and treated as if employed by a single employer (sec. 414(b) and (c)). Similarly, all employees of employers that are members of an affiliated service group are treated as employed by a single employer (sec. 414(m)). The employee leasing rules (sec. 414(n)) also apply. If an employer could be treated as operating separate lines of business for a year for pension plan purposes, the employer may apply the equal contribution rules separately to each separate line of business for that year.

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[30] The dollar limit can be expressed either as a flat dollar amount or as a percentage of the weighted average premium for the class of enrollment. The following examples illustrate this rule. Example 1: An employer contribution for each employee of 80 percent of the cost of the coverage up to a maximum annual contribution of $3,000 would satisfy the equal contribution rule. Example 2: An employer contribution for each employee of 90 percent of the cost of the coverage under the plan, but no more than 100 percent of the weighted average premium for the class of enrollment of the employee would satisfy the equal contribution rule.

[31] The term "weighted average premium" is defined in sec. 1952 of the Social Security Act.

Examples.—

Example 1.—Assume that an employer's full-time employees work in several community rating areas and that the weighted average premiums for single coverage and coverage for a couple with children vary among those areas as set forth below:

	Single WAP	Couple with children WAP
Community rating area No. 1	$2,000	$4,000
Community rating area No. 2	3,000	6,000
Community rating area No. 3	4,000	8,000

Assume further that the employer elects to satisfy the equal contribution rule by contributing the same percentage (75 percent) of the weighted average premium for each class of enrollment in each community rating area to all of its full- time employees. In this example, employer contributions for employees in the single and couple with children classes of enrollment could vary as follows:

	Single WAP	Couple with children WAP
Community rating area No. 1	$1,500	$3,000
Community rating area No. 2	2,250	4,500
Community rating area No. 3	3,000	6,000

Further assume that the employer limits its contributions to the lesser of the weighted average premium for the classes of enrollment or a fixed dollar amount ($3,000). In this case, employer contributions for single coverage and coverage for a couple with children could vary as follows:

	Single WAP	Couple with children WAP
Community rating area No. 1	$1,500	$3,000
Community rating area No. 2	2,250	3,000
Community rating area No. 3	3,000	3,000

Example 2.—Assume that an employer offers to pay 80 percent of a $4,000 premium (i.e., $3,200) for coverage under a certified standard health plan for one of its full-time single employees. The employer offers to contribute the following amount for coverage for any employee: 80 percent of the cost of coverage under the plan selected by the employee, but no more than $3,200. This satisfies the equal contribution requirement.

Example 3.—Assume the same facts as in example 2, but in addition, the employer offers to pay 50 percent of the $4,000 premium (i.e., $2,000) for single coverage under a certified standard health plan for one of its part-time employees who works 20 hours per week. Under the bill, the employer is required to make contributions to all part-time employees that work at least 10 but less than 24 hours per week but may elect to prorate such contributions based on the number of hours worked by such part-time employees. Thus, for example, the equal contribution rule would be satisfied if the employer makes the following contribution for employees that work 10 hours per week: 10/20 multiplied by the same dollar amount contributed on behalf of the employee who works 20 hours per week (10/20 x $2,000 = $1,000).

Amount of excise tax

The amount of the excise tax for coverage that does not satisfy the requirements of this provision is equal to the product of: (1) the sum of (a) employer contributions under an accident or health plan for coverage other than permitted coverage, and (b) the total employer contributions for coverage under certified standard health plans and certified supplemental health plans that constitute permitted coverage during any portion of the year in which there is discriminatory coverage; and (2) the highest corporate tax rate (currently 35 percent).[32]

The excise tax applies to all employers that violate the voluntary contribution rules, including tax-exempt and governmental employers. The excise tax is not deductible.

No excise tax will be imposed with respect to any period for which it is established to the satisfaction of the Secretary of the Treasury that the employer did not know or, through exercising reasonable diligence, would not have known, that violations of the voluntary contribution rules existed. In addition, no excise tax will be imposed for any violation of the voluntary contribution rules if such violation is due to reasonable cause and not to willful neglect, and is corrected during the 30-day period beginning on the first date the employer knew, or exercising reasonable diligence would have known that such failure existed. Further, in the case of a violation which is due to reasonable cause and not to willful neglect, the Secretary of the Treasury can waive all or part of any excise tax, to the extent that the payment of such tax would be excessive relative to the failure involved.

Miscellaneous rules

For purposes of the provision, a partnership is treated as the employer of each partner and an S corporation is treated as the employer of each shareholder who is an employee within the meaning of section 401(c) of the Code. The term "employer contribution" means, with respect to coverage under a health plan, the portion of the cost of the coverage that is provided to or on behalf of an employee by an employer. The term "employer contribution" also includes salary reduction amounts under a cafeteria plan. In the case of a cafeteria plan, employer contributions available under the plan (rather than actual employer contributions) are taken into account under the equal contribution rule.

It is intended that the voluntary contribution rules do not apply to employer contributions for direct services that are determined by the Secretary of the Treasury to be primarily aimed at workplace health care and health promotion or related population-based preventive health activities, to the extent the Secretary determines imposition of the excise tax would be inconsistent with the purposes of the bill.

The Secretary of the Treasury is authorized to prescribe such regulations as are necessary to carry out the purposes of the provision, including regulations providing for the determination of the amount of any employer contributions and the prevention of avoid-

[32] The bill provides that any amounts collected with respect to this tax are not transferred ("covered over") to any possession.

ance of the excise tax through the use of certain arrangements (described in Code sec. 414(o)).

EFFECTIVE DATE

The voluntary contribution rules apply on or after January 1, 1996.

2. Elimination of Exclusion of Health Benefits Provided Through a Flexible Spending Arrangement (sec. 722 of the bill and sec. 106 of the Code)

PRESENT LAW

Cafeteria plans

Under present law, compensation generally is includible in gross income when actually or constructively received, i.e., when it is made available to the individual or the individual has an election to receive such amount. Under one exception to the general principle of constructive receipt, no amount is included in the gross income of a participant in a cafeteria plan maintained by an employer solely because the participant may elect among cash and certain employer-provided qualified benefits. In general, a qualified benefit is a benefit that is excludable from an employee's gross income by reason of a specific provision of the Internal Revenue Code. Employer-provided accident or health coverage is a qualified benefit.

The cafeteria plan exception from the principle of constructive receipt also applies for employment tax purposes.

Flexible spending arrangements

A flexible spending arrangement ("FSA") is a reimbursement account or similar arrangement (whether provided through commercial insurance or otherwise) under which an employee is reimbursed for medical expenses or other employer-provided qualified benefits, such as dependent care. FSAs that are part of a cafeteria plan generally are funded through salary reduction. FSAs may also be provided by an employer outside a cafeteria plan. FSAs are commonly used, for example, to reimburse employees for medical expenses not covered by insurance. If certain conditions are satisfied, amounts reimbursed under an FSA for medical expenses (other than premiums) are excludable from gross income and wages for employment tax purposes.

Proposed Treasury regulations define a health FSA as a benefit program that provides employees with coverage under which specified, incurred expenses may be reimbursed (subject to reimbursement maximums and any other reasonable conditions) and under which the maximum amount of reimbursement that is reasonably available to a participant for a period of coverage is not substantially in excess of the total premium (including both employee-paid and employer-paid portions of the premium) for such participant's coverage. A maximum amount of reimbursement is not substantially in excess of the total premium if the maximum amount is less than 500 percent of the premium.

REASONS FOR CHANGE

Flexible spending arrangements provide tax benefits for first-dollar health care coverage (e.g., copayments and deductibles) as well as uninsured expenses. Thus, individuals receiving the care do not pay the full cost of the coverage; some of it is subsidized by the Federal Government. This subsidy can lead to overutilization of health care services and can contribute to increases in health care costs. In addition, under the bill, because all individuals have access to a standard benefit package, there is no need to provide a subsidy for such expenses. Thus, the Committee believes that it is appropriate to eliminate the exclusion for benefits provided under a flexible spending arrangement.

EXPLANATION OF PROVISION

Under the bill, accident or health benefits provided under an FSA are includible in income and wages for income and employment tax purposes. An FSA is defined generally as under the proposed Treasury regulations. Under the bill, an FSA is a benefit program which provides employees with coverage (whether through commercial insurance or otherwise) under which (1) specified incurred expenses may be reimbursed (subject to reimbursement maximums and other reasonable conditions), and (2) the maximum amount of reimbursement which is reasonably available to a participant for such coverage is less than 500 percent of the cost of such coverage. In the case of an insured plan, the maximum amount reasonably available is to be determined on the basis of the underlying coverage.

EFFECTIVE DATE

The provision is generally effective on and after January 1, 1996. A delayed effective date is provided with respect to collectively bargained plans.

3. Two-Year Extension of the Deduction for Health Insurance Costs of Self-Employed Individuals (sec. 723 of the bill and sec. 162(l) of the Code)

PRESENT LAW

Under present law, individuals who itemize deductions may deduct amounts paid during the taxable year (if not reimbursed by insurance or otherwise) for medical care of the taxpayer, or the taxpayer's spouse and dependents, to the extent that the total of such expenses exceeds 7.5 percent of the taxpayer's adjusted gross income (AGI).

In addition, under present law, self-employed individuals cannot exclude the value of health insurance from gross income. For this purpose, self-employed individuals include sole proprietors, partners in partnerships, and more than 2-percent shareholders of S corporations. Prior to January 1, 1994, a self-employed individual could deduct from gross income 25 percent of the health insurance costs of the individual and his or her spouse or dependents. The 25-percent deduction was not available for any month if the self-employed individual was eligible for employer-paid (i.e., employer sub-

sidized) health benefits under a plan of an employer of the individual or the individual's spouse. In addition, no deduction was available to the extent that the deduction exceeded the taxpayer's earned income.

REASONS FOR CHANGE

The bill provides a deduction for all individuals who are not eligible for employer-subsidized health insurance. The Committee believes it is appropriate to extend the 25-percent deduction for health insurance expenses of self-employed individuals until the new deduction is effective.

EXPLANATION OF PROVISION

The bill extends the 25-percent deduction for health insurance expenses of self-employed individuals, effective for taxable years beginning after December 31, 1993, and before January 1, 1996.

EFFECTIVE DATE

The 25-percent deduction for self-employed individuals is extended effective for taxable years beginning after December 31, 1993, and before January 1, 1996.

4. Limitation on Prepayment of Medical Insurance Premiums (sec. 724 of the bill and sec. 213(d) of the Code)

PRESENT LAW

Under present law, a taxpayer who itemizes deductions may deduct amounts paid during the taxable year (if not reimbursed by insurance or otherwise) for medical care of the taxpayer, and the taxpayer's spouse and dependents to the extent that the total of such expenses exceeds 7.5 percent of the taxpayer's adjusted gross income (AGI).

Under a special rule, premiums paid during the taxable year by a taxpayer before he or she attains age 65 for insurance that covers medical care for the taxpayer after the taxpayer attains age 65, or the taxpayer's spouse or a dependent, are treated as expenses paid during the taxable year for insurance that constitutes medical care if premiums for the insurance are payable (on a level payment basis) under the contract for a period of 10 years or more or until the year in which the taxpayer attains age 65 (but in no case for a period of less than five years).

A series of revenue rulings has held that, under certain circumstances, the portion of a fee paid for lifetime care that is properly allocable to medical expenses is deductible in the year paid, even though the medical services will not be performed until a future time, if at all.[33] The Internal Revenue Service has recently issued a revenue ruling stating that the prior rulings should not be interpreted as allowing a current deduction of payments for future medical care (including medical insurance) extending substantially beyond the close of the taxable year in situations where the future care is not purchased in connection with obtaining lifetime care of

[33] See Rev. Rul. 75–302, 1975–2 C.C. 86; Rev. Rul. 75–303, 1975–2 C.B. 87; Rev. Rul. 76–481, 1976–2 C.B. 82.

the type described in the prior rulings.[34] The recent revenue ruling states that it will not be applied to amounts paid before October 14, 1993, or to amounts paid on or after October 14, 1993, pursuant to the terms of a binding contract entered into before that date if such terms were in effect on that date.

REASONS FOR CHANGE

The Committee believes that permitting taxpayers to deduct the cost of health insurance premiums in advance of the period during which the insurance coverage is to be provided allows taxpayers to manipulate the timing of deductions based on cash expenditures and is contrary to general principles for the recognition of income and deductions.

EXPLANATION OF PROVISION

The bill provides that, for purposes of the itemized deduction for medical expenses and the 100-percent deduction for qualified health care costs of individuals, amounts paid during a taxable year that are allocable to insurance coverage or medical care to be provided more than 12 months after the month in which the payment is made will be treated as paid ratably over the period during which the coverage or care is to be provided. The provision does not amend the special rule under present law for post-age 65 medical insurance.

EFFECTIVE DATE

The provision applies to amounts paid after December 31, 1994.

Subtitle C—Deduction for Individuals Purchasing Own Health Insurance

1. Deduction for Health Insurance Costs of Individuals (sec. 731 of the bill and sec. 213 of the Code)

PRESENT LAW

Under present law, individuals who itemize deductions may deduct amounts paid during the taxable year (if not reimbursed by insurance or otherwise) for medical care of the taxpayer, or the taxpayer's spouse and dependents, to the extent that the total of such expenses exceeds 7.5 percent of the taxpayer's adjusted gross income (AGI).

In addition, under present law, self-employed individuals cannot exclude the value of health insurance from gross income. For this purpose, self-employed individuals include sole proprietors, partners in partnerships, and more than 2-percent shareholders of S corporations. Prior to January 1, 1994, a self-employed individual could deduct from gross income 25 percent of the health insurance costs of the individual and his or her spouse or dependents. The 25-percent deduction was not available for any month if the self-employed individual was eligible for employer-paid (i.e., employer subsidized) health benefits under a plan of an employer of the individual or the individual's spouse. In addition, no deduction was avail-

[34] Rev. Rul. 93–72, 1993–94 IRB 7 (Nov. 1, 1993).

able to the extent that the deduction exceeded the taxpayer's earned income.

REASONS FOR CHANGE

Present and prior law provide inequitable tax treatment for the purchase of health insurance depending on how the insurance is purchased. The value of employer-provided health care is excludable from income without limit. Under prior law, self-employed individuals who were not eligible for employer-subsidized health care could deduct 25-percent of their health insurance costs. Under present and prior law, individuals who do not receive employer-provided health care can deduct the cost of health insurance only to the extent that total medical expenses exceed 7.5 percent of gross income. The bill addresses the inequity of present and prior law by allowing all individuals a deduction for 100 percent of the cost of the standard benefit package.

EXPLANATION OF PROVISION

The bill provides a 100-percent deduction [35] for health insurance costs of individuals (including self-employed individuals) who do not have employer-subsidized health coverage.

The 100-percent deduction applies only to the cost of insurance with respect to a certified standard health plan. Thus, uninsured and out-of-pocket medical expenses (e.g., copayments, deductibles, and uncovered expenses), and premiums paid for supplemental or other nonstandard insurance are not eligible for the deduction, but are deductible to the extent that total medical expenses exceed 7.5 percent of AGI. Expenses that are eligible for the deduction are not taken into account for purposes of determining whether total medical expenses exceed the 7.5 percent floor.

The 100-percent deduction is not available for any month with respect to coverage of an individual if the individual is eligible to participate in a subsidized certified standard health plan maintained by an employer. For example, if an individual is eligible to participate in a subsidized certified standard health plan of an employer, but such plan does not offer subsidized coverage of dependents of the individual, then the deduction is available with respect to the purchase of dependent health insurance coverage. In such a case, the deduction applies only with respect to the additional cost of the dependent coverage.

EFFECTIVE DATE

The 100-percent deduction for insurance expenses is effective for taxable years beginning on or after January 1, 1996.

[35] The amount of the deduction may be reduced to offset deficits in Federal health care spending pursuant to section 791 of the bill.

Subtitle D—Exempt Organizations

1. Tax Treatment of Organizations Providing Health Care Services and Related Organizations (secs. 741 and 742 of the bill and secs. 501, 509, 6033, 6104, and 6710 and new secs. 4958 and 4959 of the Code)

PRESENT LAW

Tax-exempt status of hospitals and other charities

Code section 501(c)(3) lists certain types of organizations that are exempt from Federal income tax, including those organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes no part of the net earnings of which inures to the benefit of any private shareholder or individual. Contributions to such organizations generally are deductible for Federal income, estate, and gift tax purposes. In addition, such organizations are eligible for tax-exempt financing that is not subject to the State volume cap otherwise applicable to private users of tax-exempt financing and, in the case of hospitals, are exempt from the $150 million limit otherwise applicable to the amount of tax-exempt financing from which a section 501(c)(3) organization can benefit.

Although Code section 501(c)(3) does not specifically refer to furnishing medical care or operating a not-for-profit hospital, such activities have long been considered to further charitable purposes.[36] However, the mere provision of not-for-profit medical care is not, by itself, sufficient to allow an organization to qualify for exemption under section 501(c)(3). Rather, an organization must demonstrate that its activities are targeted to a charitable class. The precise nature of that charitable class has been defined only through administrative guidance, and not by statute.

In 1956, the Internal Revenue Service (IRS) issued Revenue Ruling 56–185, 1956–1 C.B. 202, setting forth the conditions that a not-for-profit hospital must satisfy to qualify for recognition as a tax-exempt charitable organization under section 501(c)(3). The IRS ruled that a hospital would be exempt if it met the following four conditions: (1) it must be organized as a not-for-profit organization for the purpose of operating a hospital for the care of the sick; (2) it must be operated, to the extent of its financial ability, for those not able to pay for the services rendered and not exclusively for those able and expected to pay[37]; (3) it must not restrict use of its facilities to a particular group of physicians; and (4) its earnings must not inure, directly or indirectly, to the benefit of any private shareholder or individual.

In 1969, the IRS issued Revenue Ruling 69–545, 1969–2 C.B. 117, which established the so-called "community benefit" standard.

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[36] Although not-for-profit hospitals generally are recognized as tax-exempt by virtue of being "charitable" organizations, some also may qualify for exemption as "educational" organizations because they are organized and operated primarily for medical education purposes.

[37] With respect to the "financial ability" requirement, the IRS noted that: The fact that its charity record is relatively low is not conclusive that a hospital is not operated for charitable purposes to the full extent of its financial ability. It may furnish services at reduced rates which are below cost, and thereby render charity in that manner. It may also set aside earnings which it uses for improvements and additions to hospital facilities. It must not, however, refuse to accept patients in need of hospital care who cannot pay for such services.

Relying upon regulations issued ten years earlier,[38] the IRS noted that the promotion of health is "one of the purposes in the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, such as indigent members of the community, provided that the class is not so small that its relief is not of benefit to the community." The IRS also modified Revenue Ruling 56–185 to eliminate the specific requirement that the hospital must be operated, to the extent of its financial ability, for those not able to pay for the services rendered and not exclusively for those able and expected to pay.

The "community benefit" standard, which remains the principal standard applied by the IRS today, focuses on a number of factors which indicate that the operation of a hospital benefits the community rather than serving private interests. In Revenue Ruling 69–545, the IRS determined that the community benefit standard was satisfied by a hospital that operated an emergency room open to all persons and provided hospital care in non-emergency situations for everyone able to pay the cost thereof, either themselves, or through third-party reimbursement.[39] The hospital at issue in Rev. Rul. 69–545 also had a board of directors drawn from the community and an open medical staff policy, treated persons paying their bills with the aid of public programs (such as Medicare and Medicaid), and applied any surplus receipts to improving facilities, equipment, patient care, and medical training, education and research. The same "community benefit" standard applies in determining whether an HMO qualifies for tax-exempt status under section 501(c)(3), although slightly different characteristics are examined.[40]

Exempt status of social welfare organizations

Code section 501(c)(4) provides an exemption from income tax for non-profit organizations operated primarily to promote the common good and general welfare of the people in the community. Contributions to such organizations generally are not deductible for Federal income, estate, and gift tax purposes, and such organizations are not eligible to benefit from tax-exempt financing beyond financing available to other private users.

An HMO seeking exemption as a social welfare organization under section 501(c)(4) is not required to possess all of the same characteristics as an HMO that qualifies for exemption under section 501(c)(3); however, its activities generally must satisfy a com-

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[38] Three years after publication of Revenue Ruling 56–185, the Treasury Department significantly revised its regulations interpreting section 501(c)(3). Treas. Reg. section 1.501(c)(3)–1(d)(2) provides that "the term 'charitable' is used in section 501(c)(3) in its generally accepted legal sense and is, therefore, not to be construed as limited by the separate enumeration in section 501(c)(3) of other tax-exempt purposes which may fall within the broad outlines of 'charity' as developed by judicial decisions."

[39] In Rev. Rul. 83–157, 1983–2 C.B. 94, the IRS clarified that the operation of an emergency room was not a prerequisite for a hospital to have tax-exempt status under section 501(c)(3), if a State health planning agency made an independent determination that the operation of an emergency room would be unnecessary and duplicative. The IRS concluded that, in such a case, the presence of the other factors set forth in Rev. Rul. 69–545 indicated that the hospital promoted the health of a class of persons broad enough to benefit the community.

[40] See, e.g., *Geisinger Health Plan* v. *Commissioner*, 985 F.2d 1210 (3rd Cir. 1993) (holding that network model HMO did not qualify for section 501(c)(3) status because its activities did not primarily benefit the community).

munity benefit standard similar to, but less exacting than, that imposed on a charitable HMO.[41]

Private inurement

Charities.—Section 501(c)(3) specifically conditions tax-exempt status for all organizations described in that section on the requirement that no part of the net earnings of the organization inures to the benefit of any private shareholder or individual (the so-called "private inurement test").[42]

Social welfare organizations.—A tax-exempt social welfare organization described in section 501(c)(4) must be organized on a nonprofit basis and must be operated exclusively for the promotion of social welfare. In contrast to section 501(c)(3), however, there is no specific statutory rule in section 501(c)(4) prohibiting the net earnings of a social welfare organization described in section 501(c)(4) from inuring to the benefit of a private shareholder or individual.[43]

Sanctions for private inurement and other violations of exemption standards

Organizations described in section 501(c)(3) are classified as either public charities or private foundations. Penalty excise taxes may be imposed under the Code when a public charity makes improper political expenditures (sec. 4955) or excess or disqualifying lobbying expenditures (secs. 4911 and 4912). However, the Code generally does not provide for the imposition of penalty excise taxes in cases where a 501(c)(3) public charity or a section 501(c)(4) social welfare organization engages in a transaction that results in private inurement. In such cases, the only sanction that specifically is authorized under the Code is revocation of the organization's tax-exempt status.

Transactions engaged in by private foundations (but not public charities) are subject to special penalty excise taxes under the Code if the transaction is a prohibited "self-dealing" transaction (sec. 4941) or does not accomplish a charitable purpose (sec. 4945). Nonprofit hospitals, and other nonprofit entities the principal purpose or functions of which are providing medical care, are classified as public charities and, thus, are not subject to the special penalty excise tax provisions governing private foundations.

Filing and public disclosure rules applicable to tax-exempt organizations

Tax-exempt organizations generally are required to file an annual information return (Form 990) with the IRS. Code section 6104 requires that a tax-exempt organization (other than a private foundation) make available for public inspection at the organization's principal office a copy of the organization's Form 990 (except for the names of contributors to the organization) for the three

[41] See generally, GCM 39829 (August 30, 1990) (reviewing IRS position regarding HMOs).

[42] Compare GCM 39862 (November 22, 1991) (transactions in which part of hospitals' net revenue stream sold to physicians found to constitute private inurement) with PLR 9112006 (December 20, 1990) (incentive compensation plan in which all employees participate found to not jeopardize tax-exempt status of hospital).

[43] Even where no prohibited private inurement exists, however, more than incidental private benefits conferred on individuals may result in the organization not being operated "exclusively" for an exempt purpose. See, e.g., *American Campaign Academy* v. *Commissioner*, 92 T.C. 1053 (1989).

most recent taxable years. This public inspection requirement also extends to the organization's application to the IRS for recognition of tax-exempt status, the IRS determination letter, and certain other related documents.

REASONS FOR CHANGE

Nonprofit health care organizations should not qualify for tax-exempt status unless they provide services that are beneficial to the community as a whole. Therefore, the bill includes statutory rules to ensure that nonprofit health care organizations are responsive to the needs of their communities. In addition, to ensure that the advantages of tax-exempt status ultimately benefit the community, the bill extends the present-law section 501(c)(3) private inurement prohibition to nonprofit health care organizations described in section 501(c)(4) and provides for intermediate sanctions that may be imposed when nonprofit health care organizations described in section 501(c)(3) or 501(c)(4) engage in transactions with certain insiders that result in private inurement. The bill also enhances oversight and public accountability of nonprofit health care organizations through additional reporting of information by nonprofit health care organizations to the Internal Revenue Service (IRS) and increased public access to documents filed by such organizations with the IRS.

EXPLANATION OF PROVISIONS

New statutory requirements for tax-exempt health care organizations

The bill imposes new requirements on tax-exempt organizations described in section 501(c)(3) or 501(c)(4) that have as their predominant activity the provision of "health care services."[44] (The bill refers to such organizations as "applicable tax-exempt health care organizations.") The new requirements, therefore, apply to tax-exempt hospitals, clinics, nursing homes, old age homes, and HMOs. The new requirements do not apply to organizations whose predominant activities are non-health care service activities (e.g., an educational organization, if the predominant activities of the organization do not involve the delivery of health care services to patients). In addition, the bill specifically provides that the new requirements do not apply to an organization that demonstrates (in a manner not inconsistent with regulations as the Secretary of Treasury may prescribe) that one of its principal purposes is academic training or medical research; nor do the new requirements apply to an organization that provides health care services exclusively on an uncompensated basis regardless of the patient's ability to pay. The new requirements do not apply to State and local governmental entities.

Under the bill, in addition to satisfying a community benefit standard, applicable tax-exempt health care organizations are re-

[44] The term "health care services" means: (1) any activity of providing medical care (as defined in section 213 (d)(1)(A)) to individuals; (2) any activity (such as nursing or old age home care) which is treated as accomplishing an exempt purpose of a 501(c)(3) organization solely because it is carried on as part of an activity described in (1) above; and (3) insurance (that is not commercial-type insurance under section 501(m)) for activities described in (1) or (2) above.

quired to satisfy the following four requirements in order to be eligible for tax-exempt status.

(1) The organization must provide (directly or indirectly) significant "qualified outreach services." The term "qualified outreach services" is defined as health care services, or related preventive care, educational, or social services programs, provided (a) in an area that is medically underserved with respect to such health care services (i.e., a health professional shortage area "HPSA" designated by the Secretary of HHS or an area or population group reasonably determined by the organization, in a manner not inconsistent with Treasury regulations, to have a shortage of health professionals relative to the number of individuals needing such services in the area or population group), (b) below cost to individuals otherwise unable to afford such services, or (c) at specialty emergency care facilities that normally operate at a loss (i.e., emergency trauma, emergency psychiatry, or burn centers). An organization will demonstrate that it provides significant qualified outreach services on a facts-and-circumstances basis. An organization has the option of directly furnishing such services or indirectly providing such services by making a grant or contribution to a donee organization that furnishes qualified outreach services. The provision of insurance constitutes a qualified outreach service only if provided on a subsidized basis.

(2) With the participation of community representatives, the organization must annually assess the health care and qualified outreach service needs of the community and develop a written plan that sets forth how the organization plans to meet those needs.

(3) The organization must not discriminate against individuals in the provision of health care services on the basis of whether the individual is insured by a government-sponsored health plan (e.g., Medicare or Medicaid).[45]

(4) The organization must not discriminate against individuals in the provision of emergency health care services on the basis of the individual's ability to pay.[46]

Organizations that fail to satisfy one or more of the above new statutory requirements are subject to revocation of their tax-exempt status and, in such event, will be ineligible to receive contributions that are deductible by the donor for Federal income, estate, or gift tax purposes.

Effective date.—The new statutory requirements governing applicable tax-exempt health care organizations take effect on January 1, 1995.

HMO qualification under section 501(c)(3)

Under the bill, an HMO seeking tax-exempt status under section 501(c)(3) is required to furnish substantially all of its primary care

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[45] The Committee intends that an organization would not violate the nondiscrimination requirement if the organization cannot accept participants in a government-sponsored health plan because the organization is subject to the requirements of section 1876(f) of the Social Security Act (requiring that at least 50 percent of enrolled membership in a health plan consists of non-Medicare or Medicaid eligible individuals).

[46] If an organization does not provide emergency services (e.g., it does not operate an emergency room), then it could not "discriminate" in the provision of such services and, therefore, is not subject to this rule. Consequently, requirements (3) and (4) (above) effectively will not apply to an HMO that does not directly provide medical services (e.g., a network-model HMO exempt under Code section 501(c)(4)).

health services at its own facilities through health care professionals who do not provide substantial health care services other than on behalf of such organization. Thus, tax-exempt status under section 501(c)(3) is available to an HMO only if it is organized according to a so-called "staff model" or "dedicated-group model." In contrast, an HMO seeking tax-exempt status under section 501(c)(4) is not required directly to furnish health care services at its own facility (but is required to meet the requirements of section 501(m), discussed below).

Effective date.—The provision is effective on the date of enactment.

Extend private inurement prohibition to social welfare organizations

The bill amends section 501(c)(4) to explicitly provide that if a social welfare organization or other organization described in that section has as its predominant activity the provision of health care services, such organization is eligible for tax-exempt status only if no part of its net earnings inures to the benefit of any private shareholder or individual.[47]

Effective date.—The provision generally is effective on June 30, 1994. However, under a special transition rule, the provision does not apply to inurement occurring prior to June 30, 1996, if such inurement results from a written contract that was binding on June 29, 1994, and at all times thereafter before such inurement occurred, and the terms of which have not materially changed.

Intermediate sanctions for violations of taxable inurement prohibition by tax-exempt health care organizations

The bill imposes two-tiered penalty excise taxes as an intermediate sanction in cases where an applicable tax-exempt health care organization (other than a private foundation) engages in a transaction resulting in "taxable inurement." In such cases, intermediate sanctions may be imposed on certain disqualified persons (i.e., insiders) who improperly benefit from a taxable inurement transaction and may be imposed on organization managers who participate in such a transaction knowing that it is improper.

"Taxable inurement" means any inurement not permitted under section 501(c)(3), or under 501(c)(4) (as amended), resulting from a transaction involving an applicable tax-exempt health care organization in which (1) the value of an economic benefit provided to or for the use of a disqualified person exceeds the value of the consideration (including performance of services) received by the organization for providing such benefit, or (2) the amount of an economic benefit provided to or for the use of a disqualified person is determined in whole or in part by the gross or net revenues of one or more activities of the organization. Thus, "taxable inurement" transactions subject to excise taxes under the bill include transactions resulting in prohibited inurement because a disqualified person engages in a non-fair market value transfer of property or other benefits with the organization or receives unreasonable compensation, as well as prohibited financial arrangements under

[47] No inference is intended regarding application of the private inurement and private benefit tests to other organizations described in section 501(c)(4).

which a disqualified person receives payment based on the organization's gross or net revenues. In this regard, the Committee instructs the Secretary of the Treasury to issue guidance regarding transactions and arrangements that give rise to taxable inurement.

Existing tax-law standards will apply in determining reasonableness of compensation and fair market value. The Committee intends that an organization will be entitled to rely on a rebuttable presumption of reasonableness with respect to a compensation arrangement with a disqualified person if it demonstrates to the satisfaction of the Secretary of the Treasury that such arrangement was approved by an independent board (or an independent committee authorized by the board) that (1) was composed entirely of individuals unrelated to and not subject to the control of the person(s) involved in the arrangement, (2) obtained and relied upon appropriate data as to comparability (e.g., compensation levels paid by similarly situated organizations, both taxable and tax-exempt, for functionally comparable positions; the location of the organization, including the availability of similar specialties in the geographic area; independent compensation surveys by nationally recognized independent firms; or actual written offers from similar institutions competing for the services of the disqualified person); and (3) adequately documented the basis for its determination (e.g., the record includes an evaluation of the individual whose compensation was being established and the basis for determining that their compensation was reasonable in light of that evaluation and data). A similar rebuttable presumption will arise with respect to the reasonableness of the valuation of property sold (or purchased) by an organization to (or from) a disqualified person if the sale (or purchase) is approved by an independent board that uses appropriate comparability data and adequately documents its determination.

In addition, the bill specifically provides that the payment of personal expenses of, or other economic benefits granted to, a disqualified person will be treated as consideration for services rendered by the disqualified person only if the organization clearly indicated its intent to so treat the economic benefits. In determining whether an organization clearly indicated its intent to treat economic benefits as compensation for services, the relevant factors include whether the appropriate decision-making body approved the transfer of economic benefits as compensation in accordance with established procedures and whether the organization and the recipient disqualified person reported the transfer as compensation on the relevant forms (e.g., the amounts are properly reported on the W–2 or Form 1099, as appropriate, of the disqualified person, and on the organization's Form 990, or other documents distributed to the public if no Form 990 is required). With the exception of nontaxable fringe benefits described in present-law section 132, an organization could not demonstrate that it clearly indicated its intent to treat economic benefits provided to a disqualified person as compensation for services merely by claiming, at the time of an IRS audit and without substantiation that is contemporaneous with the transfer of economic benefits at issue, that such benefits may be viewed as part of the disqualified person's total compensation package.

"Disqualified persons" means any person who is (1) an "organization manager" (meaning any officer, director, or trustee of an orga-

nization or any individual having powers or responsibilities similar to those of officers, directors, or trustees) or (2) any individual (other than an organization manager) who is (a) in a position to exercise substantial influence over the affairs of the organization, or (b) performing substantial medical services as a physician pursuant to an employment or other contractual relationship with the organization or a related organization.[48] In addition, "disqualified persons" includes certain family members and 35-percent owned entities[49] of persons described in (1) or (2) above, as well as any person who was a disqualified person at any time during the five-year period prior to the transaction at issue.

A disqualified person who is the beneficiary of a taxable inurement transaction is subject to a first-tier penalty tax equal to 25 percent of the amount of the taxable inurement (e.g., the amount of compensation exceeding reasonable compensation or the amount of a prohibited transaction based on the organization's gross or net revenues). An organization manager who participates in a taxable inurement transaction knowing that it is an improper transaction is subject to a first-tier penalty tax of 2.5 percent of the amount of the taxable inurement (subject to a maximum amount of tax of $10,000).

Additional, second-tier taxes may be imposed if the taxable inurement is not corrected within a specified time period.[50] In such cases, a disqualified person who is the beneficiary of the taxable inurement is subject to a penalty tax equal to 200 percent of the amount of the taxable inurement. An organization manager who refuses to agree to correction is subject to a penalty tax equal to 50 percent of the amount of taxable inurement (subject to a maximum amount of tax of $10,000). For this purpose, the term "correction" means undoing the excess benefit to the extent possible, establishing safeguards to prevent future such excess benefit, and where fully undoing the excess benefit is not possible, such additional corrective action as prescribed by Treasury regulations.

The intermediate sanctions for taxable inurement transactions may be imposed by the IRS in lieu of (or in addition to) revocation of an organization's tax-exempt status. If more than one disqualified person or manager is liable for a penalty excise tax, then all such persons shall be jointly and severally liable for such tax.[51] Under the bill, the IRS has authority to abate the excise tax penalty (under present-law section 4962) if it is established that the violation was due to reasonable cause and not due to willful neglect

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[48] The mere fact that a physician has staff privileges to admit patients at an institution does not, by itself, mean that the physician performs "substantial" medical services at the institution.

[49] For purposes of the provision, family members are determined under present-law section 4926(d), except that such members also include siblings (whether by whole or half blood) of the individual and spouses of such siblings. The term "35-percent owned entities" means corporations, partnerships, and trusts or estates in which a disqualified person owns more than 35 percent of the combined voting power, profits interest, or beneficial interest.

[50] Under the bill, correction must be made on or prior to the earlier of (1) the date of mailing by the IRS of a notice of deficiency under section 6212 with respect to the first-tier penalty excise tax imposed on the disqualified person, or (2) the date on which such tax is assessed.

[51] Where the bill's provisions are parallel to the present-law intermediate sanction regime governing private foundations (e.g., determining whether an organization manager knowingly participated in an improper transaction, the taxable period for correction, and joint and several liability), the Committee intends that parallel provisions of the intermediate sanction regimes be interpreted in a similar manner.

and the transaction at issue was corrected within the required correction period.

To prevent an organization from avoiding the penalty excise taxes through termination of its tax-exempt status, the bill also provides for the imposition of a tax on applicable tax-exempt health care organizations that terminate their tax-exempt status. The amount of the tax is equal to the lesser of (1) the aggregate tax benefits that an organization can substantiate that it has received from its exemption from tax under Code section 501(a), or (2) the value of the net assets of such organization.[52] The Secretary of the Treasury is permitted to abate all or a portion of the tax if an applicable tax-exempt health care organization distributes all of its net assets to one or more charitable organizations described in Code section 501(c)(3) that have been in existence for a continuous 5-year period. In addition, applicable tax-exempt health care organizations that are described in Code section 501(c)(4) are permitted to distribute their net assets to one or more organizations described in Code section 501(c)(4) that have been in existence for a continuous 5-year period. An applicable health care organization is permitted to terminate its exempt status only if it has paid the tax (or any portion thereof that is not abated) and the organization has notified the Secretary of its intent to terminate its exempt status (or the Secretary has made a final determination that such status has terminated).

Effective date.—The provision applies to inurement occurring on or after June 30, 1994.

Disclosure requirements

Under the bill, applicable tax-exempt health care organizations are required to make available to the general public and the IRS the written community health care and outreach service needs plan (required above), in the same manner that their annual information return (Form 990) is required to be available under present law. The bill also provides that such organizations are required to furnish, as part of their annual Form 990, information regarding their implementation of the community health care and outreach service needs plan for the year (including unrecovered costs and revenues foregone in furtherance of such plan). In addition, such organizations are required to disclose such information as the Secretary of the Treasury may require with respect to "taxable inurement" transactions (described above) improperly engaged in by the organization.[53]

The bill also provides that applicable tax-exempt health care organizations are required to comply with requests from individuals who seek a copy of the organization's written community health care and outreach service needs plan and, if so requested, a copy of the Form 990.[54] Upon such a request, the organization is required to supply copies without charge other than a reasonable fee

[52] In calculating these amounts, rules similar to the rules applicable to private foundations set forth in Code section 507(d), (e), and (f) apply.

[53] The present-law penalties applicable to failure to file a timely, complete, and accurate return (sec. 6652(c)) will apply in cases where an applicable tax-exempt health care organization fails to comply with the bill's reporting requirements.

[54] If so requested, copies must be supplied of the community health care and outreach service needs plans or Forms 990 for any of the organization's three most recent taxable years.

for reproduction and mailing costs. If the request for copies is made in person, then the organization must immediately provide such copies. If the request for copies is made other than in person (e.g., by mail or telephone), then copies must be provided within 30 days. However, an organization may be relieved of its obligation to provide copies if the Secretary of the Treasury determines, upon application by the organization, that the organization is subject to a harassment campaign (e.g., repeated, excessive requests for copies) such that waiver of the obligation to provide copies is in the public interest.

Effective date.—The provisions governing reporting and public disclosure by applicable tax-exempt health care organizations take effect on January 1, 1995.

2. Treatment of Health Maintenance Organizations, Parent Organizations and Health Insurance Purchasing Cooperatives (sec. 743 of the bill and secs. 501(m), 501(c) and 509 of the Code)

PRESENT LAW

Health maintenance organizations

Section 501(m) provides that an organization described in section 501(c)(3) or 501(c)(4) of the Code is exempt from tax only if no substantial part of its activities consists of providing "commercial-type insurance." In the case of an organization that is exempt from tax after this rule is applied, the activity of providing commercial-type insurance is treated as a taxable unrelated trade or business, and the tax is determined by applying the rules applicable to insurance companies. Commercial-type insurance generally includes any insurance of a type provided by commercial insurance companies. Present law provides that commercial-type insurance does not include incidental health insurance provided by a health maintenance organization (HMO) of a kind customarily provided by an HMO (sec. 501(m)(3)(B)).[55] The statute does not specify particular types of activities that satisfy this rule.

Parent organizations

Charitable organizations described in section 501(c)(3) are classified either as public charities or private foundations. In general, an organization will be classified as a public charity if it (1) receives significant support (generally more than one third) in the form of contributions from the general public or (2) is a church, school or hospital. In addition, section 509(a)(3) provides that public charities include certain "support" organizations which are organized and operated exclusively to benefit one or more specified public or publicly supported charitable organizations. Public charities are not subject to the special rules applicable to private foundations, such as a prohibition against self-dealing and tax on net investment income, and contributions to public charities are subject to more liberal deduction rules than are contributions to private foundations.

[55] The Internal Revenue Service has interpreted these provisions with respect to HMOs in G.C.M. 39828 (August 30, 1990); G.C.M. 39829 (August 30, 1990); and G.C.M. 39830 (August 30, 1990).

Qualified health insurance purchasing cooperatives

Present law provides no rule that applies specifically to qualified health insurance purchasing cooperatives (as established under the bill and described in part III of subtitle D of title XXI of the Social Security Act).

REASONS FOR CHANGE

The Committee believes that, because HMOs are an important element of the provision of health care services under the bill, additional clarification of the definition of commercial-type insurance is needed with respect to HMOs.

Many hospitals are part of reorganized systems that are under the control of a parent organization that serves essentially as a holding company for the system. Because the status of such parent organizations as public charities or private foundations is unclear under present-law, the Committee believes that it is appropriate to clarify that such organizations are not private foundations.

In recognition of the public interests served by qualified health insurance purchasing cooperatives, the Committee believes that such organizations should be afforded the benefits of Federal tax-exemption, subject to certain limitations.

EXPLANATION OF PROVISION

Health maintenance organizations

Under the bill, the provision of (or the arranging for the provision of) medical care on a prepaid basis by an HMO is not treated as providing commercial-type insurance if and only if such care is: (1) care provided by the organization to its members at its own facilities through health professionals who do not provide substantial health care services other than on behalf of the organization; (2) care provided by a health care professional to a member of the organization on a basis under which substantially all of the risks with respect to rates of utilization by the member is assumed by the provider of such care; (3) care other than primary care provided to a member pursuant to a referral by the HMO; or (4) emergency care provided to a member at a location outside the member's area of residence.

For example, an HMO's provision of care falls within the first category above, in the case of a staff or dedicated group model HMO that hires health care providers (as employees or independent contractors) to provide medical care exclusively to HMO members at the HMO's facilities.

An HMO's provision of (or arranging for provision of) care falls within the second category above, if the HMO pays health care professionals on a fixed or capitated basis, where such payments are based on the number of members served by the health care professional, but not on the extent of services provided to a member.

The requirement that substantially all of the risks of rates of utilization of the care provider's services by members be borne by the provider is intended to limit the use of payment arrangements that do not shift substantially all the risk to the provider. For example, an HMO that is tax-exempt under section 501(c)(4) and makes capitated payments to a network of health care professionals in a

particular area generally is not treated as providing commercial-type insurance under the provision. By contrast, assume the HMO expands its operation to a nearby area, and it chooses to do so by arranging to provide medical care through a network of physicians in that area on a fee-for-service basis. The HMO is treated as providing commercial-type insurance. As under present law, depending on the substantiality of the activity of providing commercial-type insurance, the HMO is either subject to tax on unrelated trade or business income with respect to the activity, or becomes ineligible for tax-exempt status.

An HMO's provision of (or arranging for provision of) care falls within the third category, above, if care other than primary care is provided to a member pursuant to a referral by the HMO (including, for this purpose, its health care professionals), or approval or ratification by the HMO.

Parent organizations

The bill clarifies that, under present-law section 509(a), organizations that serve as parent holding companies for hospitals or medical research organizations may qualify as public charities rather than private foundations.

Qualified health insurance purchasing cooperatives

Qualified health insurance purchasing cooperatives established under the bill are eligible for Federal tax-exempt status, provided that private inurement, lobbying, and political activity restrictions are satisfied (similar to present-law section 501(c)(3)). Such health insurance purchasing cooperatives are not eligible to use financing provided from the proceeds of tax-exempt bonds.

EFFECTIVE DATE

These provisions are effective on the date of enactment.

3. Tax Treatment of Taxable Organizations Providing Health Insurance and Other Prepaid Health Care Services (sec. 744 of the bill and sec. 831 of the Code)

PRESENT LAW

Under present law, no special rule provides that taxable health maintenance organizations (HMOs), or organizations similar to them, are treated as property and casualty insurance companies for Federal tax purposes. The tax treatment of a taxable HMO (e.g., an HMO organized on a for-profit basis) depends largely on the extent to which it qualifies as an insurance company. At present, the majority of HMOs are taxable (rather than tax-exempt). Many, but not all, of these organizations have determined their Federal tax on the assumption that they qualify as property and casualty insurance companies.

In determining taxable income, property and casualty insurance companies include (among other income and gains) underwriting income (sec. 832(b)(1)). In calculating underwriting income, a property and casualty insurance company generally may take a reserve deduction for a portion (80 percent) of the increase for the year in its unearned premiums and for the discounted amount of losses in-

curred (including incurred but not reported losses) (secs. 832(b) (4) and (5) and 846). These deductions may not reflect the "all events" test or the economic performance requirements that generally apply to accrual-method taxpayers.

REASONS FOR CHANGE

The Committee believes it is advisable to clarify the Federal tax treatment of taxable organizations whose primary and predominant business activity is to insure or reinsure accident and health risks, or to operate like an HMO (or enter into arrangements that resemble those of an HMO), regardless of whether such organizations are treated as insurance companies under State law or other applicable law. Thus, the bill treats such organizations as property and casualty insurance companies for Federal tax purposes.

EXPLANATION OF PROVISION

The bill expands the scope of organizations treated as taxable property and casualty insurance companies. Under the provision, any organization that is not tax-exempt, is not a life insurance company, is not an organization to which section 833 applies, and whose primary and predominant business activity during the taxable year falls in one of three categories, is treated as a property and casualty insurance company for Federal tax purposes. In applying this provision, an organization's "primary and predominant" business activity is intended to mean the activity which constitutes more than half of the organization's business activities, determined on a reasonable basis (for example, as a fraction of gross revenues from all business activities).

The three categories of activities are: (1) issuing accident and health insurance contracts or reinsuring accident and health risks; (2) operating as an HMO; or (3) entering into arrangements under which fixed payments or premiums are received by the organization as consideration for providing or arranging for the provision of health care services and substantially all the risks of the rates of utilization of such services is assumed by the provider of such services. No inference is intended that taxable organizations (whether or not treated as insurance companies under applicable State law or regulation) whose activities consist of traditional insurance activities such as arranging for the provision of medical care, or reimbursing for medical care, on a fee-for-service basis, are not insurance companies for Federal tax purposes.

The "primary and predominant" requirement is modified in the case of organizations that have, as a material business activity, the issuing or reinsurance of accident and health insurance contracts. For such organizations, the administering of accident and health insurance contracts is treated under the bill as part of such business activity for purposes of determining whether the organization's activities fall within the scope of category (1) above.

It is anticipated that, in the case of a staff or dedicated group model HMO (where the HMO hires health care professionals either as employees or independent contractors), no loss reserve deduction for incurred but not reported (IBNR) losses would be allowable with respect to such health care professionals' services. In general, in those circumstances, utilization of services of such health care

professionals is or can be known by the end of the HMO's taxable year. On the other hand, to the extent the period of health insurance coverage of members of the HMO extends beyond the end of the HMO's taxable year (e.g., where premiums or prepayments for health care services are not due or paid monthly, but rather are due or paid annually or quarterly over a period other than the HMO's taxable year), then a deduction with respect to the increase in unearned premiums for the year (reduced as required by present law) would be appropriate.

EFFECTIVE DATE

The provision is effective for taxable years beginning after December 31, 1994.

A transition rule provides that, for an organization other than one which (1) treats itself as subject to tax as a property and casualty insurance company on its original Federal tax return for taxable years beginning in 1992 through 1994, or (2) is tax-exempt for its last taxable year beginning before 1995, the change made by the provision is treated as a change in method of accounting, and adjustments under section 481 are taken into account for its first taxable year beginning after December 31, 1994. It is not intended that an organization described under the provision that received approval to change its method of accounting before December 31, 1994 so as to be treated as a property and casualty insurance company for Federal tax purposes be subject to the rule under the provision relating to taking into account in one year the adjustments under section 481, i.e., such an organization's section 481 adjustments would not be accelerated by the provision. Under this transition rule, in the case of a taxable organization that is treated as subject to the requirements of section 848 (relating to capitalization of policy acquisition expenses) for its first taxable year beginning after December 31, 1994, any adjustment attributable to not being treated as subject to section 848 in a prior year is treated as attributable to a change in method of accounting, and taken into account for its first taxable year beginning after December 31, 1994.

The provision also provides a transition rule for organizations exempt from tax for the last taxable year beginning before January 1, 1995. For such an organization, except as otherwise provided in regulations, (1) no adjustment is taken into account for the organization's first taxable year beginning after December 31, 1994 under section 481 (or any other provision) on account of a change in method of accounting required by the provision, and (2) for purposes of determining gain or loss, the adjusted basis of any asset held by the organization on the first day of its first taxable year beginning after December 31, 1994 is treated as equal to its fair market value as of that day. Regulations may prescribe circumstances in which the application of this transition rule is inappropriate and the extent to which other rules apply in such circumstances. Such circumstances may include, for example, those in which an item of gain, loss, income, deduction or credit would have been taxable to the organization before its first taxable year beginning before 1995 (because, for example, it was treated as subject to unrelated business income tax).

4. Organizations Subject to Section 833 (sec. 745 of the bill and sec. 833 of the Code)

PRESENT LAW

An organization described in sections 501(c) (3) or (4) of the Code is exempt from tax only if no substantial part of its activities consists of providing commercial-type insurance (sec. 501(m)). Special rules apply to certain eligible health insurance organizations. Eligible health insurance organizations are (1) Blue Cross or Blue Shield organizations existing on August 16, 1986, which have not experienced a material change in structure or operations since that date, and (2) other organizations that meet certain community-service-related requirements and substantially all of whose activities involve the providing of health insurance. Section 833 provides that eligible organizations are generally treated as stock property and casualty insurance companies.

Section 833 provides a special deduction for eligible organizations which is equal to 25 percent of the claims and expenses incurred during the year, less the adjusted surplus at the beginning of the year. This deduction is calculated by computing surplus, taxable income, claims incurred, expenses incurred, tax-exempt income, net operating loss carryovers, and other items attributable to health business. The deduction may not exceed taxable income attributable to health business for the year (calculated without regard to this deduction).

In addition, section 833 eliminates, for eligible organizations, the 20-percent reduction in unearned premium reserves that applies generally to all property and casualty insurance companies.

REASONS FOR CHANGE

The Committee believes fairness dictates that the special rules benefitting Blue Cross and Blue Shield organizations under section 833 should apply to certain organizations that became taxable by reason of the same provision of the Tax Reform Act of 1986 that made Blue Cross and Blue Shield organizations taxable, if such organizations are not Blue Cross or Blue Shield organizations but otherwise meet the eligibility requirements. The Committee believes these special rules should apply to such organizations for the same period that they have applied to Blue Cross and Blue Shield organizations.

EXPLANATION OF PROVISION

The bill applies the special rules under section 833 to the same extent they are provided to certain existing Blue Cross or Blue Shield organizations, in the case of any organization that (1) is not a Blue Cross or Blue Shield organization existing on August 16, 1986, and (2) otherwise meets the requirements of section 833(c)(2) (including the requirement of no material change in operations or structure since August 16, 1986). Under the bill, an organization qualifies for this treatment only if (1) it is not a health maintenance organization and (2) it is organized under and governed by State laws which are specifically and exclusively applicable to not-for-profit health insurance or health service type organizations.

EFFECTIVE DATE

The provision is effective for taxable years beginning after December 31, 1986.

5. Tax Exemption for High-Risk Insurance Pools (sec. 746 of the bill and sec. 501(c)(27) of the Code)

PRESENT LAW

No provision of present law specifically provides for tax-exempt status for organizations providing health insurance coverage to persons unable to obtain health insurance coverage in the private insurance market because of health conditions. Section 501(c)(6) of the Code provides for tax-exempt status for business leagues and certain other organizations not organized for profit and no part of the net earnings of which inures to the benefit of any private shareholder or individual. Section 501(c)(4) provides for tax-exempt status for certain civic leagues or organizations not organized for profit but operated exclusively for the promotion of social welfare; however, such an organization may be exempt only if no substantial part of its activities consists of providing commercial-type insurance. In the case of a State or any political subdivision of a State, present law provides an exclusion for income derived from the exercise of any essential governmental function (sec. 115). Health insurance risk pools have been established in some States, and some of them (depending on their mode of organization and sources of funding) have been determined by the Internal Revenue Service to be exempt from tax under section 501(c)(6), or claim that income is excludable under section 115.

REASONS FOR CHANGE

Some State risk pools currently have difficulty obtaining tax-exempt status because present law is not specifically designed for State risk pools. The Committee believes that, until the health care reform provisions of the bill become effective, States should have an incentive to provide health insurance to persons who otherwise cannot obtain insurance because of their health status. Thus, the bill includes a temporary provision under which organizations that provide insurance to such persons are tax exempt if they meet certain requirements relating to State involvement in the organization's operation and funding.

EXPLANATION OF PROVISION

The bill expands the list of organizations exempt from tax under section 501(c) to include a qualified high risk health insurance pool. A qualified high risk health insurance pool generally means an entity that is established by a State or political subdivision of a State to provide health insurance, on a nonprofit basis, to persons unable to obtain health insurance because of health conditions. Such an entity qualifies only if certain additional requirements are met. First, the State or political subdivision must (1) participate in the ongoing governance of the entity and (2) subsidize the operation of the entity. Second, no part of the net earnings of the entity may inure to the benefit of any private shareholder, member, or individ-

ual. The provision expires with respect to taxable years beginning after December 31, 1996.

EFFECTIVE DATE

The provision applies to taxable years beginning after December 31, 1989, and before January 1, 1997.

6. Tax Treatment of 501(c)(3) Bonds Similar to Governmental Bonds (sec. 748 of the bill and secs. 141–150, 265, and 56 of the Code)

PRESENT LAW

Interest on State and local government bonds generally is excluded from income if the bonds are issued to finance direct activities of these governments (sec. 103). Interest on bonds issued by these governments to finance activities of other persons, e.g., private activity bonds, is taxable unless a specific exception is included in the Code. One such exception is for private activity bonds issued to finance activities of private, charitable organizations described in Code section 501(c)(3) ("section 501(c)(3) organizations") when the activities do not constitute an unrelated trade or business (sec. 141(e)(1)(G)).

Classification of section 501(c)(3) organization bonds as private activity bonds

Before enactment of the Tax Reform Act of 1986, States and local governments and section 501(c)(3) organizations were defined as "exempt persons," under the Code bond provisions. As exempt persons, section 501(c)(3) organizations were not treated as "private" persons, and their bonds were not "industrial development bonds" or "private loan bonds" (the predecessor categories to current private activity bonds).

Under present law, a bond is a private activity bond if its proceeds are used in a manner violating either (a) a private business test or (b) a private loan test. The private business test is a conjunctive two-pronged test. First, the test limits private business use of governmental bonds to no more than 10 percent of the proceeds.[56] Second, no more than 10 percent of the debt service on the bonds may be secured by or derived from private business users of the proceeds. The private loan test limits to the lesser of 5 percent or $5 million the amount of governmental bond proceeds that may be used to finance loans to persons other than governmental units.

Special restrictions on tax-exemption for section 501(c)(3) organization bonds

As stated above, present law treats section 501(c)(3) organizations as private persons; thus, bonds for their use may only be issued as private activity "qualified 501(c)(3) bonds," subject to the restrictions of Code section 145. The most significant of these re-

[56] No more than 5 percent of bond proceeds may be used in a private business use that is unrelated to the governmental purpose of the bond issue. The 10-percent debt service test, described below, likewise is reduced to 5 percent in the case of such "disproportionate" private business use.

strictions limits the amount of outstanding bonds from which a section 501(c)(3) organization may benefit to $150 million. In applying this "$150 million limit," all section 501(c)(3) organizations under common management or control are treated as a single organization. The limit does not apply to bonds for hospital facilities, defined to include only acute care, primarily inpatient, organizations. A second restriction limits to no more than five percent the amount of the net proceeds of a bond issue that may be used to finance any activities (including all costs of issuing the bonds) other than the exempt purposes of the section 501(c)(3) organization.

Legislation enacted in 1988 imposed low-income tenant occupancy restrictions on existing residential rental property that is acquired by section 501(c)(3) organizations in tax-exempt-bond-financed transactions. These restrictions require that a minimum number of the housing units comprising the property be continuously occupied by tenants having family incomes of 50 percent (60 percent in certain cases) of area median income for periods of up to 15 years. These same low-income tenant occupancy requirements apply to for-profit developers receiving tax-exempt private activity bond financing.

Other restrictions

Several restrictions are imposed on private activity bonds generally that do not apply to bonds used to finance State and local government activities. Many of these restrictions also apply to qualified 501(c)(3) bonds.

No more than two percent of the proceeds of a bond issue may be used to finance the costs of issuing the bonds, and these monies are not counted in determining whether the bonds satisfy the requirement that at least 95 percent of the net proceeds of each bond issue be used for the exempt activities qualifying the bonds for tax-exemption.

The weighted average maturity of a bond issue may not exceed 120 percent of the average economic life of the property financed with the proceeds.

A public hearing must be held and an elected public official must approve the bonds before they are issued (or the bonds must be approved by voter referendum).

If property financed with private activity bonds is converted to a use not qualifying for tax-exempt financing, certain loan interest penalties are imposed.

Both governmental and private activity bonds are subject to numerous other Code restrictions, including the following:

(1) The amount of arbitrage profits that may be earned on tax-exempt bonds is strictly limited, and most such profits must be rebated to the Federal Government;

(2) Banks may not deduct interest they pay to the extent of their investments in most tax-exempt bonds; and

(3) Interest on private activity bonds, other than qualified 501(c)(3) bonds, is a preference item in calculating the alternative minimum tax.

REASONS FOR CHANGE

The Committee believes a distinguishing feature of American society is the singular degree to which the United States maintains a private, non-profit sector of private health care, higher education, and other charitable institutions in the public service. The Committee believes it is important to assist these private institutions in their advancement of the public good. The Committee finds particularly inappropriate the restrictions of present law which place these section 501(c)(3) organizations at a financial disadvantage relative to substantially identical governmental institutions. For example, a public hospital generally has unlimited access to tax-exempt bond financing, while a private, non-profit hospital is subject to a $150 million limitation on outstanding bonds to the extent the bonds finance health care facilities that do not qualify under the present-law definition of hospital. The Committee is concerned that this and other restrictions inhibit the ability of America's private, non-profit institutions to modernize their health care facilities. The Committee believes the tax-exempt bond rules should treat more equally State and local governments and those private organizations which are engaged in similar actions advancing the public good.

EXPLANATION OF PROVISION

The bill amends the tax-exempt bond provisions of the Code to conform generally the treatment of bonds for section 501(c)(3) organizations to that provided for bonds issued to finance direct State or local government activities. Certain restrictions, described below, that have been imposed on qualified 501(c)(3) bonds (but not on governmental bonds) since 1986, and that address specialized policy concerns, are retained.

Repeal of private activity bond classification for bonds for section 501(c)(3) organizations

The concept of an "exempt person" that existed under the Code bond provisions before 1986, is reenacted. An exempt person is defined as (a) a State or local governmental unit or (b) a section 501(c)(3) organization, when carrying out its exempt activities under Code section 501(a). Thus, bonds for section 501(c)(3) organizations are generally no longer classified as private activity bonds. Financing for unrelated business activities of such organizations continue to be treated as a private activity for which tax-exempt financing is not authorized.

As exempt persons, section 501(c)(3) organizations are subject to the same limits as States and local governments on using their bond proceeds to finance private business activities or to make private loans. Thus, generally no more than 10 percent of the bond proceeds[57] can be used in a business use of a person other than an exempt person if the Code private payment test is satisfied, and no more than 5 percent ($5 million if less) can be used to make loans to such "nonexempt" persons.

[57] This limit would be reduced to 5 percent in the case of disproportionate private use as under the present-law governmental bond disproportionate private use limit.

Repeal of most additional special restrictions on section 501(c)(3) organization bonds

Present Code section 145, which establishes additional restrictions on qualified 501(c)(3) bonds, is repealed, along with the restriction on bond-financed costs of issuance for section 501(c)(3) organization bonds (sec. 147(h)). This eliminates the $150 million limit on nonhospital bonds for section 501(c)(3) organizations.

Retention of certain specialized requirements for section 501(c)(3) organization bonds

As stated above, the bill retains certain specialized restrictions on bonds for section 501(c)(3) organizations. First, the bill retains the requirement that existing residential rental property acquired by a section 501(c)(3) organization in a tax-exempt-bond-financed transaction satisfy the same low-income tenant requirements as similar housing financing for for-profit developers. Second, the bill retains the present-law maturity limitations applicable to bonds for section 501(c)(3) organizations, and the public approval requirements applicable generally to private activity bonds. Third, the bill continues to apply the penalties on changes in use of tax-exempt-bond-financed section 501(c)(3) organization property to a use not qualified for such financing.

Finally, the bill makes no amendments, other than technical conforming amendments, to the tax-exempt arbitrage restrictions, the alternative minimum tax tax-exempt bond preference, or the provisions generally disallowing interest paid by banks on monies used to acquire or carry tax-exempt bonds.

EFFECTIVE DATE

The provision applies to bonds issued after December 31, 1994.[58]

Subtitle E—Tax Treatment of Long-Term Care Insurance and Services

1. Tax Treatment of Long-Term Care Insurance and Services (secs. 751 and 752 of the bill and secs. 106, 125, 213 and 7702B of the Code)

PRESENT LAW

Deduction for medical expenses

In determining taxable income for Federal income tax purposes, a taxpayer is allowed an itemized deduction for unreimbursed expenses that are paid by the taxpayer during any taxable year for medical care of the taxpayer, the taxpayer's spouse, or a dependent of the taxpayer, to the extent that such expenses exceed 7.5 percent of the adjusted gross income of the taxpayer for such year (sec. 213). For this purpose, expenses paid for medical care generally are defined as amounts paid: (1) for the diagnosis, cure, mitigation, treatment, or prevention of disease (including prescription medicines or drugs and insulin), or for the purpose of affecting any

[58] The committee intends for example that any qualified 501(c)(3) bond issued during the period January 1, 1986—December 31, 1994, shall be treated as an exempt person bond after enactment of the bill.

structure or function of the body (other than cosmetic surgery not related to disease, deformity, or accident); (2) for transportation primarily for, and essential to, medical care referred to in (1); or (3) for insurance (including Part B Medicare premiums) covering medical care referred to in (1) and (2).

Exclusion for amounts received under accident or health insurance

Amounts received by a taxpayer under accident or health insurance for personal injuries or sickness generally are excluded from gross income to the extent that the amounts received are not attributable to medical expenses that were allowed as a deduction for a prior taxable year (sec. 104).

Treatment of accident or health plans maintained by employers

Contributions of an employer to an accident or health plan that provides compensation (through insurance or otherwise) to an employee for personal injuries or sickness of the employee, the employee's spouse, or a dependent of the employee, are excluded from the income of the employee for income and payroll tax purposes (secs. 106 and 3121(a)(2)). In addition, amounts received by an employee under such a plan generally are excluded from gross income to the extent that the amounts received are paid, directly or indirectly, to reimburse the employee for expenses incurred by the employee for the medical care of the employee, the employee's spouse, or a dependent of the employee (sec. 105). For this purpose, expenses incurred for medical care are defined in the same manner as under the rules regarding the deduction for medical expenses.

REASONS FOR CHANGE

The Committee desires to provide an incentive for individuals to take financial responsibility for their long-term health care. Thus, the bill provides generally for treatment of long-term care services as a deductible medical expense, and the exclusion from income of certain amounts paid under long-term care insurance contracts and long-term care riders to life insurance contracts that meet the bill's requirements. The Committee also believes that it is important to clarify the treatment of long-term care services and long-term care insurance, which is not completely clear under present law. However, the Committee is concerned about the effects of providing more favorable tax treatment for long-term care insurance than for any similar product under present law. Thus, the Committee believes that employer contributions for long-term care insurance should not be excludable from income. The Committee believes that long-term care insurance and services that do not meet the requirements of the bill should not receive favorable tax treatment.

EXPLANATION OF PROVISIONS

In general

Services that satisfy the requirements of the bill are deductible as medical expenses.

Insurance contracts, and riders to life insurance contracts, that meet the requirements of the bill ("qualified long-term care insurance policies") are subject to the tax treatment set forth in the bill.

Any amount received under a long-term care insurance policy that does not meet the requirements of the bill are not treated as an amount received for personal injuries or sickness and are not excludable from gross income.

Tax treatment of long-term care services

In general

The bill provides that certain services that are provided to an incapacitated individual (defined as "qualified long-term care services") are treated as medical care for purposes of the deduction for medical expenses. Thus, under the bill, a taxpayer is allowed an itemized deduction for unreimbursed expenses that are paid by the taxpayer during any taxable year for qualified long-term care services that are provided to the taxpayer, the taxpayer's spouse, or a dependent of the taxpayer, to the extent that such expenses and other eligible medical expenses of the taxpayer exceed 7.5 percent of the adjusted gross income of the taxpayer for such year. In addition, under the bill, eligible medical expenses for purposes of the medical expense deduction include premiums paid for insurance that provides coverage for qualified long-term care services, but only if such insurance is provided under a qualified long-term care insurance policy (as defined below).

Definition of qualified long-term care services

In general

The term "qualified long-term care services" is defined as the necessary diagnostic, curing, mitigation, treating, preventive, therapeutic, rehabilitative, maintenance, and personal care services (whether performed in a residential or nonresidential setting) that are required by an individual during any period that such individual is an incapacitated individual, but only if (1) the primary purpose of the services is to provide needed assistance with any activity of daily living or protection from threats to health and safety due to severe cognitive impairment, and (2) the services are provided pursuant to a continuing plan of care that is prescribed by a licensed professional. In addition, in order to constitute qualified long-term care services, the services cannot be provided by any relative (directly or through a partnership, corporation, or other entity) of the incapacitated individual unless the relative is a licensed professional with respect to the services provided.[59]

Definition of incapacitated individual

An incapacitated individual generally is defined as any individual who is certified by a licensed professional within the preceding 12-month period as (1) being unable to perform, without substantial assistance from another individual, at least two activities of daily living, or (2) having severe cognitive impairment as defined

[59] For this purpose, a relative of an incapacitated individual includes: (1) a son or daughter, or a descendant of either; (2) a stepson or stepdaughter; (3) a brother, sister, stepbrother, or stepsister; (4) the individual's father or mother, or an ancestor of either; (5) a stepfather or stepmother; (6) a son or daughter of a brother or sister; (7) a brother or sister of the individual's father or mother; and (8) a son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law.

by the Secretary of the Treasury in consultation with the Secretary of Health and Human Services. For purposes of determining whether an individual is an incapacitated individual, substantial assistance includes cueing or substantial supervision.

For purposes of the definition of an incapacitated individual, the activities of daily living (ADLs) are (1) eating, (2) toileting, (3) transferring, (4) bathing, and (5) dressing. A licensed professional is (1) a physician or registered professional nurse, or (2) any other individual who satisfies such requirements as may be prescribed by the Secretary of the Treasury after consultation with the Secretary of Health and Human Services.

Tax treatment of qualified long-term care insurance policies

The bill provides that, for purposes of the Internal Revenue Code: (1) except as provided below, a qualified long-term care insurance policy is treated as an accident or health insurance contract, (2) amounts (other than policyholder dividends or premium refunds) received under such a contract or plan with respect to qualified long-term care services are treated as amounts received for personal injuries or sickness and as reimbursement for expenses actually incurred for purposes of the medical expense deduction, (3) generally, a plan of an employer that provides coverage under a qualified long-term care insurance policy is treated as an accident or health plan with respect to such coverage, except that no exclusion is provided for employer-provided coverage under a long-term care insurance policy, (4) amounts paid for a qualified long-term care insurance policy are treated as amounts paid for insurance for purposes of the medical expense deduction, and (5) a qualified long-term care insurance policy is treated as a guaranteed renewable contract subject to the rules of Code section 816(e).

Thus, under the bill, amounts received under a qualified long-term care insurance policy are excluded from the gross income of the recipient to the extent that the amounts are not attributable to expenses that were allowed as a deduction for a prior taxable year (i.e., medical expenses or expenses for qualified long-term care services).

The bill provides that employer contributions for long-term care insurance are includible in gross income. In addition, because employer contributions for long-term care are includible in income, long-term care is not a qualified benefit for purposes of the cafeteria plan rules and therefore cannot be provided through a cafeteria plan.

Definition of qualified long-term care insurance policy

In general

An insurance policy is a "qualified long-term care insurance policy" if: (1) the policy is a certified long-term care insurance policy as defined in section 21011(b)(2) of the Social Security Act (relating to Federal standards and requirements for private long-term care insurance); (2) benefits under the policy are limited to individuals who are certified by a licensed professional within the preceding 12-month period as being unable to perform, without substantial assistance from another individual (including assistance involving

cueing or substantial supervision) two or more activities of daily living or who have a severe cognitive impairment; and (3) the policy satisfies the requirements specified below relating to (a) the payment of premiums, (b) cash value and the borrowing of money, (c) refunds of premiums and dividends, (d) the coverage of expenses reimbursable under Medicare or covered under comprehensive health coverage, and (e) the maximum benefit.

Payment of premiums

To be a qualified long-term care insurance policy, the policy is required to provide that the premium payments under the policy may not be made earlier than the date that such payments would have been made if the policy provided for level annual premium payments over the life expectancy of the insured or, if shorter, 20 years. A policy does not fail to meet this requirement merely because the policy provides that premiums are waived if the insured becomes certified by a licensed professional as unable to perform two activities of daily living or having severe cognitive impairment (as described above).

Prohibition on cash value and borrowing

An insurance contract constitutes a qualified long-term care insurance policy only if the policy does not provide for a cash value or other money (other than refunds of premiums and dividends described above) that can be paid, assigned, pledged as collateral for a loan, or borrowed.

Refunds of premiums and dividends

To be a qualified long-term care insurance policy, the contract has to provide that policyholder dividends must be applied as a reduction in future premiums or to increase future benefits (to the extent consistent with the limit on maximum benefits). The policy has to provide that refunds of premiums upon a partial surrender or cancellation of the policy are required to be applied as a reduction in future premiums. Further, the policy has to provide that any refund that occurs by reason of the death of the insured or upon the complete surrender or cancellation of the policy cannot exceed the aggregate premiums previously paid under the contract. If an amount is refunded under a qualified long-term care insurance policy by reason of the death of the insured or upon complete surrender or cancellation of the policy, the amount received would be included in the gross income of the recipient to the extent that a deduction or exclusion was allowable with respect to the premiums.

Coverage of expenses reimbursable under Medicare or other coverage

In addition, to constitute a qualified long-term care insurance policy, the policy cannot provide for payment or reimbursement of any expense incurred to the extent that the expense is paid or reimbursed under Medicare or under a certified standard health plan described in the Health Security Act.

Maximum permitted benefits

A qualified long-term care insurance policy cannot provide for benefits in excess of $150 per day (or the equivalent amount within the calendar year in the case of payments on other than a per diem basis). All policies issued with respect to an individual are treated as one policy for this purpose. For 1997, the $150 limit increased by the percentage increase in the consumer price index for calendar year 1996 plus 1½ percent. For subsequent years, the dollar limit is adjusted annually for inflation in accordance with a cost index to be developed by the Secretary of Health and Human Services to measure increases in costs of nursing homes and similar facilities.

Benefits under a qualified long-term care insurance policy may be paid on a reimbursement basis or without regard to the expenses incurred during the period to which the payments relate. In either case, such payments are treated as compensation for expenses paid for medical care for purposes of the deduction for medical expenses.

Treatment of life insurance contracts that provide coverage of qualified long-term care services

Except as provided in Treasury regulations, in the case of long-term care insurance coverage provided by a rider to a life insurance contract, the requirements for a policy to constitute a qualified long-term care insurance policy apply as if the portion of the contract that provides long-term care insurance were a separate contract. For this purpose, the long-term care insurance portion of the contract means only the terms and benefits under a life insurance contract that are in addition to the terms and benefits of the contract without regard to long-term care coverage. Payments made under a qualified long-term care rider do not become includible in income, however, solely because such payments reduce the death benefit or the cash surrender value of the life insurance contract.

Premium payments for long-term care coverage provided by rider (if any) and charges against the life insurance contract's cash surrender value for such coverage are treated as premiums for purposes of the premium payment rule described above (relating to the shorter of the insured's life expectancy or 20 years). The guideline premium limitation (sec. 7702(c)) for a life insurance contract is increased, as of any date, by the sum of any charges to the cash surrender value (but not premiums) to pay for long-term care insurance coverage, less any such charges the imposition of which reduces the premiums paid for the contract. Further, no medical expense deduction is allowed for charges against the life insurance contract's cash surrender value used to reduce premiums, unless such charges are includible in income and the coverage provided by the rider is a qualified long-term care insurance policy.

A payment of a long-term care benefit under the rider must not reduce the cash surrender value of the life insurance contract proportionately more than it reduces the death benefit under the life insurance contract. Thus, the percentage reduction by reason of the payment in the cash surrender value of the life insurance contract may not exceed the percentage reduction by reason of the payment in the death benefit payable under the life insurance contract.

Treasury regulations

The bill directs the Secretary of the Treasury to prescribe such regulations as may be necessary to carry out the requirements of the provisions of the bill relating to long-term care, including regulations to prevent the avoidance of such provisions by providing long-term care insurance 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.

EFFECTIVE DATES

The provision of the bill relating to the deductibility of expenses paid for qualified long-term care services applies to taxable years beginning after December 31, 1995. The other provisions of the bill relating to long-term care apply to policies issued after December 31, 1995. A policy issued before January 1, 1996, that satisfies the requirements of a qualified long-term care insurance policy on and after January 1, 1996, is treated as being issued on January 1, 1996. It is not intended, however, that this rule change the issue date of a life insurance policy with a long-term care insurance rider, for purposes of sections 7702, 7702A or 101(f) of the Code. For purposes of applying section 7702, 7702A or 101(f) of the Code to any contract, the issuance of a qualified long-term care insurance rider (or conformance of an existing rider to the qualification requirements) is not treated as a modification or material change to such contract.

A special transitional rule is provided for any long-term care policy issued on or before January 1, 1996. Under this rule, if, after the date of enactment of the bill and before January 1, 1996, the contract is exchanged for a qualified long-term care insurance policy, no gain or loss is recognized upon the exchange. If any money or other property is received in the exchange, then any gain is recognized to the extent of the sum of the money and the fair market value of the other property received. For purposes of this transition rule, 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 is treated as an exchange.

2. Tax Treatment of Accelerated Death Benefits Under Life Insurance Contracts (secs. 753 and 754 of the bill and secs. 101(g) and 818(g) of the Code)

PRESENT LAW

Treatment of amounts received under a life insurance contract

If a contract meets the definition of a life insurance contract, gross income does not include insurance proceeds that are paid pursuant to the contract by reason of the death of the insured (sec. 101(a)). In addition, the undistributed investment income ("inside buildup") earned on premiums credited under the contract is not subject to current taxation to the owner of the contract. The exclusion from income applies regardless of whether the death benefits are paid as a lump sum or otherwise.

Amounts received under a life insurance contract (other than a modified endowment contract) prior to the death of the insured are includible in the gross income of the recipient to the extent that the amount received exceeds the taxpayer's investment in the contract (generally, the aggregate amount of premiums paid less amounts previously received that were excluded from gross income).

Treatment of amounts received under a failed life insurance contract

If a contract fails to meet the definition of a life insurance contract, inside buildup on the contract is generally subject to tax. Under section 7702(g), income on the contract for the year in which a contract fails to meet the definition of life insurance (and income on the contract for all prior years) generally is treated as ordinary income received or accrued by the holder during that year. For this purpose, income on the contract is the excess of (1) the increase in the net surrender value of the contract during the taxable year and the cost of the life insurance protection provided during the taxable year, over (2) the premiums paid under the contract during the taxable year (sec. 7702(g)(1)(B)). In addition, a portion of the amount paid by reason of the death of the insured may be includible in income; that is, only the excess of the amount paid by reason of the death of the insured over the net surrender value of the contract is treated as life insurance proceeds eligible for the exclusion provided under section 101 (sec. 7702(g)(2)).

Requirements for a life insurance contract

To qualify as a life insurance contract for Federal income tax purposes, a contract must be a life insurance contract under the applicable State or foreign law and must satisfy either of two alternative tests: (1) a cash value accumulation test, or (2) a test consisting of a guideline premium requirement and a cash value corridor requirement (sec. 7702(a)).

Proposed regulations on accelerated death benefits

The Secretary of the Treasury has issued proposed regulations[60] under which certain "qualified accelerated death benefits" paid as a result of the terminal illness of the insured would be treated as paid by reason of the death of the insured and therefore, under the proposed regulations, would qualify for the present-law exclusion from income. In addition, the proposed regulations would permit an insurance contract that includes a qualified accelerated death benefit rider to qualify as a life insurance contract under section 7702.

Under the proposed regulations, a benefit would qualify as a qualified accelerated death benefit only if it meets three requirements. First, the qualified accelerated death benefit can be payable only if the insured becomes terminally ill. Second, the amount of the accelerated benefit must equal or exceed the present value of the reduction in the death benefit otherwise payable. Third, the cash surrender value and the death benefit under the policy must be proportionately reduced as a result of the accelerated benefit payment. For purposes of the proposed regulations, an insured per-

[60] Prop. Treas. Reg. Secs. 1.101–8, 1.7702–0, 1.7702–2, and 1.7702A–1 (December 15, 1992).

son would be treated as terminally ill if he or she has an illness that, despite appropriate medical care, the insurer reasonably expects to result in death within 12 months from the date of payment of the accelerated death benefit. The proposed regulations would not explicitly require a doctor's certification as to the patient's condition.

Under the proposed regulations, the maximum permissible discount rate would be the greater of (1) the applicable Federal rate (AFR) that applies under the discounting rules for property and casualty insurance loss reserves, or (2) the interest rate applicable to policy loans under the contract. Discounting would be calculated assuming the death benefit would have been paid 12 months after the payment of the accelerated death benefit.

REASONS FOR CHANGE

The Committee wishes to provide a limited exception, in the case of certain terminally ill insured individuals, to the present-law rule permitting an exclusion from income only for amounts that are paid under a life insurance contract by reason of the death of the insured. The Committee believes that the exclusion should be permitted only in those cases in which the amount is received within 12 months before the insured individual's reasonably expected death. A period longer than 12 months could become speculative and not realistically related to the time of the individual's death (when the present-law exclusion for amounts paid by reason of death applies). The Committee also believes that protection of policyholders warrants limitations on the method and maximum rate of discount permitted, and also warrants a requirement that the cash surrender value may not be disproportionately reduced in relation to the death benefit by the amount paid under the provision.

EXPLANATION OF PROVISION

The bill provides an exclusion from gross income for certain amounts received under a life insurance contract if the insured under the contract is terminally ill. For this purpose, an individual is considered terminally ill if the insurer determines, after receipt of an acceptable certification by a licensed physician, that the individual has an illness or physical condition that is reasonably expected to result in death within 12 months of the certification.

The exclusion under the bill is applicable only if two requirements are met. First, under a present value test, the amount received must equal or exceed the present value of the reduction in the death benefit otherwise payable under the life insurance contract. Second, under a ratio test, the payment of the amount must not reduce the cash surrender value of the contract proportionately more than the death benefit payable under the contract. In other words, the percentage derived by dividing the cash surrender value of the contract immediately after the distribution by the cash surrender value of the contract immediately before the distribution must equal or exceed the percentage derived by dividing the death benefit payable immediately after the distribution by the death benefit payable immediately before the distribution. The amount received is intended to include a series of payments.

For purposes of the present value test, the present value of the reduction in the death benefit is determined by reference to a maximum permissible discount rate, and by assuming that the death benefit would have been paid on the date that is 12 months from the date of the physician's certification. The maximum permissible discount rate is the highest of the following three interest rates: (1) the 90-day Treasury bill yield (as most recently published), (2) Moody's Corporate Bond Yield Average-Monthly Average Corporates (or any successor rate) for the month ending two months before the date the rate is determined, or (3) the rate used to determine cash surrender values under the contract during the applicable period plus 1 percent per annum. It is intended that the rate be determined as of the date (or dates) that the payment is made.

For example, assume that an insured is certified as being terminally ill on January 1, 1995. Assume also that the maximum permissible discount rate is 10 percent and that the cash surrender value of the contract is $100,000 and the death benefit payable is $500,000. Finally, assume that an accelerated death benefit is paid on July 1, 1995 which reduces the death benefit payable under the contract by $200,000 (i.e., from $500,000 to $300,000). Under these facts, the applicable discount period would be six months (i.e., the period between July 1, 1995 and January 1, 1996)[61] and thus, the amount of the accelerated death benefit paid must equal or exceed $190,280 (i.e., the $200,000 reduction in the death benefit payable discounted at 10 percent for six months). In addition, the cash surrender value of the contract after distribution of the accelerated death benefit must equal or exceed $60,000.

If the accelerated death benefit under the contract is paid in connection with a lien against the death benefit rather than an actual reduction in the death benefit on a discounted basis, then the amount of the lien, and interest charges with respect to any amount in connection with the lien, are taken into account as follows, so as to achieve parity between use of the lien method and use of a discounted payment. First, for purposes of applying the present value test and the ratio test (described above), the amount of the lien is treated as a reduction in the death benefit and in the cash surrender value. Any interest charges, with respect to any amount in connection with the lien, that could encumber the cash surrender value or the death benefit in the future are also treated as a reduction in the cash surrender value and the death benefit at the time of the accelerated benefit payment. Second, any interest rate applicable with respect to any amount in connection with the lien cannot exceed the maximum permissible discount rate that applies under the present value test (described above). Thus, such interest cannot exceed the amount of the discount that would have been permitted had the accelerated benefit been paid on a discounted basis instead of by use of a lien, and the lien may not encumber the cash surrender value proportionately more that it encumbers the death benefit.

The provision does not apply in the case of an amount paid to any taxpayer other than the insured, if such taxpayer has an insur-

[61] January 1, 1996 is the date 12 months after the date of the physician's certification.

able interest by reason of the insured being a director, officer or employee of the taxpayer, or by reason of the insured being financially interested in any trade or business carried on by the taxpayer.

For life insurance company tax purposes, the provision treats a qualified accelerated death benefit rider to a life insurance contract as life insurance. A qualified accelerated death benefit rider is any rider on a life insurance contract that provides for a distribution to an individual upon the insured becoming a terminally ill individual (as defined above), but only if such payments under the rider are payments that are excludable under this provision.

EFFECTIVE DATE

The provision generally applies to amounts received after the date of enactment. However, the present value test (i.e., the rule that the amount received as an accelerated death benefit must equal or exceed the present value of the reduction in the death benefit) does not apply to any amount received before January 1, 1995. The issuance of a qualified accelerated death benefit rider to a life insurance contract is not treated as a modification or material change of the contract (and is not intended to affect the issue date of any contract under section 101(f)). The provision treating a qualified accelerated death benefit rider as life insurance for life insurance company tax purposes is effective on January 1, 1995.

Subtitle F—Health Care Trust Funds

1. Establishment of Health Care Trust Funds (sec. 761 of the bill and new secs. 9551–9553 of the Code)

PRESENT LAW

No provision.

REASONS FOR CHANGE

The Committee desires to ensure that there are identifiable funds available to finance programs established under the bill.

EXPLANATION OF PROVISIONS

The bill establishes three new health-related trust funds in the Internal Revenue Code.

Health Security Trust Fund

There is established a Health Security Trust Fund consisting of the following amounts: (1) amounts equivalent to taxes received from the new excise taxes imposed on tobacco products (only to the extent of the increase provided under the bill), and on high cost health plans; (2) amounts determined by the Secretary of Treasury, in consultation with the Secretary of HHS, equal to the sum of (a) reductions in Federal expenditures under title XIX of the Social Security Act ("SSA") resulting from the provisions of the bill, and (b) any reductions in payments to States under title XIX of the SSA by reason of the State maintenance-of-effort requirement under section 1931(d) of the SSA; (3) amounts determined by the Secretary, in consultation with the Secretary of HHS, equal to the de-

crease in Federal expenditures attributable to the provisions of subtitle G of title XXI of the SSA (relating to automobile insurance coordination); (4) amounts equivalent to the following amounts received by the Treasury: (a) criminal fines imposed and collected and amounts resulting from the forfeiture of property in cases involving a Federal health care offense (as defined in section 1128D of the SSA); (b) penalties and damages imposed and collected under the False Claims Act in cases involving claims related to the provision of health care items and services; and (c) administrative penalties and assessments imposed and collected under section 1128A of the SSA; (5) amounts transferred by the Secretary of HHS from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Insurance Trust Fund equal to reductions in expenditures out of such Trust Funds resulting from the provisions subtitle (G) of title XXI of the SSA, as added by the bill (relating to automobile insurance coordination); (6) amounts transferred by the Secretary of HHS recovered under section 1128A of the SSA with respect to a certified health plan or certified long-term care policy which are not repaid to the plan or policy, and any money gifts or bequests made to the United States for allocation to the Federal Outlay Program Fraud and Abuse Control Account, described below; and (7) interest credited to it under Code section 9602(b). There are five Accounts established within the Trust Fund, as follows.

1. The Health Insurance Account will receive all amounts in the Trust Fund not allocated to other Accounts. Amounts from this Account will be appropriated to carry out the health insurance premium assistance program and cost-sharing program established under part B of title XIX of the SSA. However, to the extent that amounts in this Account are insufficient to pay for the assistance and grants, the remaining payments are to be made from other funds available in the Treasury. Therefore, the amount of assistance and grants are determined by the eligibility and grant formulas, and not by the amount of funds available in this Account.

2. The Infrastructure Development Account will receive $1.3 billion per fiscal year.[62] Amounts from this Account will be appropriated to carry out the programs established under parts I and II of subtitle F of title XXI of the SSA (relating to (1) grants for the development and operation of community health groups and for capital assistance; and (2) demonstration projects to promote telemedicine and other uses of the telecommunications network in rural areas).

3. The State Health Quality and Consumer Protection Account will receive $200 million for fiscal year 1995; $500 million for fiscal years 1996 through 1998; and $450 million for fiscal years 1990 through 2004. Amounts from this Account will be appropriated to carry out the programs established by section 21003(c)(3), 21503, and 21816 of the SSA (relating to (1) support to States for establishing an accreditation, certification, enforcement, and information program with respect to health care coverage; (2) implementing quality improvement research through demonstration projects; and

[62] This amount would be adjusted by changes in the Consumer Price Index for fiscal years beginning after 1999.

(3) support to States which establish and maintain complaint review systems and early dispute resolution programs).

4. The Long-term Care Account will receive amounts appropriated to the Trust Fund by reason of a decrease in Federal expenditures attributable to the provisions of subtitle G of title XXI of the SSA (relating to automobile insurance coordination), as well as any amounts transferred to the Health Security Trust Fund from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Insurance Trust Fund (relating to automobile insurance coordination). Amounts in this Account will be appropriated to carry out the program established under part C of title XIX of the SSA.

5. The Federal Outlay Program Fraud and Abuse Account will receive the first $75 million each fiscal year, plus 50 percent of additional amounts from the following amounts transferred to the Trust Fund: (1) criminal fines imposed and collected and amounts resulting from the forfeiture of property in cases involving a Federal health care offense (as defined in section 1128D of the SSA); (2) penalties and damages imposed and collected under the False Claims Act in cases involving claims related to the provision of health care items and services; and (3) administrative penalties and assessments imposed and collected under section 1128A of the SSA. In addition, the Account will receive any amounts transferred to the Trust Fund by the Secretary of HHS recovered under section 1128A of the SSA with respect to a certified health plan or certified long-term care policy which are not repaid to the plan or policy, and any money gifts or bequests made to the United States for allocation to the Account. Amounts in this Account will be appropriated to carry out the program described in section 1128C of the SSA. However, no amounts in the Account which are made available to any Federal agency will replace or reduce the amount of appropriations for such agency under appropriations acts.

Amounts not expended from any of these Accounts during any fiscal year will be carried over by the respective Account to subsequent fiscal years. Interest credited to the Trust Fund under Code section 9602(b) will be allocated to each Account ratably on the basis of the balance in each Account as of the beginning of the fiscal year.

Graduate Medical Education and Academic Health Centers Trust Fund

The Graduate Medical Education and Academic Health Centers Trust Fund consists of two Accounts. Each of these Accounts will be funded out of amounts received in the Treasury from the assessments on insured and self-insured plans (under new Code sections 4501 and 4502) (other than any portion of such amounts transferred to the Biomedical and Behavioral Research Trust Fund, described below). In addition, the Secretary of HHS will transfer the following amounts to the Trust Fund each fiscal year from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Insurance Trust Fund: (1) the amount that would have been paid from the Federal Hospital Insurance Trust Fund under section 1886(d)(5)(B) of the SSA (as in effect before enactment of the bill); and (2) the amount that would have been paid out of the

Federal Hospital Insurance Trust Fund and the Federal Supplementary Insurance Trust Fund under section 1886(h) of the SSA (as in effect before enactment of the bill). The Trust Fund will also receive interest credited to it under Code section 9602(b).

The Graduate Medical and Nursing Education Account will receive (1) amounts equivalent to the amount that would have been paid out of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Insurance Trust Fund under section 1886(h) of the SSA (as in effect before enactment of the bill), plus (2) the excess of (a) amounts made available under subpart I of part D of title XVIII of the SSA over (b) the amount that would have been paid from the Federal Hospital Insurance Trust Fund under section 1886(d)(5)(B) of the SSA (as in effect before enactment of the bill). Amounts in this Account will be available to carry out the programs established under subpart I of part D of title XVIII of the SSA.

The Academic Health Centers Account will receive (1) amounts equivalent to the amount that would have been paid from the Federal Hospital Insurance Trust Fund under section 1886(d)(5)(B) of the SSA (as in effect before enactment of the bill), plus (2) the excess of (a) amounts made available under subpart II of part D of title XVIII of the SSA over (b) the amount that would have been paid from the Federal Hospital Insurance Trust Fund under section 1886(d)(5)(B) of the SSA (as in effect before enactment of the bill). Amounts in this Account will be available to carry out the programs established under subpart II of part D of title XVIII of the SSA.

Any amount not expended from these Accounts during any fiscal year will be carried over by the respective Account to subsequent fiscal years. If the amount received in the Trust Fund is either greater or less than the amount required to be allocated to the Accounts, then the amounts to be allocated to each Account will be increased or reduced proportionately, as appropriate. Interest credited to the Trust Fund under Code section 9602(b) will be allocated to each Account ratably on the basis of the balance in each Account as of the beginning of the fiscal year.

Biomedical and Behavioral Research Trust Fund

The Biomedical and Behavioral Research Trust Fund will receive amounts equivalent to 14.3 percent of amounts received in the Treasury from the assessments on insured and self-insured plans. The Trust Fund will also receive interest credited to it under Code section 9602(b). Amounts in the Fund will, subject to appropriations, be paid annually to the Secretary of HHS on behalf of the National Institutes of Health ("NIH"). The Secretary of HHS will distribute such amounts as follows: (1) 3 percent to the Office of the Director of the NIH and for construction of intramural and extramural buildings and facilities; (2) 20 percent to the Agency for Health Care Policy and Research for health care services research; and (3) the remainder to member institutes of the NIH in proportion to the amount of annual appropriations for each member institute. However, no amounts in the Trust Fund will replace or reduce the amount of appropriations for the NIH under appropriations acts.

Subtitle G—Other Revenue Provisions

1. Employment Status Proposal Required from Department of the Treasury (sec. 771 of the bill)

PRESENT LAW

In general

In general, the determination of whether an employer-employee or independent contractor relationship exists for Federal tax purposes is made under a common-law test. Under this test, an employer-employee relationship generally exists if the person contracting for the services has the right to control not only the result of the services, but also the means by which that result is accomplished (Treas. Reg. sec. 31.3401(c)–(1)(b)). Whether the requisite control exists is determined based on the facts and circumstances. The Internal Revenue Service (IRS) uses a 20-factor test for this purpose. Rev. Rul. 87–41, 1987–1 C.B. 296. In addition to the common-law test, there are statutory provisions classifying certain workers as employees or independent contractors for certain purposes.

Section 530 of the Revenue Act of 1978

In the late 1960s, the IRS increased enforcement of the employment tax laws, and controversies developed between the IRS and taxpayers as to whether businesses had correctly classified certain workers as independent contractors rather than as employees. In response to this problem, Congress enacted section 530 of the Revenue Act of 1978 ("section 530"), which generally permits a taxpayer to treat an individual as not being an employee for employment tax purposes regardless of the individual's actual status under the common-law test, unless the taxpayer has no reasonable basis for such treatment and if certain additional requirements are satisfied. Section 530 does not apply in the case of an individual who, pursuant to an arrangement between the taxpayer and another person, provides services for such other person as an engineer, designer, drafter, computer programmer, systems analyst, or other similarly skilled worker engaged in a similar line of work.

Section 530 does not apply for income tax purposes. Thus, the service recipient's determination of whether an individual is an employee for income tax purposes is made without regard to section 530. In addition, section 530 does not apply to the worker for employment or income tax purposes. The determination of whether an individual is an employee for purposes of determining his or her income and employment tax liabilities is made without regard to section 530.

REASONS FOR CHANGE

Under present law, significant tax consequences result from the classification of a worker as an employee or independent contractor. Some of these differences relate to withholding and employment tax requirements, as well as the ability to exclude certain types of compensation from income or take tax deductions for certain expenses. Some of the provisions of the bill place greater sig-

nificance on the proper classification of a worker as an independent contractor or employee, because requirements with respect to health care coverage depend in part on such status. The present-law rules for determining whether a worker is an employee or an independent contractor continue to result in misclassification of workers and uncertainty among taxpayers. Misclassification of workers can be either inadvertent or deliberate. Proper classification of workers is inherently difficult in some cases because it is a factual determination. The Committee believes that the present-law standards for worker classification could be modified to provide more certainty for both the IRS, employers, and workers and, in some cases, more appropriate results. However, because of the difficulties of determining appropriate classification rules, the Committee believes further study of specific legislative proposals should be made before statutory changes are adopted

EXPLANATION OF PROVISION

The bill directs the Secretary of the Treasury to submit a legislative proposal providing statutory standards relating to the classification of workers as employees or independent contractors to the tax writing committees of the Congress by January 1, 1996.

EFFECTIVE DATE

The provision is effective on the date of enactment.

2. Increase in Services Reporting Penalties (sec. 772 of the bill and sec. 6721 of the Code)

PRESENT LAW

Information reporting requirements (secs. 6041(a) and 6041A(a))

Under the Code, a person engaged in a trade or business who makes payments during the calendar year of $600 or more to a person for rents, salaries, wages, premiums, annuities, compensations, remunerations, emoluments, or other fixed or determinable gains, profits, and income, must file an information return with the Internal Revenue Service ("IRS") reporting the amount of such payments, as well as the name, address and taxpayer identification number of the person to whom such payments were made (sec. 6041(a)).[63] A similar statement must also be furnished to the person to whom such payments were made (sec. 6041(d)).

The Code contains an additional provision requiring that a service recipient (i.e., a person for whom services are performed) engaged in a trade or business who makes payments of remuneration in the course of that trade or business to any person for services performed must file with the IRS an information return reporting such payments (and the name, address, and taxpayer identification number of the recipient) if the remuneration paid to the person during the calendar year is $600 or more (sec. 6041A(a)). A similar

[63] A number of exceptions to this requirement are provided in Treasury regulations. In addition, to the extent the general information reporting requirements of this provision overlap specific information reporting requirements elsewhere in the Code, taxpayers are generally required to report only once, under the more specific information reporting provision.

statement must also be furnished to the person to whom such payments were made (sec. 6041A(e)).

Failure to file correct information returns (sec. 6721)

Any person that fails to file a correct information return[64] with the IRS on or before the prescribed filing date is subject to a penalty that varies based on when, if at all, the correct information return is filed. If a person files a correct information return after the prescribed filing date but on or before the date that is 30 days after the prescribed filing date, the penalty is $15 per return, with a maximum penalty of $75,000 per calendar year. If a person files a correct information return after the date that is after 30 days after the prescribed filing date but on or before August 1 of that year,[65] the penalty is $30 per return, with a maximum penalty of $150,000 per calendar year. If a correct information return is not filed on or before August 1, the amount of the penalty is $50 per return, with a maximum penalty of $250,000 per calendar year.

There is a special rule for de minimis failures to include the required, correct information. This exception applies to incorrect information returns that are corrected on or before August 1. Under the exception, if an information return is originally filed without all the required information or with incorrect information and the return is corrected on or before August 1, then the original return is treated as having been filed with all of the correct required information. The number of information returns that may qualify for this exception for any calendar year is limited to the greater of (1) 10 returns or (2) one-half of one percent of the total number of information returns that are required to be filed by the person during the calendar year.

In addition, there are special, lower maximum levels for this penalty for small businesses. For this purpose, a small business is any person having average annual gross receipts for the most recent 3 taxable years ending before the calendar year that do not exceed $5 million. The maximum penalties for small businesses are: $25,000 (instead of $75,000) if the failures are corrected on or before 30 days after the prescribed filing date; $50,000 (instead of $150,000) if the failures are corrected on or before August 1; and $100,000 (instead of $250,000) if the failures are not corrected on or before August 1.

If a failure to file a correct information return with the IRS is due to intentional disregard of the filing requirement, the penalty for each such failure is increased to the greater of $100 or 10 percent[66] of the amount required to be reported correctly, with no limitation on the maximum penalty per calendar year (sec. 6721(e)). The increase in the penalty applies regardless of whether a corrected information return is filed, the failure is de minimis, or the person subject to the penalty is a small business.

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[64] This term is defined in sec. 6724(d)(1), and refers to certain information reporting requirements in the Code, including secs. 6041(a) and 6041A(a).

[65] Subsequent references to August 1 means August 1 of the year that includes the prescribed filing date.

[66] This percentage varies depending upon the type of information return. With respect to information returns required under sections 6041(a) and 6041A(a), the applicable percentage is 10 percent (sec. 6721(e)(2)).

Failure to furnish correct payee statements (sec. 6722)

Any person that fails to furnish a correct payee statement[67] to the person to whom the statement is required to be furnished on or before the prescribed due date is subject to a penalty of $50 per statement, with a maximum penalty of $100,000 per calendar year. If the failure to furnish a correct payee statement is due to intentional disregard of the requirement, the penalty increases to $100 per statement or, if greater, 10 percent[68] of the amount required to be shown on the statement, with no limitation on the maximum penalty per calendar year.

Failure to comply with other information reporting requirements (sec. 6723)

Any person that fails to comply with other specified information reporting requirements on or before the prescribed date is subject to a penalty of $50 for each failure, with a maximum penalty of $100,000 per calendar year. The information reporting requirements specified for this purpose include any requirement to include a correct taxpayer identification number on a return, a statement, or any other document (other than an information return or payee statement) and any requirement to furnish a correct taxpayer identification number to another person (Treas. Reg. sec. 301–6723–1(a)(4)).

Waiver, definitions, and special rules (sec. 6724)

Any of the information reporting penalties may be waived if it is shown that the failure to comply is due to reasonable cause and not to willful neglect. For this purpose, reasonable cause exists if (1) there are significant mitigating factors for the failure, such as the fact that a person has an established history of complying with the information reporting requirements, or the failure was caused by events beyond the person's control, and (2) the person acted in a responsible manner both before and after the failure occurred (Treas. Reg. sec. 301.6724–1(a)(2)).

REASONS FOR CHANGE

The Committee believes that increasing the penalty to reflect the amount that is reported incorrectly on information returns will improve compliance with the reporting requirements. Improving compliance with the reporting requirements will help ensure that independent contractors report all of their income, which determines eligibility for subsidies under the bill.

EXPLANATION OF PROVISION

The bill modifies the penalty for failure to file correct information returns with respect to two types of information returns: (1) information returns under section 6041(a), but only if such returns relate to payments to any person for services performed by such per-

[67] This term is defined in sec. 6724(d)(2), and refers to certain information reporting requirements in the Code, including secs. 6041(d) and 6041A(e).
[68] Five percent for several types of statements.

son (other than as an employee);[69] and (2) returns regarding remuneration for services under section 6041A(a). In general, both of these sections of the Code relate to information returns with respect to payments made to non-employees, such as independent contractors.[70]

In general, the bill increases the penalty for failure to file specified information returns correctly on or before August 1 from $50 for each return to the greater of $50 or 5 percent of the amount required to be reported correctly but not so reported. The $250,000 maximum penalty for failures to file correct information returns during any calendar year continues to apply under the bill.

The bill also provides for an exception to this increase where substantial compliance has occurred. The bill provides that this exception would apply with respect to a calendar year if the aggregate amount that is timely and correctly reported under sections 6041(a) and 6041A(a) with respect to services for that calendar year is at least 97 percent of the aggregate amount required to be reported under these two sections of the Code with respect to services for that calendar year. If this exception applies, the present-law penalty of $50 for each return would continue to apply.

The bill does not affect the following provisions of present law: (1) the reduction in the $50 penalty where correction is made within a specified period; (2) the exception for de minimis failures; (3) the lower limitations for persons with gross receipts of not more than $5,000,000; (4) the increase in the penalty in cases of intentional disregard of the filing requirement; (5) the penalty for failure to furnish correct payee statements under section 6722; (6) the penalty for failure to comply with other information reporting requirements under section 6723; and (7) the reasonable cause and other special rules under section 6724.

EFFECTIVE DATE

The provision applies to information returns the due date for which (without regard to extensions) is more than 30 days after the date of enactment.

3. Nonrefundable Credit for Certain Primary Health Services Providers (sec. 775 of the bill and new sec. 23 of the Code)

PRESENT LAW

Geographically targeted tax provisions

In general, the operation of Internal Revenue Code rules does not vary based on the location within the United States of income-producing activity. Nonetheless, present law provides favorable Federal income tax treatment for certain U.S. corporations that operate in Puerto Rico, the U.S. Virgin Islands, or possessions of the United States to encourage the conduct of trades or business within these areas. In addition, certain Code sections provide additional benefits in targeted geographic areas (e.g., low-income housing

[69] Thus, the provision does not apply to information returns filed under section 6041(a), that do not report payments for services.

[70] Employers are required to provide information with respect to wages paid to their employees on Form W–2 under section 6051; consequently, those information returns would not be affected by the bill.

credit and qualified mortgage bond provisions target certain economically distressed areas).

The Omnibus Budget Reconciliation Act of 1993 ("1993 Act") provides for the designation of nine empowerment zones and 95 enterprise communities in economically distressed areas satisfying certain criteria. The designations are to be made during 1994 and 1995, and generally will remain in effect for 10 years. During the period the designation is in effect, special tax incentives (i.e., an employer wage credit, additional section 179 expensing, and expanded tax-exempt financing) are available for certain business activities conducted in empowerment zones. Expanded tax-exempt financing benefits are available for certain facilities located in enterprise communities. In addition, the 1993 Act provides accelerated depreciation benefits and an incremental employer wage credit for certain business activities conducted on Indian reservations.

Tax benefits available for medical care providers

Code section 108(f) provides an exclusion from Federal income tax for what otherwise would be discharge-of-indebtedness income if a student loan is discharged pursuant to a provision in the loan agreement that requires the student to work for a period of time in certain professions for any of a broad class of employers. Section 108(f) applies only to student loans made from funds provided by the Federal Government, a State or local government, or certain public benefit corporations described in section 501(c)(3). For example, the favorable treatment provided by section 108(f) applies when a government agency discharges a student loan upon the student's provision of medical services to an underserved area.

Present law does not provide for a special credit against Federal income taxes for individuals who provide medical services in medically underserved geographic areas.

Nontax benefits for medical care providers

Other, non-tax provisions of Federal law provide that certain health care professionals who agree to work full time for at least two years at an approved government or nonprofit employment site within a "health professional shortage area" (HPSA) are eligible for scholarships or repayments of student loans.[71] The scholarship and loan repayment programs are administered by the National Health Service Corp (NHSC), which is part of the Department of Health and Human Services.[72]

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[71] HPSAs are designated geographic areas, as well as certain designated population groups and government facilities. Currently, more than 2,400 primary care HPSAs have been designated, covering all or parts of 1,800 counties in the United States. There are also over 1000 dental HPSAs and over 700 mental health HPSAs. HPSAs are designated by the Bureau of Primary Health Care, which is part of the United States Public Health Service, HPSAs are identified on the basis of State and local government requests for designation. Primary care HPSAs are designated on the basis of rate of poverty, access to primary health care, low birthweight births, infant mortality, and the physician/population ratio. See vol. 59 *Federal Register* No. 14 (January 21, 1994) at 3411–5307. The NHSC Revitalization Amendments of 1990 (sec. 333A of Pub. Law 101–697) require that the Secretary of HHS annually prepare a list of HPSAs in order of greatest shortage of medical practitioners (by using certain exclusive factors) and that priority in the assignment of National Health Service Corp (NHSC) personnel be given to government or nonprofit entities serving HPSAs with the greatest shortages. See 42 U.S.C. 254f–1.

[72] As of September 30, 1993, a total of 1,163 practitioners (i.e., primary-care physicians and physician assistants, general practice dentists, primary-care nurse practitioners, and certified

Continued

REASONS FOR CHANGE

The Committee believes that, in view of the shortage of primary health service practitioners in certain underserved areas, it is appropriate to provide a tax credit to encourage primary health service practitioners to serve in such areas.

EXPLANATION OF PROVISION

A physician who provides primary health services in certain medically underserved areas is eligible for a nonrefundable credit against Federal income taxes of $1,000 per month for up to 36 months ($500 per month if the physician already is providing primary health services in any underserved area at the time the credit becomes effective on January 1, 1995).[73] The credit rate is $500 per month in the case of a physician assistant, nurse-practitioner, or certified nurse-midwife (regardless of when the individual began providing medical services in an underserved area). The credit is available to a taxpayer only if he or she provides primary health services[74] on a full-time basis in a "health professional shortage area" (HPSA) (as defined under present-law section 332(a)(1)(A) of the Public Health Service Act).[75] To be eligible for the credit, the taxpayer is required to obtain certification from the Bureau of Primary Health Care, United States Public Health Service of the Department of Health and Human Services, that he or she is a full-time provider of primary health services in a HPSA, and, in the case of a taxpayer working in a HPSA located within a metropolitan statistical area, that he or she performs such services (as an employee or independent contractor) for a governmental or nonprofit entity.[76] The credit is not available, however, if the taxpayer participated in the National Health Service Corps (NHSC) scholarship or loan repayment program. The credit is not allowed as an offset against alternative minimum tax (AMT) liability (Code sec. 26).

Under the provision, a taxpayer is required to work full time providing primary health services in a HPSA for 24 consecutive months (following certification) in order to receive the tax credit. If a taxpayer does not provide primary health services on a full-time basis in a HPSA for at least 24 consecutive months (following certification), any credit previously claimed will be completely recaptured and no credit will be allowed for the current or future taxable years. If a taxpayer performs full-time primary health services in a HPSA for at least 24 consecutive months (following certification), then there will be no recapture of credits previously claimed. The

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nurse midwives) were providing medical care in HPSAs throughout the United States pursuant to the NHSC scholarship and loan repayment programs.

[73] For purposes of the credit, the term "physician" has the meaning given such term by section 1861(r) of the Social Security Act.

[74] The term "primary health services" has the meaning given such term by section 330(b)(1) of the Public Health Service Act.

[75] See Title 42, U.S. Code, sections 254e and 254f–1. For purposes of the provision, medically underserved areas include geographic areas, population groups, and public facilities that have HPSA designation.

[76] For purposes of the credit, a practitioner will be treated as providing services in a HPSA, even if the area no longer has designation as such, so long as the area is designated as a HPSA when the practitioner is certified by the Department of HHS as providing primary health services in the area (i.e., the practitioner already is providing primary health services in an area designated as a HPSA on December 31, 1994, or subsequently begins providing such services in the area when it is designated as a HPSA).

Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, is granted authority to waive recapture of credits when a taxpayer fails to provide services in a HPSA for at least 24 months due to extraordinary circumstances.

EFFECTIVE DATE

The provision is effective for taxable years beginning after 1994.

4. Expensing of Medical Equipment (sec. 776 of the bill and sec. 179 of the Code)

PRESENT LAW

Depreciation rules

In general, the cost of property that has a useful life longer than one year must be capitalized and recovered over time pursuant to depreciation or amortization rules. Tangible depreciable property placed in service after 1986 is depreciated under the modified Accelerated Cost Recovery System (MACRS) enacted as part of the Tax Reform Act of 1986. Under MACRS, high technology medical equipment is depreciated for regular tax purposes over a 5-year recovery period using the 200-percent declining balance method. "High technology medical equipment" means any electronic, electromechanical, or computer-based high technology equipment used in the screening, monitoring, observation, diagnosis, or treatment of patients in a laboratory, medical, or hospital environment.

In general, the benefits of the accelerated MACRS deductions are reduced for property under an alternative depreciation system that applies to foreign use property, tax-exempt use property, tax-exempt bond financed property, certain imported property, and property which the taxpayer so elects. The alternative depreciation system also is used to compute corporate earnings and profits. The benefits are reduced by calculating depreciation using the straight-line method over the property's class life. A property's class life generally corresponds to its Asset Depreciation Range (ADR) midpoint life and often is longer than the recovery period applicable for regular tax purposes. The class lives of the alternative depreciation system also are used for purposes of the corporate and individual alternative minimum tax. The class lives of some assets are set by statute, regardless of the asset's ADR midpoint life. The class life of high technology medical equipment is set by statute at five years.

Section 179 expensing allowances

In lieu of depreciation, a taxpayer with a sufficiently small amount of annual investment may elect to deduct immediately up to $17,500 of the cost of qualifying property placed in service for the taxable year under section 179.[77] In general, qualifying property is defined as depreciable tangible personal property that is purchased for use in the active conduct of a trade or business. The $17,500 amount is reduced (but not below zero) by the amount by

[77] Section 1397A of the Code increases the amount allowed to be expensed under section 179 by an enterprise zone business by the lesser of: (1) $20,000 or (2) the cost of section 179 property that is qualified zone property placed in service during the taxable year.

which the cost of qualifying property placed in service during the taxable year exceeds $200,000. In addition, the amount eligible to be expensed for a taxable year may not exceed the taxable income of the taxpayer for the year that is derived from the active conduct of a trade or business. Any amount that is not allowed as a deduction because of the taxable income limitation may be carried forward to succeeding taxable years (subject to similar limitations).

REASONS FOR CHANGE

The Committee believes that it is appropriate to provide tax incentives to encourage primary care physicians to locate and practice in health professional shortage areas.

EXPLANATION OF PROVISION

The bill increases the amount allowed to be expensed under section 179 in a taxable year by the lesser of: (1) the cost of section 179 property which is health care property placed in service during the year or (2) $15,000. For this purpose, "health care property" means section 179 property: (1) which is medical equipment used in the screening, monitoring, observation, diagnosis, or treatment of patients in a laboratory, medical, or hospital environment; (2) which is owned (directly or indirectly) and used by a physician (as defined by 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 ("HPSA") (as defined in section 332(a)(1)(A) of the Public Health Service Act); and (3) substantially all the use of which is in such area. Physicians providing primary health services within metropolitan statistical areas (as defined by section 143(k)(2) of the Internal Revenue Code) are eligible for the additional section 179 expensing only if they perform such services for, or on behalf of, a governmental or nonprofit entity.

As provided in (2) above, a taxpayer must satisfy both an ownership and a use test in order to be eligible for the additional expensing provided by the bill. First, the property must be owned (directly or indirectly) by a physician. For this purpose, indirect ownership would include ownership by an entity in which substantially all the ownership interests are held by physicians. Second, the property must be used in the active conduct of a physician's full-time trade or business of providing primary health services in a HPSA. For this purpose, "use" means more than a de minimis amount of use and does not include leasing the equipment as a lessor.[78] In addition, in the case of multiple or indirect ownership, substantially all the owners must use the property. Thus, for example, property owned by a partnership that has two physicians as equal partners will not qualify for the additional expensing unless both partners use the property in the active conduct of their full-

[78] Property that is both used in the active conduct of a physician's full-time trade or business of providing primary health care services in a HPSA and leased will qualify for the additional expensing if there is sufficient use of the property in the active conduct of the physician's trade or business.

time trades or businesses of providing primary health services in a HPSA for more than a de minimis amount of use.

As under present-law section 179, the Secretary of the Treasury may provide, by regulations, for recapturing the benefit provided by the provision with respect to any property that ceases to be health care property at any time. For this purpose, property will not be treated as having ceased to be health care property solely because an area that was designated as a HPSA when the property was placed in service subsequently has its HPSA designation withdrawn by the Department of Health and Human Services.

EFFECTIVE DATE

The provision applies to property placed in service in taxable years beginning after December 31, 1994.

5. Post-Retirement Medical and Life Insurance Reserves (sec. 781 of the bill and sec. 419A of the Code)

PRESENT LAW

Under present law, employer-provided post-retirement medical benefits are generally excludable from the gross income of a plan participant or beneficiary. In addition, an employer may deduct contributions, within limits, made to a welfare benefit fund for retiree health and life insurance benefits of its employees. A welfare benefit fund is, in general, any fund that is part of a plan of an employer, and through which the employer provides welfare benefits to employees or their beneficiaries.

Contributions by an employer to a welfare benefit fund are not deductible under the usual income tax rules, but if they otherwise would be deductible under the usual rules (e.g., if they are ordinary and necessary business expenses), the contributions are deductible within limits for the taxable year in which such contributions are made to the fund.

The amount of the deduction otherwise allowable to an employer for a contribution to a welfare benefit fund for any taxable year may not exceed the qualified cost of the fund for the year. The qualified cost of a welfare benefit fund for a year is the sum of (1) the qualified direct cost of the fund for the year and (2) the addition (within limits) to the qualified asset account under the fund for the year, reduced by (3) the after-tax income of the fund.

A qualified asset account under a welfare benefit fund is an account consisting of assets set aside to provide for the payment of disability payments, medical benefits, supplemental unemployment compensation benefits or severance pay benefits, or life insurance benefits. Under present law, an account limit is provided for the amount in a qualified asset account for any year.

The account limit for any taxable year may include a reserve to provide certain post-retirement medical and life insurance benefits. This limit allows amounts reasonably necessary to accumulate reserves under a welfare benefit plan so that the liabilities for post-retirement medical and life insurance benefits with respect to a group of employees can be prefunded over the working lives of such employees.

Under present law, if an employer maintains a welfare benefit fund that provides a disqualified benefit during any taxable year, the employer is subject to an excise tax equal to 100 percent of the disqualified benefit. A disqualified benefit includes (1) a benefit provided to a key employee other than from a separate account required to be established for such an employee, (2) any post-retirement medical or life insurance benefit that is provided in a discriminatory manner, and (3) any portion of a welfare benefit fund reverting to the employer.

REASONS FOR CHANGE

The Committee believes that taxpayers have inappropriately interpreted the present-law rules relating to the funding of post-retirement medical and life insurance coverage to permit the funding of such benefits in a lump sum in certain circumstances. The Committee believes that such interpretations of the rules may reduce the benefit security of employees who are entitled to such post-retirement benefits and may allow an employer to manipulate the timing of deductions in order to maximize the tax benefit. However, the Committee concludes that a rule permitting funding no more rapidly than over the working lives of employees may unduly lengthen the period over which an employer could fund such benefits. The Committee believes that allowing for the funding of such benefits over the working lives of employees, but not over a period of less than 10 years strikes an appropriate balance among the interests of employers, employees, and tax policy.

Further, the Committee believes that amounts contributed to a welfare benefit plan by an employer for post-retirement medical and life insurance benefits should be used only to provide such benefits and should not be used to provide other benefits under the plan. The Committee concludes that requiring amounts contributed for post-retirement benefits to be treated as a separate account under the welfare benefit plan accomplishes this goal.

EXPLANATION OF PROVISION

Under the provision, the minimum period during which the cost of post-retirement medical and life insurance coverage could be funded under a welfare benefit fund is at least 10 years. Thus, an employer is permitted to deduct the costs of funding such coverage on a level basis over the working lives of covered employees, but not over a period of less than 10 years.

The provision clarifies that a reserve to provide post-retirement medical and life insurance benefits under a welfare benefit plan must be maintained as a separate account. In addition, any payment from the separate account required to be maintained for post-retirement medical and life insurance benefits that is not used to provide a post-retirement medical or life insurance benefit is included in the list of disqualified benefits for which the employer is subject to a 100-percent excise tax.

No inference is intended as to the proper interpretation under present law of the funding rules with respect to post-retirement medical and life insurance benefits or as to whether present law permits amounts contributed to provide such benefits to be used to provide for other benefits.

EFFECTIVE DATES

The provision relating to reserves for post-retirement medical and life insurance benefits under welfare benefit plans is effective for contributions paid or accrued after December 31, 1994, in taxable years ending after that date. The provision requiring that the reserve for post-retirement medical and life insurance benefits be maintained as a separate account is effective for contributions paid or accrued after the date of enactment, in taxable years ending after that date.

6. Coordination With Health Care Continuation Provisions (sec. 782 of the bill and sec. 4980B of the Code)

PRESENT LAW

In general, an employer with 20 or more employees must provide health plan participants with the opportunity to continue their coverage in the employer's health plan for a specified period of time after the occurrence of certain qualifying events that otherwise would have terminated such coverage.

The qualifying events that may trigger rights to continuation coverage are (1) the death of the employee, (2) the voluntary or involuntary termination of the employee's employment (other than by reason of gross misconduct), (3) a reduction of the employee's hours, (4) the divorce or legal separation of the employee, (5) the employee becoming entitled to benefits under Medicare, (6) a dependent child of the employee ceasing to be a dependent under the employer's plan, and (7) in certain cases the commencement of bankruptcy proceedings with respect to an employer. The maximum period of health care continuation coverage that may be elected is 36 months, except in the case of termination of employment or reduction of hours for which the maximum period is 18 months. The 18-month period is extended to 29 months in certain cases involving the disability of the plan participant. Certain events, such as the failure by the plan participant to pay the required premium, may trigger an earlier cessation of the health care continuation coverage.

Within limits, employers may require health plan participants that elect health care continuation coverage to pay for such coverage.

REASONS FOR CHANGE

The health care continuation provisions were designed to protect employees and their dependents from temporary loss of health coverage that could occur as a result of various events, such as termination of employment. The health care continuation rules were intended to bridge the gap until new coverage could be obtained. The provisions of the bill providing access to health care coverage lessen, but do not eliminate, the need for health care continuation rules. Under the bill, disruptions of health care coverage could still occur. For example, in the absence of the health care continuation rules, an individual who changes jobs might have to change health care plans several times before obtaining a new job and new coverage, even if the period of unemployment is brief. The health care

continuation provisions would help minimize changes in health care plans. Thus, the Committee believes the continuation health care rules should be retained, but that the period of continuation coverage should be shortened.

EXPLANATION OF PROVISION

The bill retains the present-law health care continuation rules, except that the maximum period of continuation coverage that can be elected by a qualified beneficiary for any qualifying event is reduced. Under the bill, a qualified beneficiary can elect health care continuation coverage for the longer of 6 months or until the end of the calendar year in which the qualifying event occurs.

EFFECTIVE DATE

The provision is effective with respect to qualifying events that occur on or after January 1, 1997.

7. Credit for Cost of Personal Assistance Services Required by Employed Individuals (sec. 783 of the bill and new sec. 24 of the Code)

PRESENT LAW

There is no tax credit for the costs of personal assistance required by individuals. Certain medical expenses, however, are deductible under section 213. Also, the costs of certain improvements to property may be included in the basis of a taxpayer's property unless it is otherwise deductible under section 213.

REASONS FOR CHANGE

The Committee believes that the cost of work-related support services represents a significant expense for physically impaired taxpayers. For such taxpayers with modest incomes, those expenses may be an impediment to seeking employment. Providing a subsidy to these taxpayers through a credit limited by the amount of earned income may encourage physically impaired taxpayers to become employed.

EXPLANATION OF PROVISION

The bill provides a nonrefundable tax credit for up to 50 percent of an individual's personal assistance expenses up to $15,000.

Individuals are eligible to claim the credit if, by reason of any medically determinable physical impairment, they are unable to engage in any substantial gainful activity without personal assistance in carrying out activities of daily living. Such physical impairment must be expected to result in death or must be expected to last for a continuous period of not less than 12 months. Nonresident aliens are not eligible to claim the credit.

Personal assistance expenses are defined as expenses for: (1) personal assistance services appropriate to carry out the activities of daily living in or outside the home, (2) homemaker/chore services incidental to the provision of such personal assistance services, (3) assistance with life skills (in the case of an individual with a cognitive impairment), (4) communication services, (5) work-related

support services, (6) coordination of services described in this paragraph, (7) assistive technology and devices (including assessment of need and training for such services), and (8) modifications to the principal place of abode of the individual to the extent the modifications would otherwise be allowable as expenses for medical care under section 213. Activities of daily living are eating, toileting, transferring, bathing, and dressing.

The maximum annual amount of credit is the lesser of $7,500 or one-half of the individual's earned income. The amount of the credit is phased out by providing a lower credit rate for taxpayers with modified adjusted gross income (AGI) of $50,000 or more. The credit rate is reduced by ten percentage points for each $5,000 of modified AGI, starting at $50,000 of modified AGI. Thus the credit is not available for individuals with modified AGI of $70,000 or more.

The rate of the credit is determined as follows:

[In percent]

For taxpayers with modified AGI	*The credit rate is*
Less than $50,000	50
At least $50,000, but less than $55,000	40
At least $55,000, but less than $60,000	30
At least $60,000, but less than $65,000	20
At least $65,000, but less than $70,000	10
At least $70,000	0

The $15,000 (maximum amount of personal assistance expenditures eligible for the credit) and $50,000 (beginning of the credit's phaseout range) amounts are indexed for inflation for taxable years beginning after 1996. The amount of modified AGI at which the credit is entirely phased out is not indexed for inflation, but will always be $20,000 greater than the beginning of the phaseout range.

Modified AGI is adjusted gross income: (1) determined without regard to the exclusions provided for (a) interest on education savings bonds (sec. 135), (b) certain foreign earned income of United States citizens or residents living abroad (sec. 911), (c) certain income from sources within Guam, American Samoa, or the Northern Mariana Islands (sec. 931), and (d) income from sources within Puerto Rico (sec. 933); and (2) increased by the amount of tax-exempt interest received or accrued by the taxpayer during the taxable year.

Any amount taken into account in determining the credit cannot be taken into account in determining deductible medical expenses (under sec. 213). Similarly, if a credit is allowed for expenses that would otherwise increase the basis of property, the basis increase is reduced by the amount of the credit. The bill also denies the credit for payments to any person related to the taxpayer within the meaning of sections 267 or 707(b).

EFFECTIVE DATE

The provision is effective for taxable years beginning after December 31, 1995.

8. Disclosure of Return Information for Administration of Certain Programs Under the Health Security Act (sec. 784 of the bill and sec. 6103 of the Code)

PRESENT LAW

The Internal Revenue Code prohibits disclosure of tax returns and return information, except to the extent specifically authorized by the Code (sec. 6103). Unauthorized disclosure is a felony punishable by a fine not exceeding $5,000 or imprisonment of not more than five years, or both (sec. 7213). An action for civil damages also may be brought for unauthorized disclosure (sec. 7431). No tax information may be furnished by the Internal Revenue Service (IRS) to another agency unless the other agency has established procedures satisfactory to the IRS for safeguarding the tax information it receives (sec. 6103(p)).

REASONS FOR CHANGE

The Committee believes access to certain items of tax information should be provided to government agencies administering health subsidy programs to assist them in determining eligibility for, and establishing correct benefit levels under, the health subsidy programs.

EXPLANATION OF PROVISION

The bill permits disclosure of certain taxpayer return information to officers and employees of any Federal, State, or local agency administering health subsidy programs for use in verifying eligibility for, and establishing correct benefit levels under, such subsidies. Disclosable return information is limited to adjusted gross income, the untaxed portion of social security benefits, tax-exempt interest income, marital status and the number of dependents.[79]

Under the bill, taxpayer return information may only be disclosed in response to a taxpayer's application for a health subsidy, only to officers and employees of an agency responsible for administering the subsidy (including officers and employees of an agency responsible for reviewing and auditing health subsidy determinations), and only to the extent necessary to make that determination. The Committee anticipates that information will be provided by means of low cost computer exchanges of information (e.g., tape-to-tape exchanges).

The bill requires any Federal, State, or local agency receiving taxpayer return information to comply with the safeguards presently contained in the Code governing the use of disclosed tax information.[80] Also, the bill applies the present-law penalties for unauthorized disclosure of information to recipient agencies and their employees.

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[79] In addition, the bill treats welfare benefits as income for purposes of computing eligibility for a health subsidy. Welfare benefits are not income for tax purposes and are not presently reported to the IRS. They are therefore not return information for purposes of the tax disclosure rules.

[80] Also, prior to receiving any taxpayer information, an agency is required to establish procedures satisfactory to the IRS for safeguarding the tax information it receives (sec. 6103(p)).

EFFECTIVE DATE

The provision is effective on the date of enactment.

9. Special Rule for Deferred Compensation Plans of Group Medical Practices (sec. 785 of the bill and sec. 457 of the Code)

PRESENT LAW

Under an eligible unfunded deferred compensation plan of a State or local government or tax-exempt entity (a sec. 457 plan), amounts of current compensation that are deferred by or on behalf of a plan participant are included in gross income when they are paid or made available. The maximum permitted annual deferral under all such plans covering the same individual is the lesser of (1) $7,500 or (2) 33⅓ percent of compensation.

REASONS FOR CHANGE

The Committee believes it appropriate to eliminate certain restrictions on the amount of deferred compensation of persons providing services through a group medical practice.

EXPLANATION OF PROVISION

Under the bill, the limit on annual deferrals under a section 457 plan does not apply in the case of an individual covered under an excess benefit arrangement maintained by a group medical practice which is exempt from tax under section 501(c)(3). In addition, amounts deferred under such an arrangement are not taken into account in applying the annual limit to other section 457 plans covering the same individual. An excess benefit arrangement is an arrangement which is maintained solely for the purpose of providing benefits in excess of the limitations on contributions and benefits imposed by section 415 of the Code on tax-qualified pension plans.

EFFECTIVE DATE

The provision is effective for taxable years beginning after December 31, 1994.

Sec. 791. Ensuring Health Care Financing

PRESENT LAW

Congress enacted the Gramm-Rudman-Hollings Act (Pub. L. No. 99–177) in 1985, to provide an incentive for the President and Congress to reduce the deficit each year through the regular legislative process. The Gramm-Rudman-Hollings Act established a declining series of deficit targets (referred to as "maximum deficit amounts") leading to a balanced budget in fiscal year 1991. The Act enforced the deficit targets by the "sequestration process," under which automatic spending reductions would occur if the projected deficit exceeded the deficit targets.

In 1987, after the Supreme Court ruled the sequestration triggering mechanism in the Gramm-Rudman-Hollings Act unconstitutional due to legislative branch involvement, Congress amended the Act, extending the goal of a balanced budget to fiscal year 1993 and placing responsibility for the automatic triggering of sequestration

in the hands of the Director of the Office of Management and Budget (OMB).

Congress revised the sequestration process in the Budget Enforcement Act (BEA) of 1990. First, the Act extended the process through fiscal year 1995 (although the budget was not required to be balanced by that time). Second, the Act shifted the focus of deficit control away from overall deficit reduction targets, to a policy requiring that new Federal legislation not increase Federal deficits. This pay-as-you-go requirement was accomplished by establishing: (1) discretionary spending caps which effectively require that new or increased discretionary spending be offset by decreases in other discretionary programs; and (2) a pay-as-you-go (PAY–GO) requirement to ensure that legislative changes in entitlement spending and revenues are fully paid for. The BEA made the spending caps and PAY–GO requirement enforceable by sequestration. Congress extended the spending caps and the PAY–GO requirement through fiscal year 1998 in the Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103–66.

The pay-as-you-go policy was broadened in the FY 1994 and FY 1995 concurrent resolutions on the budget, which imposed a 10-year pay-as-you-go requirement on entitlement and revenue legislation considered by the Senate. Legislation violating the requirement is subject to a point of order, which may only be waived by a supermajority of 60 votes.

The existing statutory PAY–GO constraints through FY 1998 and the Senate's 10-year pay-as-you-go point of order, operate to prevent the enactment of legislation which is projected at the time of enactment to cause increases in the deficit for any year through fiscal year 2004.

COMMITTEE PROVISION

The Committee proposal includes a failsafe mechanism designed to implement automatic mid-course corrections if this legislation is projected, following enactment, to be underfunded. The correction mechanism would also be triggered in the event of unanticipated increases in Medicare or Medicaid spending or unanticipated revenue losses due to specified health tax expenditures.

In general, if the President's budget for any fiscal year projects that the new subsidies, new tax deduction and other new expenditures would not be fully paid for by the new revenues and the Medicare and Medicaid savings (reduced by unanticipated increases in those programs), then the increased spending would be fully offset by a combination of (1) a reduction in spending for premium and cost-sharing assistance; (2) a reduced deduction for individuals purchasing their own health insurance; and (3) increases in the out-of-pocket limits set for the standard and basic benefit packages by the National Health Board. The mechanism would operate as detailed below.

Entitlement to subsidies and tax deductions made contingent on automatic deficit reduction

The legal entitlement to premium and cost-sharing assistance, and the tax deduction for individuals purchasing their own health

insurance would be subject to the operation of the deficit failsafe mechanism explained below.

Current health spending estimate

The committee provision requires the President to issue, no later than 60 days after enactment, a "current health spending estimate" (CHSE). The CHSE is to include projections of the following for fiscal years 1996 through 2004: total outlays for Medicare expenditures and Medicaid expenditures (including administrative costs); and revenue losses associated with the employee exclusion of employer-provided accident and health coverage and the deductibility of individual medical expenses in excess of 7.5 percent of adjusted gross income.

Since projections for these items are not available beyond fiscal year 2004, the CHSE for later years is determined by applying an annual adjustment factor (to be determined by OMB) to each of the applicable estimates as set forth for FY 2004.

The statutory language makes clear that the calculation of "total outlays" for Medicare is to be offset by Medicare Part B premiums, which are scored as offsetting receipts.

For purposes of the CHSE, it is assumed that any estimates of discretionary spending will be calculated according to the rules set forth in section 257 of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended.

Annual health reform estimate

The President would be required to include in each Budget, beginning with the Budget for fiscal year 1996, a "Health Reform Estimate" (HRE) for the upcoming fiscal year, the current fiscal year, and (beginning with the FY 97 budget) the prior fiscal year. The HRE for each of the three applicable fiscal years is a calculation of: updated projections of the items included in the CHSE (including unanticipated changes in Medicare and Medicaid) *plus* new health reform outlays *minus* net health reform revenues.

This calculation will show to what extent health reform outlays, plus any unanticipated increases in Medicare and Medicaid expenditures, are offset by new health reform revenues and savings.

New health reform outlays include: total outlays for premium and cost-sharing assistance (including administrative costs); and other changes in outlays resulting from this Act, including discretionary appropriations.

Net health reform revenues is equal to: total revenues for the applicable fiscal year due to the increase in the tobacco excise tax and the tax on high cost health plans provided in this Act; minus total revenue losses projected for the deduction for purchase by individuals and the self-employed of health insurance policies; plus or minus other changes in revenues resulting from this Act (including any carryover of excess financing from the prior year).

For purposes of the HRE, it is assumed that any estimates of discretionary spending will be calculated according to the rules set forth in section 257 of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended.

Determination of unfinanced health spending and excess health financing

Each year, the President's budget is to include a comparison of the CHSE with the HRE for: the upcoming fiscal year, the current fiscal year, and (beginning with the FY 97 budget) the prior fiscal year. If the applicable HRE *exceeds* the applicable CHSE, the President would be required to report the amount of the excess as "unfinanced health spending" for the applicable fiscal year. If the applicable HRE is *less than* the applicable CHSE, the President would be required to report such difference as "excess health financing" for the applicable fiscal year.

If the President's budget includes a determination of excess health financing for a fiscal year, such amount would be included in calculating the HRE for the subsequent fiscal year, by including the amount in the calculation of net new revenues for that year's HRE. In this way, excess financing for one year will cushion the subsequent year from potential reductions, which need not occur in view of the cumulative effect of the two years.

Offsetting unfinanced health spending

If the President's Budget includes a determination of unfinanced health spending for the upcoming fiscal year, the current fiscal year, or the fiscal year which ended the prior October, such determination would be required to be accompanied by an executive order effective on October 1 of that calendar year which fully offsets, in the upcoming fiscal year, the total amount of unfinanced health spending.

The offsets are to be accomplished through a combination of: (1) reducing premium assistance and cost-sharing assistance provided by this Act; (2) reducing the new tax deduction; and (3) increasing out-of-pocket limits in the standard and basic benefit packages.

These offsets are to be applied "proportionally," to the extent practicable, but in no case is proportionality to prevent fully offsetting the unfinanced health spending.

A priority rule is established for reducing premium and cost-sharing assistance. Assistance is divided into two classes: assistance to pregnant women and children, and assistance to others. Any required reductions are to come initially from the latter category; assistance to pregnant women and children is not to be reduced unless and until the maximum amount of reductions have been taken from all others.

Reduction of tax deductions is to be achieved by reducing the percentage of eligible premium costs which are deductible in the applicable year. Any such reductions are to be accompanied by Treasury regulations implementing such reduction.

Increases in out-of-pocket limits in the standard and alternative benefits packages are to be made to the extent the President determines that such actions will produce measurable Federal outlay savings. Any order increasing out-of-pocket limits would be required to be accompanied by National Health Benefits Board regulations implementing such increases.

Recommendations for alternative reductions

If the President's Budget for a fiscal year is accompanied by an executive order, as specified above, the National Health Care Commission would be required to transmit to the Speaker of the House of Representatives and the President of the Senate, within a reasonable time, a report including alternative proposals to offset the projected excess outlays.

GAO audit of reductions

If the President has issued an executive order under these provisions, the General Accounting Office is required to report to Congress, as soon thereafter as possible, an analysis of whether the executive order has fully complied with the requirements of these provisions.

Effective date

Upon enactment.

III. Votes of the Committee

A. In compliance with paragraph 7(c) of Rule XXVI of the Standing Rules of the Senate, following is a tabulation of the votes cast by each member of the committee in favor of and in opposition to the Riegle motion to report this original bill to the Senate:

YEAS—12	NAYS—8
Mr. Moynihan	Mr. Baucus
Mr. Boren	Mr. Rockefeller
Mr. Bradley	Mr. Packwood
Mr. Mitchell	Mr. Dole
Mr. Pryor	Mr. Roth
Mr. Riegle	Mr. Grassley
Mr. Daschle	Mr. Hatch
Mr. Breaux	Mr. Wallop
Mr. Conrad	
Mr. Danforth	
Mr. Chafee	
Mr. Durenberger	

B. In compliance with paragraph 7(b) of Rule XXVI of the Standing Rules of the Senate, following is a tabulation of each rollcall vote taken during mark-up of this legislation.

VOTES ON JUNE 30, 1994

Vote #1: Baucus amendment to exempt small businesses from the employer mandate, defeated 6–14.

Yeas: Baucus, Mitchell, Pryor, Rockefeller, Daschle, Conrad.

Nays: Moynihan, Boren, Bradley, Riegle, Breaux, Packwood, Dole, Roth, Danforth, Chafee, Durenberger, Grassley, Hatch, Wallop.

Vote #2: Packwood amendment to strike the employer mandate, passed 14–6.

Yeas: Baucus, Boren, Bradley, Breaux, Conrad, Packwood, Dole, Roth, Danforth, Chafee, Durenberger, Grassley, Hatch, Wallop.

Nays: Moynihan, Mitchell, Pryor, Riegle, Rockefeller, Daschle.

Vote #3: Chafee, Breaux amendment to establish a new coverage "trigger," passed 12–8.

Yeas: Moynihan, Baucus, Boren, Bradley, Mitchell, Pryor, Daschle, Breaux, Conrad, Danforth, Chafee, Durenberger.

Nays: Riegle, Rockefeller, Packwood, Dole, Roth, Grassley, Hatch, Wallop.

Vote #4: Bradley amendment to strike section VI A(2) and (3) and replace with a new High Cost Plan Assessment, passed 11–9.

Yeas: Boren, Bradley, Mitchell, Pryor, Rockefeller, Daschle, Breaux, Conrad, Danforth, Chafee, Durenberger.

Nays: Moynihan, Baucus, Riegle, Packwood, Dole, Roth, Grassley, Hatch, Wallop.

VOTES ON JULY 1, 1994

Vote #5: Grassley amendment on payment for nurse practitioners & physician assistants, passed by voice vote.

Vote #6: Roth motion to strike pre-funding of postal retiree health benefits, passed by voice vote.

Vote #7: Mitchell amendment on Medicare volume performance standard, passed by voice vote.

Vote #8: Riegle amendment on special coverage for pregnant women and children, passed 12–8.

Yeas: Moynihan, Baucus, Boren, Bradley, Mitchell, Pryor, Riegle, Rockefeller, Daschle, Breaux, Conrad, Chafee.

Nays: Packwood, Dole, Roth, Danforth, Durenberger, Grassley, Hatch, Wallop.

Vote #9: Baucus amendment to strike ammunition tax (other than 10,000% tax on expanding barbed and .50-caliber ammunition), passed 15–5.

Yeas: Baucus, Boren, Mitchell, Pryor, Rockefeller, Daschle, Breaux, Conrad, Packwood, Dole, Roth, Durenberger, Grassley, Hatch, Wallop.

Nays: Moynihan, Bradley, Riegle, Danforth, Chafee.

Vote #10: Hatch amendment to strike assessment on large firms, passed 13–7.

Yeas: Boren, Riegle, Breaux, Conrad, Packwood, Dole, Roth, Danforth, Chafee, Durenberger, Grassley, Hatch, Wallop.

Nays: Moynihan, Baucus, Bradley, Mitchell, Pryor, Rockefeller, Daschle.

Vote #11: Chairman's amendment to the mark, adopted by unanimous consent.

Vote #12: Pryor, Rockefeller, Conrad, Riegle & Chafee amendment on home and community based care financed by automobile insurance coordination, passed 16–4.

Yeas: Moynihan, Baucus, Boren, Bradley, Mitchell, Pryor, Riegle, Rockefeller, Daschle, Breaux, Conrad, Dole, Roth, Chafee, Grassley, Hatch.

Nays: Packwood, Danforth, Durenberger, Wallop.

Vote #13: Danforth amendment to strike VI(C) on malpractice reforms and insert new provisions on malpractice, passed 11–8.

Yeas: Baucus, Boren, Breaux, Conrad, Dole, Danforth, Chafee, Durenberger, Grassley, Hatch, Wallop.

Nays: Moynihan, Bradley, Mitchell, Pryor, Riegle, Rockefeller, Daschle, Packwood.

Vote #14: Wallop motion to strike premium assessment to fund academic health centers, defeated 7–13.

Yeas: Baucus, Packwood, Dole, Roth, Grassley, Hatch, Wallop.

Nays: Moynihan, Boren, Bradley, Mitchell, Pryor, Riegle, Rockefeller, Daschle, Breaux, Conrad, Danforth, Chafee, Durenberger.

Vote #15: Rockefeller amendment on community rating, defeated 6–14.

Yeas: Baucus, Mitchell, Pryor, Riegle, Rockefeller, Daschle.

Nays: Moynihan, Boren, Bradley, Breaux, Conrad, Packwood, Dole, Roth, Danforth, Chafee, Durenberger, Grassley, Hatch, Wallop.

Vote #16: Hatch amendment to exclude abortions from the comprehensive benefit package except in certain circumstances, defeated 9–11.

Yeas: Breaux, Conrad, Dole, Roth, Danforth, Durenberger, Grassley, Hatch, Wallop.

Nays: Moynihan, Baucus, Boren, Bradley, Mitchell, Pryor, Riegle, Rockefeller, Daschle, Packwood, Chafee.

Vote #17: Grassley amendment to preserve constitutional State authority regarding abortions, passed 11–9.

Yeas: Baucus, Boren, Breaux, Conrad, Dole, Roth, Danforth, Durenberger, Grassley, Hatch, Wallop.

Nays: Moynihan, Bradley, Mitchell, Pryor, Riegle, Rockefeller, Daschle, Packwood, Chafee.

Vote #18: Danforth amendment on no requirement for abortion services, passed 12–8.

Yeas: Moynihan, Boren, Pryor, Breaux, Conrad, Dole, Roth, Danforth, Durenberger, Grassley, Hatch, Wallop.

Nays: Baucus, Bradley, Mitchell, Riegle, Rockefeller, Daschle, Packwood, Chafee.

Vote #19: Danforth conscience clause for providers, health plans, employers and purchasers of health care, passed 12–8.

Yeas: Moynihan, Boren, Daschle, Breaux, Conrad, Dole, Roth, Danforth, Durenberger, Grassley, Hatch, Wallop.

Nays: Baucus, Bradley, Mitchell, Pryor, Riegle, Rockefeller, Packwood, Chafee.

Vote #20: Danforth amendment to prevent subsidization of abortion, defeated 8–12.

Yeas: Breaux, Conrad, Dole, Roth, Danforth, Grassley, Hatch, Wallop.

Nays: Moynihan, Baucus, Boren, Bradley, Mitchell, Pryor, Riegle, Rockefeller, Daschle, Packwood, Chafee, Durenberger.

VOTES ON JULY 2, 1994

Vote #21: Packwood amendment to change open enrollment from 30 to 90 days, passed by voice vote.

Vote #22: Packwood amendment to specify no restriction on employers of large firms to buy insurance at community rates, defeated 6–14.

Yeas: Packwood, Dole, Roth, Grassley, Hatch, Wallop.

Nays: Moynihan, Baucus, Boren, Bradley, Mitchell, Pryor, Riegle, Rockefeller, Daschle, Breaux, Conrad, Danforth, Chafee, Durenberger.

Vote #23: Breaux, Conrad amendment regarding tax exemption for state high risk pools, passed by voice vote.

Vote #24: Roth amendment to provide for a catastrophic plan/ medical savings account, defeated 7–13.

Yeas: Boren, Packwood, Dole, Roth, Grassley, Hatch, Wallop.

Nays: Moynihan, Baucus, Bradley, Mitchell, Pryor, Riegle, Rockefeller, Daschle, Breaux, Conrad, Danforth, Chafee, Durenberger.

Vote #25: Wallop motion to strike general revenue payment to trust fund, passed 11–9.

Yeas: Baucus, Breaux, Packwood, Dole, Roth, Danforth, Chafee, Durenberger, Grassley, Hatch, Wallop.

Nays: Moynihan, Boren, Bradley, Mitchell, Pryor, Riegle, Rockefeller, Daschle, Conrad

Vote #26: Conrad amendment on premium credit for mandatory premiums to the United Mine Workers Combined Fund, defeated 9–11.

Yeas: Boren, Conrad, Packwood, Dole, Danforth, Chafee, Grassley, Wallop, Roth.

Nays: Moynihan, Baucus, Bradley, Mitchell, Pryor, Riegle, Rockefeller, Daschle, Breaux, Durenberger, Hatch.

Vote #27: Wallop amendment on Medicare physician self-referral, passed by voice vote.

Vote #28: Durenberger amendment on deferred compensation paid to certain group medical practices, passed by voice vote.

Vote #29: Dole amendment to provide that the National Health Care Commission is not authorized to address issues related to defining an employee for tax purposes, passed by voice vote.

Vote #30: Durenberger amendment on state flexibility, passed 11–9.

Yeas: Boren, Bradley, Mitchell, Breaux, Conrad, Packwood, Roth, Danforth, Chafee, Durenberger, Grassley.

Nays: Moynihan, Baucus, Pryor, Riegle, Rockefeller, Daschle, Dole, Hatch, Wallop.

Vote #31: Boren motion to strike all single-payer references, defeated 10–10.

Yeas: Boren, Breaux, Packwood, Dole, Roth, Danforth, Chafee, Durenberger, Hatch, Wallop.

Nays: Moynihan, Baucus, Bradley, Mitchell, Pryor, Riegle, Rockefeller, Daschle, Conrad, Grassley.

Vote #32: Hatch amendment providing for a study on sub-acute care, passed by voice vote.

Vote #33: Hatch amendment on state demonstration projects on no-fault liability (as modified to include "may"), passed by voice vote.

Vote #34: Hatch amendment on Medicare Part B marriage penalty, defeated 4–16.

Yeas: Roth, Grassley, Hatch, Wallop.

Nays: Moynihan, Baucus, Boren, Bradley, Mitchell, Pryor, Riegle, Rockefeller, Daschle, Breaux, Conrad, Packwood, Dole, Danforth, Chafee, Durenberger.

Vote #35: Durenberger amendment regarding classification of church health plans, passed by voice vote.

Vote #36: Hatch amendment on marriage penalty in Medicare Part B subsidy recapture, passed by voice vote.

Vote #37: Grassley, Moynihan amendment on discrimination against providers based on academic degree, passed by unanimous consent.

Vote #38: Wallop. (2nd Degree) amendment (to fail-safe mechanism) to strike payment of subsidies from general fund, defeated 6–14.

Yeas: Packwood, Dole, Roth, Grassley, Hatch, Wallop.

Nays: Moynihan, Baucus, Boren, Bradley, Mitchell, Pryor, Riegle, Rockefeller, Daschle, Breaux, Conrad, Danforth, Chafee, Durenberger.

Vote #39: Chafee amendment on fail-safe mechanism, passed 14–6.

Yeas: Moynihan, Boren, Bradley, Mitchell, Pryor, Riegle, Rockefeller, Daschle, Breaux, Conrad, Packwood, Danforth, Chafee, Durenberger.

Nays: Baucus, Dole, Roth, Grassley, Hatch, Wallop.

Vote #40: Danforth amendment on advisory committee on new trust funds established for academic health centers, graduate medical and nursing education, medical research and medical schools, passed by voice vote.

Vote #41: Dole amendment to limit standard benefit to subsidized population, defeated 6–14.

Yeas: Packwood, Dole, Roth, Grassley, Hatch, Wallop.

Nays: Moynihan, Baucus, Boren, Bradley, Mitchell, Pryor, Riegle, Rockefeller, Daschle, Breaux, Conrad, Danforth, Chafee, Durenberger.

IV. Budgetary Impact of the Bill

In accordance with paragraph 11 (a) of Rule XXVI of the Standing Rules of the Senate, the Committee is including the following information with respect to the budgetary impact of the bill. This information is derived from "A Preliminary Analysis of the Health Security Act As Reported by the Senate Committee on Finance," dated July 28, 1994, and prepared by the Congressional Budget Office (CBO). As of the date of filing this report, the CBO has not prepared a final cost estimate of the Committee's bill.

According to the information provided by the CBO, under the Committee's legislation the deficit would be reduced by $11.0 billion in FY 1995, by a cumulative $11.6 billion for the five year period FY 1995–1999, and by a cumulative $1.7 billion for the five year period FY 2000–2004.

The CBO report also indicates that under the Committee's bill the percent of the population covered by health insurance would increase from 85 to 91 percent in calendar 1997, and to 92 percent for 1998 and thereafter. Under provisions of the Committee's bill, 16 million persons would become insured in 1997 and this number would increase to 23 million persons by 2004—more than half of the uninsured. In part, the increase in coverage is achieved through premium and cost-sharing subsidies to 30 million families and single individuals.

The gross cost of subsidies would reach $111.3 billion by the year 2000, but, in part, would be offset by $82 billion of savings in the Medicaid program. Under the Committee's bill, Medicaid recipients

are "mainstreamed" into private health insurance plans so that as subsidies are phased in Medicaid costs are reduced.

The legislation also protects the budgets of State and local governments. For the 10 year period fiscal 1995–2004, the cumulative reduction in State and local outlays is $5.7 billion.

CBO also reports that "In the present estimates," a fail-safe mechanism, included in the legislation "would not be called into play." However, if necessary, the fail-safe mechanism, which would automatically restrain benefits provided by the Committee's bill, would "prevent the proposal from adding to the deficit * * *."

Pursuant to paragraph XXVI (11)(a)(3) of the Standing Rules of the Senate, the Committee states that no Federal agency has provided budget estimates for this legislation with which comparisons might be made.

Tables appearing on the following pages are from the preliminary CBO report.

TABLE 1.—PRELIMINARY ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF THE HEALTH SECURITY ACT AS REPORTED BY THE COMMITTEE ON FINANCE

[By fiscal year, in billions of dollars]

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Mandatory Outlays										
Medicaid:										
1 Discontinued coverage of acute care	0	0	−24.6	−37.8	−41.0	−45.8	−51.2	−56.9	−63.1	−69.7
2 State maintenance-of-effort payments	0	0	−16.8	−24.0	−26.2	−28.4	−30.8	−33.4	−36.2	−39.2
3 Disproportionate share hospital payments	0	0	−4.1	−7.0	−9.5	−11.6	−18.8	−20.7	−22.9	−25.2
4 Long term care program/change fed match	2.5	2.8	3.1	3.5	3.9	4.4	4.9	5.5	6.1	6.9
5 Administrative savings	0	0	−0.3	−0.5	−0.5	−0.6	−0.7	−0.8	−0.8	−0.9
Total—Medicaid	2.5	2.8	−42.7	−64.7	−73.3	−82.0	−96.6	−106.3	−116.9	−128.1
Medicare:										
6 Part A reductions:										
PPS updates	0	0	−0.8	−2.3	−4.2	−6.4	−7.1	−8.1	−8.9	−9.8
Capital reduction	0	−0.7	−0.8	−0.8	−0.9	−1.0	−1.2	−1.3	−1.4	−1.6
Disproportionate share hospital reductions	0	0	0	−0.9	−1.2	−1.3	−1.4	−1.5	−1.7	−1.9
PPS-excluded payment changes	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.3
Skilled nursing facility limits	0	−0.1	−0.1	−0.2	−0.2	−0.2	−0.2	−0.2	−0.3	−0.3
Sole community hospitals	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)
Medicare dependent hospitals	(1)	0.1	0.1	0.1	(1)	(1)	0.0	0.0	0.0	0.0
Long term care hospitals	(1)	(1)	−0.1	−0.1	−0.1	−0.2	−0.2	−0.3	−0.3	−0.4
7 Essential Access Community Hospitals:										
MAF payments	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Rural primary care hospitals (RPCH) pmts	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2
8 Part B reductions:										
Updates for physician services	−0.4	−0.6	−0.6	−0.7	−0.8	−0.8	−0.9	−1.0	−1.0	−1.1
Real GDP for volume and intensity	0	0	−0.3	−0.8	−1.6	−2.5	−3.3	−4.2	−5.3	−6.6
High cost hospitals	0	0	0	−0.5	−0.8	−0.8	−0.8	−0.9	−1.0	−1.0
Elim formula driven overpayments	−0.5	−1.0	−1.3	−1.8	−2.3	−3.2	−4.2	−5.5	−7.1	−9.1
Eye & eye/ear specialty hospitals	(1)	(1)	(1)	0	0	0	0	0	0	0
Laboratory coinsurance	−0.7	−1.1	−1.3	−1.4	−1.6	−1.8	−2.0	−2.3	−2.6	−2.9
Competitive bid for part B	(1)	−0.1	−0.1	−0.1	−0.1	−0.2	−0.2	−0.2	−0.2	−0.2
Competitive bid for clinical lab services	(1)	−0.2	−0.3	−0.3	−0.3	−0.4	−0.4	−0.5	−0.5	−0.6
Nurse pract/phys assistant direct payment	0	0	0.1	0.2	0.2	0.3	0.3	0.4	0.5	0.6
Permanent extension of 25% part B premium	0	0.6	0.9	1.4	0.8	−0.8	−2.8	−5.2	−8.2	−10.6

TABLE 1.—PRELIMINARY ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF THE HEALTH SECURITY ACT AS REPORTED BY THE COMMITTEE ON FINANCE—Continued

[By fiscal year, in billions of dollars]

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
9 Parts A and B reductions:										
Medicare secondary payer	0	0	0	0	−1.2	−1.8	−1.9	−2.0	−2.2	−2.3
Expand centers of excellence	0	−0.1	−0.1	−0.1	−0.1	−0.1	(1)	(1)	0	0
Home health limits	0	0	−0.3	−0.6	−0.7	−0.7	−0.8	−0.9	−1.0	−1.0
Risk contracts	(1)	0.1	0.2	0.2	0.3	0.3	0.4	0.4	0.5	0.6
Total—Medicare	−1.3	−2.9	−4.5	−8.6	−14.5	−21.0	−26.3	−32.8	−40.0	−47.4
Other health programs:										
10 Vulnerable hospital payments	0	0	0	0	0	0	2.5	2.5	2.5	2.5
11 Home and community based care program	0	0	0.3	0.7	1.0	1.4	1.6	1.6	1.9	2.0
12 Academic Health Centers Trust Fund	0	4.7	7.0	8.0	9.1	10.3	11.3	12.3	13.3	14.3
13 Grad Medical & Nursing Education Trust Fund	0	2.7	4.0	5.8	6.9	7.6	8.2	8.9	9.6	10.4
14 Medicare transfer—Graduate medical education	0	−1.6	−2.2	−2.4	−2.5	−2.6	−2.8	−2.9	−3.1	−3.3
15 Medicare transfer—Indirect medical education	0	−4.2	−4.5	−4.9	−5.4	−5.9	−6.5	−7.2	−7.9	−8.7
Total—Other health programs	0	1.6	4.6	7.2	9.1	10.8	14.3	15.3	16.3	17.2
Designated urban/rural health care access:										
16 Investment in infrastructure development (loans)	0.3	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.5
Total—Urban/rural access	0.3	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.5
Subsidies:										
Premium subsidies:										
17 Persons between 0–200% of poverty	0	0	52.4	86.2	97.6	109.3	121.0	133.6	147.3	161.2
18 Pregnant women and kids 0–240% of poverty	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)
Cost-sharing subsidies:										
19 Persons between 0–200% of Poverty[3]	0	0	1.3	2.0	2.0	2.0	2.0	2.0	2.0	2.0
Total—Subsidies	0	0	53.7	88.2	99.6	111.3	123.0	135.6	149.3	163.2
Administrative expenses:										
20 Mandatory administrative expenses[4]	0	0	2.4	4.0	4.3	4.7	4.8	4.9	4.9	5.0

Mandatory outlay changes	1.4	1.8	13.9	26.5	25.5	24.2	19.6	17.2	14.0	10.4
Discretionary Outlays										
Administrative expenses:										
21 Administrative and start-up costs	0.5	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.1
Studies, research, & demonstrations:										
22 Network and Plan Development Grant Program	0.1	0.2	0.3	0.3	0.3	0.2	0.2	0.2	0.2	0.3
23 Operating asst—telemedicine demonstrations	0.1	0.3	0.4	0.4	0.4	0.4	0.4	0.5	0.5	0.5
24 Capital investment—grants	0.1	0.3	0.3	0.4	0.4	0.4	0.4	0.4	0.4	0.4
25 Biomedical & Behavioral Research Trust Fund	0	0.7	1.2	1.4	1.5	1.6	1.7	1.9	2.1	2.2
26 EACH/MAF/rural transition demonstrations	(1)	0.1	0.1	0.1	(1)	(1)	(1)	(1)	(1)	(1)
Total studies, research, & demonstrations	0.4	1.6	2.3	2.5	2.5	2.6	2.7	3.0	3.2	3.4
Discretionary outlay changes	0.9	2.6	3.3	3.5	3.5	3.6	3.7	4.0	4.2	4.5
Total outlay changes	2.3	4.4	17.1	30.0	29.0	27.7	23.3	21.2	18.2	14.9
Receipts										
27 Increase in tax on tobacco products	13.9	16.3	15.4	15.0	14.3	13.9	13.5	11.3	11.1	10.9
28 1.75% excise tax on pvt health ins premiums	0	3.5	6.2	7.2	7.8	8.5	9.2	10.0	10.9	11.8
29 Addl medicare part B premiums for high-income individuals	0	0	1.5	1.3	1.6	2.1	2.6	3.4	4.3	5.5
30 Increase excise tax on hollow-point bullets	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)
31 Include certain svc-rein income in SECA and excl certain invn-reln income from SECA.										
(a) General fund effect	0	−0.1	−0.1	−0.1	−0.1	−0.1	−0.1	−0.1	−0.1	−0.1
(b) OASDI effect	0	0.1	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.3
32 Extend Medicare coverage & HI tax to all state and local government employees	0	1.6	1.6	1.5	1.5	1.4	1.4	1.3	1.2	1.2
33 Impose excise tax with respect to plans failing to satisfy voluntary contribution rule	0	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)
34 Repeal flexible spending arrangements	0	0.3	0.5	0.7	1.1	1.3	1.4	1.4	1.4	1.5
35 Extend 25% ded for health ins costs of self-employed individuals	−0.5	−0.3	0	0	0	0	0	0	0	0
36 Limit on prepayment of medical premiums	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)
37 Deduct for individuals purchasing own health in	0	−1.4	−5.5	−8.1	−8.4	−8.7	−9.1	−9.8	−10.4	−11.0
38 Non-profit health care orgns/taxable orgns providing health ins & prepd health care sv	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)
39 Trmt of certain ins co with regard to sect 833	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)
40 Grant tax exempt status to State ins risk pools	(1)	(1)	0	0	0	0	0	0	0	0
41 Remove $150 million bond cap on non-hospital 501(c)93) bonds	(1)	(1)	(1)	−0.1	−0.1	−0.1	−0.1	−0.2	−0.2	−0.2
42 Clarify tax trmt of long term care ins & svcs	0	(1)	−0.2	−0.2	−0.2	−0.2	−0.3	−0.3	−0.3	−0.4
43 Tax trmt of accelerated death benefits under life insurance contracts	(1)	(1)	−0.1	−0.1	−0.1	−0.1	−0.1	−0.1	−0.1	−0.1
44 Incr in reporting penalties for nonemployees	0	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)
45 Post-retirement med & life ins services	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)
46 Modify COBRA continuation care rules	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)

TABLE 1.—PRELIMINARY ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF THE HEALTH SECURITY ACT AS REPORTED BY THE COMMITTEE ON FINANCE—Continued

[By fiscal year, in billions of dollars]

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
47 Tax credit for practitioners in underserved area	[1]	−0.1	−0.2	−0.2	−0.2	−0.1	−0.1	[1]	[1]	[1]
48 Increase expensing limit for certain med equip	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]
49 Tax credit for cost of personal asst svcs required by employed individuals	0	[1]	−0.1	−0.1	−0.1	−0.1	−0.1	−0.2	−0.2	−0.2
50 Disclosure of return info to State agencies	[8]	[8]	[8]	[8]	[8]	[8]	[8]	[8]	[8]	[8]
51 Exempt doctors from section 457 limits	[1]	−0.1	−0.1	−0.1	−0.1	−0.1	−0.1	−0.1	−0.1	−0.1
52 Impose prem tax with respect to certain high cost plans	0	[1]	0.9	1.4	1.6	1.7	1.9	1.8	1.9	2.0
53 Indirect tax effects of changes in tax trmt of employer & household health ins spending	0	[1]	1.2	1.4	1.4	1.4	1.4	1.6	1.6	1.5
Total receipt changes	13.3	19.8	21.3	19.8	20.3	21.1	21.8	20.3	21.3	22.6
Deficit:										
Mandatory changes	−11.9	−18.0	−7.4	6.7	5.2	3.1	−2.2	−3.1	−7.3	−12.2
Total changes	−11.0	−15.4	−4.2	10.2	8.7	6.6	1.5	0.9	−3.1	−7.7
Cumulative deficit effect	−11.0	−26.4	−30.6	−20.3	−11.6	−5.0	−3.4	−2.6	−5.6	−13.3

[1] Less than $50 million.
[2] Included in line 17.
[3] States would have the option to provide funding for cost-sharing subsidies for persons below 200% of poverty.
[4] States would have substantial administrative responsibilities under this plan.
[5] Negligible revenues loss.
[6] Negligible revenue gain.
[7] Negligible revenue effect.
[8] No revenue effect.

Notes.—The figures in this table include changes in authorizations of appropriations and in Social Security that would not be counted for pay-as-you-go scoring under the Budget Enforcement Act of 1990. Provisions with no cost have been excluded from this table.

Sources: Congressional Budget Office; Joint Committee on Taxation.

TABLE 2.—PRELIMINARY ESTIMATES OF THE STATE AND LOCAL BUDGETARY EFFECTS OF THE HEALTH SECURITY ACT AS REPORTED BY THE COMMITTEE ON FINANCE

[By fiscal year, in billions of dollars]

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Medicaid:										
1 Discontinued coverage of acute care	0	0	−18.4	−27.5	−30.7	−34.3	−38.4	−42.7	−47.3	−52.3
2 State maintenance-of-effort payments	0	0	16.8	24.0	26.2	28.4	30.8	33.4	36.2	39.2
3 Disproportionate share and vulnerable hospital payments [1]	0	0	0.5	0.9	1.2	1.4	−0.2	0.0	0.3	0.6

4 Administrative savings	0	0	−0.2	−0.4	−0.4	−0.5	−0.5	−0.6	−0.6	−0.7
Total—Medicaid	0	0	−1.3	−3.0	−3.7	−5.0	−8.3	−9.9	−11.4	−13.2
Cost-sharing subsidies:										
5 Persons between 0–200% of poverty[2]	0	0	1.3	2.0	2.0	2.0	2.0	2.0	2.0	2.0
Total—Subsidies	0	0	1.3	2.0	2.0	2.0	2.0	2.0	2.0	2.0
Administrative expenses:										
6 Expenses associated with subsidies	0	0	0.8	1.2	1.3	1.5	1.5	1.5	1.5	1.6
7 General admin and start up costs	0	1.4	2.2	2.4	2.4	2.5	2.7	2.8	3.0	3.2
8 Automobile insurance coordination	0	0.3	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Total—Administrative expenses	0	1.7	3.0	3.7	3.9	4.1	4.3	4.5	4.7	4.9
Total state and local budgetary impact	0	1.7	3.0	2.7	2.1	1.1	−2.0	−3.4	−4.7	−6.2

[1] The estimate assumes that states will continue to provide some assistance to hospitals serving disproportionately large numbers of uninsured or underinsured people.
[2] The states would have the option to provide funding for cost-sharing subsidies for persons below 200% of poverty.

Source: Congressional Budget Office.

TABLE 3.—HEALTH INSURANCE COVERAGE

[By calendar year, in millions of people]

	1997	1998	1999	2000	2001	2002	2003	2004
Baseline:								
Insured	224	226	228	229	230	232	233	234
Uninsured	40	40	40	41	42	43	43	44
Total	264	266	268	270	272	274	276	278
Uninsured as percentage of total	15	15	15	15	15	16	16	16
Health Security Act as reported by the Committee on Finance:								
Insured	241	244	246	249	251	253	255	257
Uninsured	23	22	22	21	21	21	21	21
Total	264	266	268	270	272	274	276	278
Increase in insured	16	18	19	20	20	21	22	23
Uninsured as Percentage of Total	9	8	8	8	8	8	8	8

Source: Congressional Budget Office.

TABLE 4.—PROJECTIONS OF NATIONAL HEALTH EXPENDITURES

[By calendar year, in billions of dollars]

	1997	1998	1999	2000	2001	2002	2003	2004
Baseline	1,263	1,372	1,488	1,613	1,748	1,894	2,052	2,220
Health Security Act as reported by the Committee on Finance	1,297	1,403	1,515	1,635	1,761	1,903	2,055	2,218
Change from baseline	34	32	27	21	13	9	3	−2

Source: Congressional Budget Office.

V. Regulatory Impact of the Bill

In accordance with paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, following is a summary of some of the regulatory effects of this legislation. It has been determined that it is impracticable, under current time constraints, to include a more comprehensive regulatory impact statement.

A. Estimated number of individuals and businesses who would be regulated and the economic effects on those individuals and businesses

1. In general, the bill would affect approximately 1500 insurance companies that would have to comply with new federal standards for health plans and long term care policies. The bill would also impact the approximately 5 million businesses that would be required to offer workers a choice of three health plans.

2. Health plans would be required to offer a standard benefits package and an alternative standard benefits package, as well as permit the sale of nonstandard and supplemental health plans. This would impact health care delivery systems, which would be organized to provide standard services, and insurers, who would price the health plans in accordance with the certification requirements.

3. The administrative simplification provisions regulate all health plans including: medicare, medicaid, auto insurance and workers compensation, all health care providers who submit claims to health plans, existing health information clearinghouses and new businesses which process health information.

4. The privacy of health provisions regulate all health plans, health care providers, certified health information network services, employers, health oversight agencies, life insurers, schools and universities, health researchers, public health authorities, and law enforcement agencies.

5. Cost-sharing arrangements, including out-of-pocket maximum amounts for individuals and families, would be determined by a National Health Benefits Board. The Board would issue regulations to clarify items and services under the categories of covered services. Regulations promulgated by the Board would have an impact on consumers, insurers and those providing services in various health care delivery settings.

6. Provisions in the bill to repeal immunity from antitrust, would affect all entities engaged in the business of health insurance, to the extent that they are not now subject to antitrust scrutiny.

7. The remedy provisions would establish procedures for all claims regarding the denial, reduction or termination of benefits. As such, these provisions would affect all health plans subject to State certification under this Act.

8. The malpractice provisions would affect all claims based on allegations of medical malpractice. The potential universe of defendants includes all health professionals against whom such a claim might be raised.

B. Impact of the bill on personal privacy of the individuals affected

Consumers are assured under the privacy provisions of the bill that their individually identifiable health information is protected by Federal law which limits authorized disclosures, prevents inappropriate disclosures, and punishes unlawful disclosures. Protections for the health security card and the personal health identifier assure that these cannot be used for purposes other than receiving or paying for health care.

Consumers also have uniform legal rights to inspect, get copies of, make corrections or amendments to, and restrict disclosures of their health records. In addition, guaranteed issue provisions under insurance reform remove the need for consumers to disclose health information to employers in order to receive employer-based health insurance coverage.

C. Additional paperwork, time, and costs required of the affected parties

On the whole, this legislation is expected to reduce the paperwork, time and costs expended in operating the national health care system.

Health plans and health care providers will have drastically reduced paperwork, time, and costs related to billing, accounting, and monitoring of health care under the administrative simplification provisions of this legislation which provide for uniform electronic procedures and standardized forms. Cooperatives and employers will also experience less administrative paperwork because of standardized and electronic means for enrollment and premium payments.

Consumers will have fewer inconveniences with billing for health care because the uniform methods for billing electronically and on

paper will be consistent for all plans. A health security card will provide identification of consumers thereby facilitating electronic access to their insurance coverage and eliminating unnecessary documentation and delays in emergency rooms. Additionally, providers will be more likely to submit insurance claims for consumers because it will be much less expensive and easier to abide by electronically standardized enrollment procedures. Guaranteed issue reforms will have the effect of reducing the paperwork involved in signing up for health insurance.

The administrative simplification provisions in the bill are expected to save over $4 billion per year in national health expenditures, through the elimination of administrative overhead and waste.

VI. Changes in Existing Law

In accordance with paragraph 12 of rule XXVI of the Standing Rules of the Senate, in the opinion of the committee, it is necessary to dispense with the requirements of this subsection to expedite the business of the Senate.

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