defined in section 818(g) of such Code (as added by this Act)) shall not be treated as a modification or material change of such contract.

SEC. 11502. TAX TREATMENT OF COMPANIES ISSUING QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.

(a) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—Section 818 (relating to other definitions and special rules) is amended by adding at the end the following new subsection:

"(g) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—For purposes of this part—

"(1) IN GENERAL.—Any reference to a life insurance contract shall be treated as including a reference to a qualified accelerated death benefit rider on such contract.

"(2) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.—For purposes of this subsection, the term 'qualified accelerated death benefit rider' means any rider on a life insurance contract if the only payments under the rider are payments meeting the requirements of section 101(g)."

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1995.

Subtitle F—Employment Status Provisions

SEC. 11601. EMPLOYMENT STATUS PROPOSAL REQUIRED FROM DEPARTMENT OF THE TREASURY.

Not later than January 1, 1996, the Secretary of the Treasury shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a legislative proposal relating to the classification of workers as employees or independent contractors.

SEC. 11602. INCREASE IN PENALTIES RELATING TO REPORTING OF PAYMENTS FOR SERVICES.

(a) INCREASE IN PENALTY.—Section 6721(a) (relating to imposition of penalty) is amended by adding at the end the following new paragraph:

"(3) INCREASED PENALTY FOR RETURNS INVOLVING PAYMENTS FOR SERVICES.—

"(A) IN GENERAL.—Subject to the overall limitation of paragraph (1), the amount of the penalty under paragraph (1) for any failure with respect to any applicable return shall be equal to the greater of $50 or 5 percent of the amount required to be reported correctly but not so reported.

"(B) EXCEPTION WHERE SUBSTANTIAL COMPLIANCE.—Subparagraph (A) shall not apply to failures with respect to applicable returns required to be filed by a person during any calendar year if the aggregate amount which is timely and correctly reported on applicable returns filed by the person for the calendar year is at least 97 percent of the aggregate amount which is required to be reported on applicable returns by the person for the calendar year.

"(C) APPLICABLE RETURN.—For purposes of this paragraph, the term 'applicable return' means any information return required to be filed under—

"(i) section 6041(a) but only if such return relates to payments to any person for services performed by such person (other than as an employee), or

"(ii) section 6041A(a)."

(b) CONFORMING AMENDMENT.—Section 6721(a)(1) is amended by striking "In" and inserting "Except as provided in paragraph (3), in".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to returns the due date for which (without regard to ex-

tensions) is more than 30 days after the date of the enactment of this Act.

Subtitle G—Tax Treatment of Funding of Retiree Health Benefits

SEC. 11701. POST-RETIREMENT MEDICAL AND LIFE INSURANCE RESERVES.

(a) MINIMUM PERIOD FOR WORKING LIVES.—Section 419A(c)(2) (relating to additional reserve for post-retirement medical and life insurance benefits) is amended by inserting "(but not less than 10 years)" after "working lives of the covered employees".

(b) SEPARATE ACCOUNTING.—

(1) REQUIREMENT.—Section 419A(c)(2) is amended by adding at the end the following new flush sentence:

"Such reserve shall be maintained as a separate account."

(2) USE OF RESERVE FOR OTHER PURPOSES.—Paragraph (1) of section 4976(b) (defining disqualified benefit) is amended by striking "and" at the end of subparagraph (B), by striking the period at the end of subparagraph (C) and inserting ", and", and by adding after subparagraph (C) the following new subparagraph:

"(D) any payment to which subparagraph (C) does not apply which is out of an account described in section 419A(c)(2) and which is not used to provide a post-retirement medical benefit or life insurance benefit."

(c) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to contributions paid or accrued after December 31, 1994, in taxable years ending after such date.

(2) SEPARATE ACCOUNTING.—The amendments made by subsection (b) shall apply to contributions paid or accrued after the date of the enactment of this Act, in taxable years ending after such date.

Subtitle H—Excise Taxes on Insured and Self-Insured Health Plans

SEC. 11801. EXCISE TAXES ON INSURED AND SELF-INSURED HEALTH PLANS.

(a) GENERAL RULE.—Chapter 34 is amended by adding at the end the following new subchapter:

"Subchapter B—Insured and Self-Insured Health Plans

"SEC. 4375. HEALTH INSURANCE AND HEALTH-RELATED ADMINISTRATIVE SERVICES.

"(a) IMPOSITION OF TAX.—There is hereby imposed—

"(1) on each taxable health insurance policy, a tax equal to 2 percent of the premiums received under such policy, and

"(2) on each amount received for health-related administrative services, a tax equal to 2 percent of the amount so received.

"(b) LIABILITY FOR TAX.—

"(1) HEALTH INSURANCE.—The tax imposed by subsection (a)(1) shall be paid by the issuer of the policy.

"(2) HEALTH-RELATED ADMINISTRATIVE SERVICES.—The tax imposed by subsection (a)(2) shall be paid by the person providing the health-related administrative services.

"(c) TAXABLE HEALTH INSURANCE POLICY.—For purposes of this section—

"(1) IN GENERAL.—Except as otherwise provided in this section, the term 'taxable health insurance policy' means any accident or health insurance policy issued with respect to individuals residing in the United States.

"(2) EXEMPTION OF CERTAIN POLICIES.—The term 'taxable health insurance policy' does not include any insurance policy if substantially all of the coverage provided under such policy relates to—

"(A) liabilities incurred under workers' compensation laws,

"(B) tort liabilities,

"(C) liabilities relating to ownership or use of property,

"(D) credit insurance, or

"(E) such other similar liabilities as the Secretary may specify by regulations.

"(3) SPECIAL RULE WHERE POLICY PROVIDES OTHER COVERAGE.—In the case of any taxable health insurance policy under which amounts are payable other than for accident and health coverage, in determining the amount of the tax imposed by subsection (a)(1) on any premium received under such policy, there shall be excluded the amount of the charge for the non-accident and health coverage if—

"(A) the charge for such non-accident and health coverage is either separately stated in the policy, or furnished to the policyholder in a separate statement, and

"(B) such charge is reasonable in relation to the total charges under the policy.

In any other case, the entire amount of the premium received under such a policy shall be subject to tax under subsection (a)(1).

"(4) TREATMENT OF PREPAID HEALTH COVERAGE ARRANGEMENTS.—

"(A) IN GENERAL.—In the case of any arrangement described in subparagraph (B)—

"(i) such arrangement shall be treated as a taxable health insurance policy,

"(ii) the payments or premiums referred to in subparagraph (B)(i) shall be treated as premiums received for a taxable health insurance policy, and

"(iii) the person referred to in subparagraph (B)(i) shall be treated as the issuer.

"(B) DESCRIPTION OF ARRANGEMENTS.—An arrangement is described in this subparagraph if under such arrangement—

"(i) fixed payments or premiums are received as consideration for any person's agreement to provide or arrange for the provision of accident or health coverage to residents of the United States, regardless of how such coverage is provided or arranged to be provided, and

"(ii) substantially all of the risks of the rates of utilization of services is assumed by such person or the provider of such services.

"(d) HEALTH-RELATED ADMINISTRATIVE SERVICES.—For purposes of this section, the term 'health-related administrative services' means—

"(1) the processing of claims or performance of other administrative services in connection with accident or health coverage under a taxable health insurance policy if the charge for such services is not included in the premiums under such policy, and

"(2) processing claims, arranging for provision of accident or health coverage, or performing other administrative services in connection with an applicable self-insured health plan (as defined in section 4376(c)) established or maintained by another person.

"SEC. 4376. SELF-INSURED HEALTH PLANS.

"(a) IMPOSITION OF TAX.—In the case of any applicable self-insured health plan, there is hereby imposed a tax for each month equal to 2 percent of the sum of—

"(1) the accident and health coverage expenditures for such month under such plan, and

"(2) the direct administrative expenditures for such month under such plan.

"(b) LIABILITY FOR TAX.—

"(1) IN GENERAL.—The tax imposed by subsection (a) shall be paid by the plan sponsor.

"(2) PLAN SPONSOR.—For purposes of paragraph (1) the term 'plan sponsor' means—

"(A) the employer in the case of a plan established or maintained by a single employer,

"(B) the employee organization in the case of a plan established or maintained by an employee organization,

"(C) in the case of—

"(i) a plan established or maintained by 2 or more employers or jointly by 1 or more employers and 1 or more employee organizations,

"(ii) a multiple employer welfare arrangement, or

"(iii) a voluntary employees' beneficiary association described in section 501(c)(9),

the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan, or

"(D) the cooperative or association described in subsection (c)(2)(F) in the case of a plan established or maintained by such a cooperative or association.

"(c) APPLICABLE SELF-INSURED HEALTH PLAN.—For purposes of this section, the term 'applicable self-insured health plan' means any plan for providing accident or health coverage if—

"(1) any portion of such coverage is provided other than through an insurance policy, and

"(2) such plan is established or maintained—

"(A) by one or more employers for the benefit of their employees or former employees,

"(B) by one or more employee organizations for the benefit of their members or former members,

"(C) jointly by 1 or more employers and 1 or more employee organizations for the benefit of employees or former employees,

"(D) by a voluntary employees' beneficiary association described in section 501(c)(9),

"(E) by any organization described in section 501(c)(6), or

"(F) in the case of a plan not described in the preceding subparagraphs, by a multiple employer welfare arrangement (as defined in section 3(40) of Employee Retirement Income Security Act of 1974), a rural electric cooperative (as defined in section 3(40)(B)(iv) of such Act), or a rural telephone cooperative association (as defined in section 3(40)(B)(v) of such Act).

"(d) ACCIDENT AND HEALTH COVERAGE EXPENDITURES.—For purposes of this section—

"(1) IN GENERAL.—The accident and health coverage expenditures of any applicable self-insured health plan for any month is the aggregate expenditures for such month for accident and health coverage provided under such plan to the ex-

tent such expenditures are not subject to tax under section 4375.

"(2) TREATMENT OF REIMBURSEMENTS.—In determining accident and health coverage expenditures during any month of any applicable self-insured health plan, reimbursements (by insurance or otherwise) received during such month for accident and health coverage expenditures shall be taken into account as a reduction in accident and health coverage expenditures.

"(3) CERTAIN EXPENDITURES DISREGARDED.—Paragraph (1) shall not apply to any 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 and health coverage which is subject to the allowance under section 167, except that, for purposes of paragraph (1), allowances under section 167 shall be considered as expenditures.

"(e) DIRECT ADMINISTRATIVE EXPENDITURES.—For purposes of this section, the term 'direct administrative expenditures' means the administrative expenditures under the plan to the extent such expenditures are not subject to tax under section 4375. In determining the amount of such expenditures, rules similar to the rules of subsection (d)(3) shall apply.

"SEC. 4377. DEFINITIONS AND SPECIAL RULES.

"(a) DEFINITIONS.—For purposes of this subchapter—

"(1) ACCIDENT AND HEALTH COVERAGE.—The term 'accident and health coverage' means any coverage which, if provided by an insurance policy, would cause such policy to be a taxable health insurance policy (as defined in section 4375(c).

"(2) INSURANCE POLICY.—The term 'insurance policy' means any policy or other instrument whereby a contract of insurance is issued, renewed, or extended.

"(3) PREMIUM.—The term 'premium' means the gross amount of premiums and other consideration (including advance premiums, deposits, fees, and assessments) arising from policies issued by a person acting as the primary insurer, adjusted for any return or additional premiums paid as a result of endorsements, cancellations, audits, or retrospective rating.

"(4) UNITED STATES.—The term 'United States' includes any possession of the United States.

"(b) TREATMENT OF GOVERNMENTAL ENTITIES.—

"(1) IN GENERAL.—For purposes of this subchapter—

"(A) the term 'person' includes any governmental entity, and

"(B) notwithstanding any other law or rule of law, governmental entities shall not be exempt from the taxes imposed by this subchapter except as provided in paragraph (2).

"(2) TREATMENT OF EXEMPT GOVERNMENTAL PROGRAMS.—In the case of an exempt governmental program—

"(A) no tax shall be imposed under section 4375 on any premium received pursuant to such program or on any amount received for health-related administrative services pursuant to such program, and

"(B) no tax shall be imposed under section 4376 on any expenditures pursuant to such program.

"(3) EXEMPT GOVERNMENTAL PROGRAM DEFINED.—For purposes of this subchapter, the term exempt governmental program means—

"(A) the insurance programs established by parts A and B of title XVIII of the Social Security Act,

"(B) medicare part C (as defined in section 59B(g)(2)),

"(C) the medical assistance program established by title XIX of the Social Security Act,

"(D) any program established by Federal law for providing medical care (other than through insurance policies) to individuals (or the spouses and dependents thereof) by reason of such individuals being—

"(i) members of the Armed Forces of the United States, or

"(ii) veterans, and

"(E) any program established by Federal law for providing medical care (other than through insurance policies) to members of Indian tribes (as defined in section 4(d) of the Indian Health Care Improvement Act).

"(c) NO COVER OVER TO POSSESSIONS.—Notwithstanding any other provision of law, no amount collected under this subchapter shall be covered over to any possession of the United States."

(b) CLERICAL AMENDMENT.—Chapter 34 is amended by striking the chapter heading and inserting the following:

"CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES

"Subchapter A. Policies issued by foreign insurers.
"Subchapter B. Insured and self-insured health plans.

"Subchapter A—Policies Issued By Foreign Insurers".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to premiums received and expenses incurred after December 31, 1995.

Subtitle I—Other Provisions

PART 1—TAX INCENTIVES FOR HEALTH SERVICES PROVIDERS

SEC. 11901. NONREFUNDABLE CREDIT FOR CERTAIN PRIMARY HEALTH SERVICES PROVIDERS.

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

"SEC. 23. PRIMARY HEALTH SERVICES PROVIDERS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"(3) PHYSICIAN.—The term 'physician' has the meaning given to such term by section 1861(r)(1) of the Social Security Act.

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

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

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

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

"(e) RECAPTURE OF CREDIT.—

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

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

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

"(i) the applicable percentage, and

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

"(2) APPLICABLE RECAPTURE PERCENTAGE.—

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

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

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

"(3) RECAPTURE EVENT DEFINED.—

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

"(B) SECRETARIAL WAIVER.—The Secretary, in consultation with the Secretary of Health and Human Serv-

ices, may waive any recapture event caused by extraordinary circumstances.

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

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

"Sec. 23. Primary health services providers."

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

SEC. 11902. EXPENSING OF MEDICAL EQUIPMENT.

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

"(1) DOLLAR LIMITATION.—

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

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

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

"(ii) $10,000."

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

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

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

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

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

(c) RECAPTURE.—Paragraph (10) of section 179(d) is amended by inserting before the period "and with respect to any health care property which ceases to be health care property at any time".

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

PART 2—HEALTH CARE WORKFORCE TRUST FUND

SEC. 11911. HEALTH CARE WORKFORCE TRUST FUND.

(a) IN GENERAL.—Subchapter A of chapter 98 (relating to trust fund code) is amended by adding at the end the following new section:

"SEC. 9512. HEALTH CARE WORKFORCE TRUST FUND.

"(a) CREATION OF TRUST FUND.—There is established in the Treasury of the United States a trust fund to be known as the 'Health Care Workforce Trust Fund', consisting of such amounts as

may be appropriated or credited to such Trust Fund as provided in this section and section 9602(b).

"(b) TRANSFERS TO FUND.—There are hereby appropriated to the Health Care Workforce Trust Fund amounts equivalent to 50 percent of the net revenues received in the Treasury from the taxes imposed under subchapter B of chapter 34 (relating to taxes on health insurance and health-related administrative services).

"(c) EXPENDITURES FROM FUND.—Amounts in the Health Care Workforce Trust Fund are available to the Secretary of Health and Human Services for making payments under sections 7021 and 7041 of the Guaranteed Health Insurance Act of 1994 and for making grants under sections 741 and 848 of the Public Health Service Act.

"(d) NET REVENUES.—For purposes of this section, the term 'net revenues' means the amount estimated by the Secretary based on the excess of—

"(1) the taxes received in the Treasury under subchapter B of chapter 34, over

"(2) the decrease in the tax imposed by chapter 1 resulting from the taxes imposed by such subchapter.".

(b) CLERICAL AMENDMENT.—The table of sections for such subchapter A is amended by adding at the end thereof the following new item:

"Sec. 9512. Health Care Workforce Trust Fund.".

PART 3—RECAPTURE OF CERTAIN HEALTH CARE SUBSIDIES RECEIVED BY HIGH-INCOME INDIVIDUALS

SEC. 11921. RECAPTURE OF CERTAIN HEALTH CARE SUBSIDIES RECEIVED BY HIGH-INCOME INDIVIDUALS.

(a) IN GENERAL.—Subchapter A of chapter 1 is amended by adding at the end thereof the following new part:

"PART IX—CERTAIN HEALTH CARE SUBSIDIES RECEIVED BY HIGH-INCOME INDIVIDUALS

"Sec. 59C. Recapture of certain health care subsidies.

"SEC. 59C. RECAPTURE OF CERTAIN HEALTH CARE SUBSIDIES.

"(a) IMPOSITION OF RECAPTURE AMOUNT.—In the case of an individual, if the modified adjusted gross income of the taxpayer for the taxable year exceeds the threshold amount, such taxpayer shall pay (in addition to any other amount imposed by this subtitle) a recapture amount for such taxable year equal to the aggregate of the Medicare part B recapture amounts (if any) for months during such year that a premium is paid under part B of title XVIII of the Social Security Act for the coverage of the individual under such part.

"(b) MEDICARE PART B PREMIUM RECAPTURE AMOUNT FOR MONTH.—For purposes of this section, the Medicare part B premium recapture amount for any month is the amount equal to the excess of—

"(1) 150 percent of the monthly actuarial rate for enrollees age 65 and over determined for that calendar year under section 1839(b) of the Social Security Act, over

"(2) the total monthly premium under section 1839 of the Social Security Act (determined without regard to subsections (b) and (f) of section 1839 of such Act).

"(c) PHASEIN OF RECAPTURE AMOUNT.—

"(1) IN GENERAL.—If the modified adjusted gross income of the taxpayer for any taxable year exceeds the threshold amount by less than $15,000, the recapture amount imposed by this section for such taxable year shall be an amount which bears the same ratio to the recapture amount which would (but

for this subsection) be imposed by this section for such taxable year as such excess bears to $15,000.

"(2) JOINT RETURNS.—If a recapture amount is determined separately for each spouse filing a joint return, paragraph (1) shall be applied by substituting '$30,000' for '$15,000' each place it appears.

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

"(1) THRESHOLD AMOUNT.—The term 'threshold amount' means—

"(A) except as otherwise provided in this paragraph, $90,000,

"(B) $115,000 in the case of a joint return, and

"(C) zero in the case of a taxpayer who—

"(i) is married (as determined under section 7703) but does not file a joint return for such year, and

"(ii) does not live apart from his spouse at all times during the taxable year.

"(2) MODIFIED ADJUSTED GROSS INCOME.—The term 'modified adjusted gross income' means adjusted gross income—

"(A) determined without regard to sections 135, 911, 931, and 933, and

"(B) increased by the amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

"(3) JOINT RETURNS.—In the case of a joint return—

"(A) the recapture amount under subsection (a) shall be the sum of the recapture amounts determined separately for each spouse, and

"(B) subsections (a) and (c) shall be applied by taking into account the combined modified adjusted gross income of the spouses.

"(4) COORDINATION WITH OTHER PROVISIONS.—

"(A) TREATED AS TAX FOR SUBTITLE F.—For purposes of subtitle F, the recapture amount imposed by this section shall be treated as if it were a tax imposed by section 1.

"(B) NOT TREATED AS TAX FOR CERTAIN PURPOSES.—The recapture amount imposed by this section shall not be treated as a tax imposed by this chapter for purposes of determining—

"(i) the amount of any credit allowable under this chapter, or

"(ii) the amount of the minimum tax under section 55.

"(C) TREATED AS PAYMENT FOR MEDICAL INSURANCE.—The recapture amount imposed by this section shall be treated as an amount paid for insurance covering medical care, within the meaning of section 213(d)."

(b) REPORTING REQUIREMENT.—

(1) Paragraph (1) of section 6050F(a) (relating to returns relating to social security benefits) is amended by striking "and" at the end of subparagraph (B) and by inserting after subparagraph (C) the following new subparagraph:

"(D) the number of months during the calendar year for which a premium was paid under part B of title XVIII of the Social Security Act for the coverage of such individual under such part, and".

(2) Paragraph (2) of section 6050F(b) is amended to read as follows:

"(2) the information required to be shown on such return with respect to such individual."

(3) Subparagraph (A) of section 6050F(c)(1) is amended by inserting before the comma "and in the case of the information specified in subsection (a)(1)(D)".

(4) The heading for section 6050F is amended by inserting "and medicare part b coverage" before the period.

(5) The item relating to section 6050F in the table of sections for subpart B of part III of subchapter A of chapter 61 is amended by inserting "and Medicare part B coverage" before the period.

(c) WAIVER OF CERTAIN ESTIMATED TAX PENALTIES.—No addition to tax shall be imposed under section 6654 of the Internal Revenue Code of 1986 (relating to failure to pay estimated income tax) for any period before April 16, 1998, with respect to any underpayment to the extent that such underpayment resulted from section 59C(a) of the Internal Revenue Code of 1986, as added by this section.

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

"Part IX. Certain health care subsidies received by high-income individuals."

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to periods after December 31, 1996, in taxable years ending after such date.

F: HSA GEPHARDT PRINTG.012

LAJ/JHP. SUBJECT TO ROCHESTER ISSUE

TITLE XII—AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

SEC. 12001. CONFORMING AMENDMENTS TO DEFINITIONS.

(a) MOVING DEFINITION OF GROUP HEALTH PLAN.—Subtitle B of title I of such Employee Retirement Income Security Act of 1974 is amended—

(1) in section 607 (29 U.S.C. 1167), by striking paragraph (1);

(2) by striking section 3(41) commencing with "(41) SINGLE-EMPLOYER PLAN.—"; and

(3) in section 3 (29 U.S.C. 1002) (as amended by paragraph (2)), by adding at the end the following new paragraph:

"(42) The term "group health plan" means an employee welfare benefit plan providing medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) to participants or beneficiaries, directly or through insurance, reimbursement, or otherwise."

(b) CLARIFICATION OF INTERRELATIONSHIP OF ERISA GUARANTEED HEALTH INSURANCE ACT OF 1994.—Section 3(42) of such Act (as amended by subsection (a)) is amended by adding at the end the following new sentence: "Such term includes a health plan (within the meaning of section 5504(4) of the Guaranteed Health Insurance Act of 1994 (as of the date of the enactment of such Act) but only to the extent such plan is an employee welfare benefit plan."

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

(1) by adding at the end the following new paragraphs:

"(43) The term 'insured' means, with respect to a group health plan, a group health plan insofar as the plan is funded through the purchase of one or more contracts of health insurance, including any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract.

"(44) The term 'self-insured' means, with respect to a group health plan, a group health plan insofar as the plan is funded in a manner other than through the purchase of one or more policies or contracts described in paragraph (42).

"(45) The term 'carrier' has the meaning provided in section 5504(2) of the Guaranteed Health Insurance Act of 1994 (as of the date of the enactment of such Act).

"(46) The term 'third party contractor' means, in connection with a group health plan, any person (other than a health plan sponsor with respect to the plan) who—

"(A) administers or processes payments made under the plan pursuant to requests for payment for items and services but is not the provider of the items and services, or

"(B) carries out any other duty of the health plan sponsor under a direct or indirect contractual arrangement with the health plan sponsor, other than providing the items and services."

SEC. 12002. REPORTING AND DISCLOSURE REQUIREMENTS FOR GROUP HEALTH PLANS.

(a) IN GENERAL.—Part 1 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1021 et seq.) is amended—

(1) by redesignating section 111 as section 112; and

(2) by inserting after section 110 the following new section:

"SPECIAL RULES FOR GROUP HEALTH PLANS

"SEC. 111. (a) IN GENERAL.—Rules issued by the Secretary under this part with respect to group health plans shall be consist-

ent with the purposes of this title and the Guaranteed Health Insurance Act of 1994.

"(b) EXPEDITIOUS REPORTING AND DISCLOSURE.—The special rules provided under subsection (a) may include rules providing for—

"(1) reductions in the periods of time referred to in this part,

"(2) increases in the frequency of reports and disclosures required under this part, and

"(3) such other changes in the provisions of this part as may result in more expeditious reporting and disclosure of group health plan terms and changes in such terms to the Secretary and to plan participants and beneficiaries,

to the extent that the Secretary determines that the rules described in this subsection are necessary to ensure timely reporting and disclosure of information consistent with the purposes of this title and the Guaranteed Health Insurance Act of 1994 as they relate to group health plans.

"(c) ADDITIONAL REQUIREMENTS.—The special rules provided under subsection (a) may include rules providing for reporting and disclosure of additional information and for reporting and disclosure at more frequent intervals—

"(1) to the Secretary, and

"(2) to participants and beneficiaries,

to the extent necessary to effectively carry out this title with respect to group health plans and in a manner that is consistent with the Guaranteed Health Insurance Act of 1994.".

(b) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act is amended by striking the item relating to section 111 and inserting the following new items:

"Sec. 111. Special rules for group health plans.
"Sec. 112. Effective date."

SEC. 12003. AMENDMENTS TO ENFORCEMENT PROVISIONS OF ERISA.

(a) IMPROVEMENTS IN ENFORCEMENT.—

(1) RECOVERY OF DAMAGES FOR FAILURE TO PROVIDE BENEFITS AS REQUIRED UNDER A HEALTH PLAN.—

(A) IN GENERAL.—Section 502(c) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132(c)) is amended by adding at the end the following new paragraph:

"(5)(A) In the case of any act or failure to act by a group health plan or the plan sponsor in violation of the terms of the plan or this title, the plan, the plan sponsor, and the carrier (in the case of an insured plan), together with each third party contractor (if any) whose act or failure to act constitutes or contributes to the violation, shall be jointly and severally liable to any plaintiff described in subsection (a)(9) aggrieved by such violation for appropriate relief, including actual, compensatory, and punitive damages and equitable relief.

"(B) Nothing in the Guaranteed Health Insurance Act of 1994 shall be construed as limiting any right or remedy provided under this title in connection with a group health plan.".

(B) STANDING OF SPONSORS AND PLANS IN ACTIONS FOR FAILURE TO MEET REQUIREMENTS.—

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

(I) in paragraph (7), by striking "or" at the end;

(II) in paragraph (8), by striking the period and inserting "; or"; and

(III) by inserting after paragraph (8) the following new paragraph:

"(9) in the case of a group health plan—

"(A) by a participant or beneficiary, or by the plan sponsor (or, in the case of a self-insured plan, by any en-

tity with a right to bring action on behalf of the plan), for the relief provided under subsection (c)(5), or

"(B) by the Secretary, on behalf of a participant or beneficiary, for the relief provided under subsection (c)(5).".

(ii) CONFORMING AMENDMENT.—Section 502(e)(1) of such Act (29 U.S.C. 1132(e)(1)) is amended—

(I) in the first sentence, by striking "subsection (a)(1)(B) of this section" and inserting "paragraph (1)(A) (with respect to relief under subsection (c)(5)), paragraph (1)(B), paragraph (7), or paragraph (9) of subsection (a)"; and

(II) in the second sentence, by striking "paragraphs (1)(B) and (7)" and insert "paragraphs (1)(A) (with respect to relief under subsection (c)(5)), paragraph (1)(B), paragraph (7), and paragraph (9)".

(2) ACTIONS FOR VIOLATIONS OF STATUTORY REQUIREMENTS.—Section 502(a)(1)(B) of such Act (29 U.S.C. 1132(a)(1)(B)) is amended by inserting "or the provisions of this title" after "plan" each place it appears.

(3) ACTIONS BY PLANS AGAINST FIDUCIARIES.—Section 502(a)(2) of such Act (29 U.S.C. 1132(a)(2)) is amended by striking "beneficiary or fiduciary" and inserting "a beneficiary, a fiduciary, a plan sponsor of a group health plan, or, in the case of a self-insured group health plan, any entity with a right to bring action on behalf of the plan".

(b) ATTORNEY'S FEES AND COSTS OF ACTION.—Section 502(g) of such Act (29 U.S.C. 1132(g)) is amended—

(1) in paragraph (1), by inserting "or (3)" after "paragraph (2)"; and

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

"(3) In any action or settlement proceeding under this title with respect to a group health plan by a participant or beneficiary under such plan, the court shall award the plaintiff reasonable attorney's fees (at generally prevailing hourly rates), reasonable expert witness fees, and other reasonable costs.".

(c) CIVIL MONEY PENALTIES FOR DENIAL OR DELAY IN PROVIDING GROUP HEALTH PLAN BENEFITS.—

(1) IN GENERAL.—Section 502(c) of such Act (as amended by the preceding provisions of this section) is further amended by adding at the end the following new paragraph:

"(6) CIVIL MONEY PENALTIES FOR DENIAL OR DELAY IN PROVIDING HEALTH PLAN BENEFITS.—The Secretary may assess a civil penalty against any group health plan, the plan sponsor of such plan, or the carrier (in the case of an insured plan) for unreasonable denial or delay in the provision of items or services, or payment therefor, and against any third-party contractor whose act or failure to act constitutes or contributes to the denial or delay, in an amount not to exceed—

"(A) $25,000 per violation, or $75,000 per violation in the case of a finding of bad faith on the part of the liable party, and

"(B) in the case of a finding of a pattern or practice of such violations engaged in by the liable party, $1,000,000 in addition to the total amount of penalties assessed under subparagraph (A) with respect to such violations.

For purposes of subparagraph (A), each violation with respect to any single individual shall be treated as a separate violation.".

(2) CONFORMING AMENDMENT.—Section 502(a)(6) of such Act (29 U.S.C. 1132(a)(6)) is amended by striking "subsection (c)(2) or (i) or (l)" and inserting "subsection (c)(2), (c)(6), (i), or (l)".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to violations occurring on or after the date of the enactment of this Act.

SEC. 12004. EXEMPTIONS FROM ERISA PREEMPTION.

(a) IN GENERAL.—Section 514(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) is amended—

(1) by amending paragraph (5) to read as follows:

"(5) Subsection (a) shall not apply to the Hawaii Prepaid Health Care Act."; and

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

"(9) Subsection (a) shall not apply to any provision of State law to the extent such provision implements a State single-payer system pursuant to subtitle A of title IV of the Guaranteed Health Insurance Act of 1994 (including the imposition of nondiscriminatory taxes in connection with such a system consistent with the requirements of such subtitle).

"(10) Subsection (a) shall not apply to any provision of State law to the extent such provision provides for a managed competition program under subtitle B of title IV of the Guaranteed Health Insurance Act of 1994 (including the imposition of nondiscriminatory taxes in connection with such a program consistent with the requirements of such subtitle).

"(11) Subsection (a) shall not apply to any provision of State law implementing a State provider payment system under subtitle C of title IV of the Guaranteed Health Insurance Act of 1994.".

(b) TEMPORARY TRANSITIONAL RULES.—

(1) IN GENERAL.—Section 514(b) of such Act (29 U.S.C. 1144(b)) (as amended by subsection (a)) is further amended by adding at the end the following new paragraphs:

"(12)(A) Except as provided in subparagraphs (C) and (D), subsection (a) shall not apply to any provision of State law described in subparagraph (B) if there is in effect an exemption under this paragraph granted to the State by the Secretary under section 12004(b)(2) of the Guaranteed Health Insurance Act of 1994 with respect to such provision.

"(B) A provision of State law is described in this subparagraph if such provision is a part of a program of comprehensive health care reform adopted by the State before the date of the enactment of the Guaranteed Health Insurance Act of 1994 under which employers are obligated to make contributions on behalf of employees and their families to group health plans providing comprehensive health benefit coverage for such employees and their families.

"(C) In any case in which the program referred to in subparagraph (A) includes a tax, subparagraph (A) shall not apply with respect to the provision of State law referred to in subparagraph (A) unless such tax is nondiscriminatory.

"(D) Subparagraph (A) shall not at any time apply in the case of any plan sponsor of a group health plan if such plan and plan sponsor would at such time be in compliance with the applicable requirements of the Guaranteed Health Insurance Act of 1994 if the provisions of such Act were in effect and fully implemented at such time.

"(E) This paragraph shall cease to be effective January 1, 1999.

"(13)(A) Subsection (a) shall not apply to any provision of State law described in subparagraph (B) if there is in effect an exemption under this paragraph granted to the State by the Secretary under section 12004(b)(2) of the Guaranteed Health Insurance Act of 1994 with respect to such provision.

"(B) A provision of State law is described in this subparagraph if such provision is part of a program consisting of a comprehensive legislative effort enacted by the State to achieve full implementation of the requirements of the Guaranteed Health Insurance Act of 1994, and—

"(i) such program has the effect of imposing requirements in relation to employees, employers, and group health plans that the Secretary finds would have the effect of imposing (under the State law) requirements which would be imposed under the Guaranteed Health Insurance Act of 1994, in rela-

tion to such employees, employers, and plans, if such Act were in effect and fully implemented,

"(ii) any tax included in such program is nondiscriminatory, and

"(iii) such program does not, directly or indirectly, discriminate against an individual on the basis of race, national origin, religion, gender, sexual orientation, language, socio-economic status, age, status of an eligible individual as a citizen of the United States, health status, or anticipated need for health services.

"(C) This paragraph shall cease to be effective January 1, 1999.

"(14)(A) Subsection (a) shall not apply to any provision of State law described in subparagraph (B) if there is in effect an exemption under this paragraph granted to the State by the Secretary under section 12004(b)(2) of the Guaranteed Health Insurance Act of 1994 with respect to such provision.

"(B) A provision of State law is described in this subparagraph to the extent such provision provides for transfer of financial responsibility for workers' compensation medical benefits to certified health plans (as defined in section 2(2) of the Guaranteed Health Insurance Act of 1994 (as of the date of the enactment of such Act)) if there is in effect an exemption granted to the State by the Secretary of Labor under this section with respect to such provision.

"(C) This paragraph shall cease to be effective 2 years after the date on which the Commission on Integration of Workers' Compensation Medical Benefits submits its report to the President and to the Congress under section 13041 of the Guaranteed Health Insurance Act of 1994.".

(2) EXEMPTION PROCEDURE.—

(A) REQUIREMENTS.—The Secretary of Labor shall grant to a State an exemption under paragraph (12), (13), or (14) of section 514(b) of the Employee Retirement Income Security Act of 1974 with respect to a provision described in such paragraph if—

(i) an application for such exemption with respect to such provision has been duly filed with the Secretary of Labor by the State in complete form in accordance with such procedures as such Secretary may prescribe, and

(ii) the Secretary of Labor finds that such exemption is—

(I) administratively feasible,

(II) not adverse to the interests of the individuals covered under certified health plans affected by the exemption, and

(III) protective of the rights and benefits of the individuals covered under such certified health plans.

An exemption granted under this subparagraph with respect to any provision of State law shall terminate at such time as any requirement of this Act which is effectively implemented by such provision takes effect.

(B) INITIAL REVIEW.—Within 40 days after receipt of each application for exemption, the Secretary of Labor shall—

(i) complete an initial review of the application,

(ii) determine whether additional information is needed from the State and notify the State in writing of such determination, and

(iii) issue a preliminary opinion concerning the likelihood that the application will be approved.

(3) DECISION.—The Secretary of Labor shall issue his or her decision on each application for an exemption under this paragraph within 60 days after the later of—

(A) the date of the his or her receipt of the application, or

(B) the date on which such Secretary receives the State's response to any notification of need for additional information made by such Secretary pursuant to paragraph (2)(B)(ii).

The decision of the Secretary of Labor shall be final, subject to reconsideration and review under paragraph (3).

(4) RECONSIDERATION AND REVIEW.—

(A) PETITIONS FOR RECONSIDERATION.—

(i) IN GENERAL.—Any State dissatisfied with the decision of the Secretary of Labor decision under paragraph (2) may, within 60 days after it has been notified of such decision, file a petition with such Secretary for reconsideration of the State's application under this paragraph (2). Within 30 days after receipt of such a petition, such Secretary shall notify the State of the time and place at which a hearing will be held for the purpose of reconsidering such application. Such hearing shall be held not less than 20 days nor more than 60 days after the date notice of such hearing is furnished to such State, unless such Secretary and such State agree in writing to holding the hearing at another time. Such Secretary shall affirm or reverse the original decision within 60 days of the conclusion of the hearing.

(ii) NO STAYS PENDING RECONSIDERATION.—Action pursuant to a decision of the Secretary of Labor under paragraph (2) shall not be stayed pending reconsideration under clause (i).

(B) COURT REVIEW.—

(i) IN GENERAL.—Any State which is dissatisfied with the final decision of the Secretary of Labor on such State's application under this subsection, as affirmed after reconsideration under subparagraph (A), may, within 60 days after it has been notified of the action of such Secretary under subparagraph (A), file with the United States court of appeals for the circuit in which such State is located a petition for review of such decision. A copy of the petition shall be forthwith transmitted by the clerk of the court to such Secretary. Such Secretary thereupon shall file in the court the record of the proceedings on which such Secretary based the decision, as affirmed under subparagraph (A).

(ii) PROCEDURE.—The findings of fact by the Secretary of Labor, if supported by substantial evidence, shall be conclusive; but the court, for good cause shown, may remand the case to such Secretary to take further evidence, and such Secretary may thereupon make new or modified findings of fact and may modify such Secretary's previous action, and shall certify to the court the transcript and record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence.

(iii) JURISDICTION AND REVIEW.—The court shall have jurisdiction to affirm the action of the Secretary of Labor or to set it aside. The judgment of the court shall be subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28, United States Code.

(c) TEMPORARY RULES GOVERNING PREEMPTION OF CERTAIN LAWS OF THE STATE OF NEW YORK.—

(1) IN GENERAL.—Section 514(b) of such Act (29 U.S.C. 1144(b)) (as amended by subsections (a) and (b)) is further amended by adding at the end the following new paragraph:

"(15)(A) Except as provided in subparagraphs (B), (D), (E), and (G), subsection (a) shall not apply to the following provisions of the law of the State of New York:

"(i) subdivisions 1(b) and 4(e) of section 2807-c of the Public Health Law (relating to 13 percent surcharge);

"(ii) subdivision 1(c) of section 2807-c of the Public Health Law (relating to uniform hospital charges);

"(iii) subdivision 2-a of section 2807-c of the Public Health Law (relating to the variable surcharge for HMOs);

"(iv) subdivision 14 of section 2807-c of the Public Health Law (relating to basic percentage allowances for bad debt and charity care);

"(v) subdivision 14-b of section 2807-c of the Public Health Law (relating to health care services allowances);

"(vi) subdivision 14-c of section 2807-c of the Public Health Law (relating to further allowances for financially distressed hospitals); and

"(vii) section 18 of chapter 266 of the laws of 1986, as amended (relating to excess malpractice insurance adjustments.

"(B) Except as provided in subparagraph (C), nothing in subparagraph (A) shall be construed to exempt from subsection (a)—

"(i) any State tax law relating to employee benefit plans, or

"(ii) any provision referred to in subparagraph (A) to the extent that any law of the State of New York appropriates amounts based on amounts collected by the State under such provision for any purpose other than carrying out the programs with respect to which the provisions described in subparagraph (A) apply.

"(C) Notwithstanding subparagraph (B), subsection (a) shall not apply to any provision of the law of the State of New York to the extent that such provision constitutes—

"(i) an HMO surcharge of the type provided for under subdivision 2-a of such section 2807-c (as in effect on February 2, 1993), or

"(ii) an allowance, of the type provided for under the provisions referred to in subparagraph (A) (as so in effect), for bad debts, charity care, health care services, or excess malpractice insurance,

but only if the law of such State appropriates or allocates amounts based on and equivalent to amounts collected by the State under such provision solely for the purpose of carrying out one or more programs with respect to which the provisions described in subparagraph (A) apply.

"(D) Subsection (a) shall apply to any provision of the law of the State of New York to the extent that such provision constitutes a surcharge of the type provided for under subdivisions 1(b) and 4(e) of section 2807-c of the Public Health Law of the State of New York (as in effect on February 2, 1993) unless such provision provides for use of amounts collected under such provision solely for the purpose of carrying out one or more programs with respect to which the provisions described in subparagraph (A) apply.

"(E) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) any amendment of any provision referred to in subparagraph (A) enacted on or after February 2, 1993, to the extent it provides for more than the effective administration of such provisions as in effect on such date, unless such amendment constitutes only a change in the methodology of determining payments to hospitals and would result in—

"(i) a surcharge described in subparagraph (C)(i) of not more than 9 percent with respect to which the requirements of subparagraph (C) are met,

"(ii) an allowance described in subparagraph (C)(ii) which does not exceed in the aggregate a Statewide average of not

more than 10 percent and with respect to which the requirements of subparagraph (C) are met, or

"(iii) a surcharge described in subparagraph (D) of not more than 13 percent with respect to which the requirements of subparagraph (D) are met.

"(F) Subsection (a) shall not apply to any amendment to chapter 2 of the laws of 1988 of the State of New York, as amended, to the extent that such amendment extends the period for which the provisions referred to in subparagraph (A) are in effect.

"(G) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the provisions described in subparagraph (A) (as in effect on or after February 2, 1993), but the Secretary may enter into cooperative arrangements under this subparagraph and section 506 with officials of the State of New York to assist them in effectuating the policies of such provisions which are superseded by such parts 1 and 4 and the preceding sections of this part.

"(H) Subsection (a) shall apply to any provision of the law of the State of New York to the extent that such provision requires an entity which may be deemed to be engaged in the business of insurance under paragraph (2) (including a health maintenance organization) to provide open enrollment and community rating (including premium adjustments for the purpose of risk adjustment).

"(I) References in this paragraph to provisions of the law of the State of New York shall be deemed references to such provisions as in effect August 1, 1993.

"(J) This paragraph shall not apply to any provision of the law of the State of New York to the extent such provision applies with respect to residents of the area described in the second sentence of section 4301 of the Guaranteed Health Insurance Act of 1994.".

(d) TREATMENT OF CONSUMER PURCHASING COOPERATIVES.—Section 514(b)(6) of such Act (29 U.S.C. 1144(b)(6)) is amended to read as follows:

"(6) Subsection (a) shall not apply with respect to any provision of State law to the extent that such provision implements a consumer purchasing cooperative pursuant to title V of the Guaranteed Health Insurance Act of 1994.".

(e) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in this subsection, the amendments made by subsection (a) shall take effect on the date of the enactment of this Act.

(2) EFFECTIVE DATE AND SUNSET OF NEW YORK RULE.—Section 514(b)(13) of the Employee Retirement Income Security Act of 1974 (added by subsection (b)) shall cease to be effective 2 years after the date of the enactment of this Act. Subparagraph (H) of such section 514(b)(13) shall apply with respect to provisions of State law in effect as of April 1, 1993.

(3) EFFECTIVE DATE OF CONSUMER PURCHASING COOPERATIVE RULE.—The amendment made by subsection (c) shall take effect January 1, 1997.

SEC. 12005. TRANSITIONAL CONTINUATION COVERAGE REQUIREMENT FOR GROUP HEALTH PLANS.

Paragraph (2) of section 602 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1162(2)) is amended by adding at the end the following new sentence: "In the case of an individual whose period of coverage under this paragraph would (but for this sentence) end after the date of the enactment of the Guaranteed Health Insurance Act of 1994 and before January 1, 1999, such period shall in no event terminate by reason of this paragraph before January 1, 1999.".

SEC. 12006. COVERAGE OF PEDIATRIC VACCINES AND WELL-CHILD SERVICES UNDER GROUP HEALTH PLANS.

(a) IN GENERAL.—Section 609(d) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1167(d)) is amended to read as follows:

"(f) COVERAGE OF COSTS OF PEDIATRIC VACCINE AND WELL-CHILD SERVICES FOR GROUP HEALTH PLANS.—

"(1) MAINTENANCE OF VACCINE COVERAGE.—A group health plan may not reduce its coverage of the costs of pediatric vaccines (as defined under section 1928(h)(6) of the Social Security Act) below the coverage it provided as of May 1, 1993.

"(2) REQUIREMENT FOR COVERAGE OF IMMUNIZATIONS AND WELL-CHILD SERVICES.—Each group health plan shall provide coverage of the following services without deductible, coinsurance, or any other form of cost-sharing:

"(A) All vaccines on the list described in section 1928(e) of the Social Security Act.

"(B) Well-child services described in section 1928(f)(2)(B) of such Act.".

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by this section shall take effect on the date of the enactment of this Act.

(2) PLAN AMENDMENTS NOT REQUIRED UNTIL JANUARY 1, 1995.—Any amendment to a plan required to be made by the amendment made by this section shall not be required to be made before the first plan year beginning on or after January 1, 1995.

SEC. 12007. ADDITIONAL AMENDMENTS RELATING TO GROUP HEALTH PLANS.

(a) TECHNICAL CORRECTIONS.—Effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1993—

(1) Subsection (a)(2)(B)(ii) of section 609 of the Employee Retirement Income Security Act of 1974 is amended by striking "section 13822" and inserting "section 13623".

(2) Subsection (a)(4) of such section 609 is amended by striking "section 13822" and inserting "section 13623".

(3) Subsection (d) of such section 609 is amended by striking "section 13830" and inserting "section 13631".

(4) Section 514(b)(7) of such Act (29 U.S.C. 1144(b)(7)) is amended by inserting ", qualified medical child support orders (within the meaning of section 609(a)(2)(A)), and the provisions of law referred to in section 609(a)(2)(B)(ii) to the extent enforced by qualified medical child support orders" before the period.

SEC. 12008. PLAN CLAIMS PROCEDURES.

Section 503 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1133) is amended—

(1) by inserting "(a) IN GENERAL.—" after "SEC. 503."; and

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

"(b) GROUP HEALTH PLANS.—A group health plan shall be treated as failing to meet the requirements of subsection (a) to the extent that the requirements of sections 9301, 9302, and 9303 of the Guaranteed Health Insurance Act of 1994 are not met with respect to such plan.".

SEC. 12009. REGULATIONS DEFINING COLLECTIVE BARGAINING AGREEMENT.

Not later than 180 days after the date of the enactment of this Act, the Secretary of Labor shall prescribe regulations defining the term "collective bargaining agreement" for purposes of this Act and title I of the Employee Retirement Income Security Act of 1974.

TITLE XIII—COORDINATION OF MEDICAL PORTION OF WORKERS' COMPENSATION AND AUTOMOBILE INSURANCE

Subtitle A—Workers' Compensation Insurance

SEC. 13000. DEFINITIONS.

In this subtitle:

(1) INJURED WORKER.—The term "injured worker" means, with respect to a certified health plan, an individual enrolled under the plan who has a work-related injury or illness for which workers' compensation medical benefits are available under State law.

(2) SPECIALIZED WORKERS' COMPENSATION PROVIDER.—The term "specialized workers' compensation provider"—

(A) means a health provider that specializes in the provision of preventive services, diagnostic services, medical treatment and medical rehabilitative services relating to work-related injuries or illness, and includes a physician specializing in occupational medicine and a non-physician specialist in occupational health or a related field; and

(B) includes a center of excellence in occupational health.

(3) WORKERS' COMPENSATION MEDICAL BENEFITS.—The term "workers' compensation medical benefits" means, with respect to an enrollee who is an employee subject to the workers' compensation laws of a State, the comprehensive medical benefits for work-related injuries and illnesses provided for under such laws with respect to such an employee.

(4) WORKERS' COMPENSATION CARRIER.—The term "workers' compensation carrier" means an insurance company that underwrites workers' compensation medical benefits with respect to one or more employers and includes an employer or fund that is financially at risk for the provision of workers' compensation medical benefits.

(5) WORKERS' COMPENSATION SERVICES.—The term "workers' compensation services"—

(A) means items and services included in workers' compensation medical benefits, including rehabilitation services and long-term care services; and

(B) includes services of a case manager under section 13001(c) and the preparation of reports relating to workers' compensation medical benefits.

PART 1—HEALTH PLAN REQUIREMENTS RELATING TO WORKERS' COMPENSATION

SEC. 13001. PROVISION OF WORKERS' COMPENSATION SERVICES.

(a) PROVISION OF BENEFITS.—Subject to subsection (b)—

(1) REQUIREMENT FOR CERTIFIED HEALTH PLANS.—

(A) IN GENERAL.—Each certified health plan shall enter into such contracts and arrangements as are necessary (in accordance with subparagraph (B)) to provide or arrange for the provision of workers' compensation services to an enrollee who is an injured worker, in return for payment from the workers' compensation carrier under section 13002. The health plan shall contract with, or arrange for the provision of service from, a range of specialized workers' compensation providers (as defined in 13000(2)) sufficient to deliver the medical and rehabilitative services

compensable under the State's workers' compensation laws.

(B) PROVISION OF SERVICES.—For purposes of this paragraph, a certified health plan provides (or arranges for the provision of) workers' compensation services with respect to an enrollee if the services are provided by—

(i) a participating provider in the plan,

(ii) any other specialized workers' compensation provider with whom the plan has entered into an agreement for the provision of such services, or

(iii) a center of excellence in occupational health designated by the State under section 13011(a), whether or not the center is a provider described in clause (i) or (ii).

(C) LIST OF SPECIALIZED WORKERS' COMPENSATION PROVIDERS.—Upon the request of an enrollee, a certified health plan shall provide a list of the plan's specialized workers' compensation providers and shall include, for each such provider, the provider's phone number, address, subspecialty, and a summary of the provider's training and relevant experience.

(2) INDIVIDUAL REQUIREMENT.—An individual entitled to workers' compensation medical benefits and enrolled in a certified health plan shall receive workers' compensation services through the provision (or arrangement for the provision) of such services by the health plan, regardless of whether the services are included in the guaranteed national benefit package.

(3) EXCEPTIONS FOR CERTAIN HEALTH PLANS FOR VETERANS, MILITARY PERSONNEL, AND INDIANS.—Paragraphs (1) and (2) shall not apply with respect to a health plan of the Department of Veterans' Affairs, of the Indian Health Service, or of the Department of Defense and individuals enrolled in such a plan.

(4) USE OF STATE-DESIGNATED CENTERS OF EXCELLENCE.—Either a certified health plan or the injured worker may elect to provide or receive benefits under this subsection through a center of excellence in occupational health designated under section 13011(a).

(5) ACCESS TO EMERGENCY SERVICES.—An injured worker shall have the same access to emergency workers' compensation services as the worker has with respect to other emergency services.

(b) ALTERNATIVE PERMITTED.—Subsection (a) shall not be construed as preventing an injured worker and a workers' compensation carrier from agreeing that workers' compensation services shall be provided other than by or through the certified health plan in which the worker is enrolled.

(c) COORDINATION.—

(1) DESIGNATION OF CASE MANAGER.—Each certified health plan shall employ or contract with one or more individuals, such as occupational nurses, with experience in the management of occupational illness and injury to provide case management services with respect to workers' compensation services provided through the plan under this section.

(2) FUNCTIONS OF CASE MANAGER.—The certified health plan (through the case manager described in paragraph (1)) is responsible for ensuring that—

(A) there is a plan of treatment (when appropriate) for each enrollee who is an injured worker designed to assure appropriate treatment and facilitate return to work;

(B) the plan of treatment is developed with the participation of the worker and communicated on a timely basis to the worker and to the workers' compensation carrier, the employer, or both for purposes of return to work planning;

(C) medical information to the extent needed to assure the enrollee's safe, healthful, and timely return to work is provided to the worker and to the workers' compensation carrier, the employer or both, as appropriate, that shall include the types of work activities an injured worker can safely perform and any specific work restrictions that may be appropriate to prevent the recurrence of the injury or illness and to permit the worker's complete recovery; and

(D) the health plan (and its providers) comply with legal duties and requirements under State workers' compensation law (including treatment protocols approved in accordance with such laws) and other Federal and State laws including those regarding the reporting of occupational injuries and diseases.

(d) ADMINISTRATION.—The Secretary of Labor shall administer this subtitle and, for such purposes, the Secretary is authorized to prescribe such rules and regulations as may be necessary and appropriate.

(e) WAIVER FOR CERTAIN STATES.—The Secretary shall waive the application of the provisions of this part and part 2 (other than sections 13011 and 13013) if the State demonstrates the following:

(1) The State has a comprehensive, mandatory workers' compensation system that covers an overwhelming majority of the workers in the State.

(2)(A) Injured workers in the State are assured a broad choice of health providers when seeking treatment for work-related illnesses and injuries.

(B) Injured workers are assured the right to seek workers' compensation services, when appropriate, from centers of excellence designated by the State under section 13011.

(C) If the State allows or requires injured workers to obtain workers' compensation medical benefits only from one or more organizations that restrict the workers' choice of providers from whom the benefits may be obtained—

(i) workers are provided an opportunity to select from among a reasonable choice of at least 3 such organizations;

(ii) such organizations are—

(I) certified by the State; and

(II) required by the State to meet minimum requirements related to quality, accessibility, and continuity of services; and

(iii) workers are provided the option to choose such an organization that is not owned or controlled by the workers' compensation carrier that underwrites the workers' compensation medical benefits with respect to the employer of the worker.

(3) The State has a system in place—

(A) to control increases in the costs of workers' compensation medical benefits; and

(B) to monitor and improve the quality of workers' compensation services provided to injured workers.

SEC. 13002. PAYMENT BY WORKERS' COMPENSATION CARRIER.

(a) PAYMENT.—

(1) IN GENERAL.—Each workers' compensation carrier that is liable for payment for workers' compensation services furnished by or through a certified health plan, regardless of whether the services are included in the guaranteed national benefit package, shall make payment for such services. If a certified health plan has provided or paid for services for which such a workers' compensation carrier is liable, such carrier shall reimburse the health plan for such services. If an individual has paid for services for which such a carrier is liable, the carrier shall reimburse the individual for such services (including cost sharing incurred for such services).

(2) USE OF FEE SCHEDULE.—Except as provided in subsection (b), such payment shall be made in accordance with the

applicable fee schedule established by the certified health plan for services provided under the guaranteed national benefit package or section 13012.

(b) ALTERNATIVE PAYMENT METHODOLOGIES.—Subsection (a)(2) shall not apply—

(1) in the case of a State that establishes an alternative payment methodology (such as payment on a negotiated fee for each case) for payment for workers' compensation services; or

(2) in the case in which a workers' compensation carrier and the certified health plan negotiate alternative payment arrangements.

(c) LIMITATION OF LIABILITY OF INJURED WORKER.—Nothing in this part shall be construed as requiring an injured worker to make any payment (including payment of any cost sharing or any amount in excess of the applicable fee schedule) to any certified health plan or health provider for the receipt of workers' compensation services.

PART 2—REQUIREMENTS OF STATES

SEC. 13011. STATE DESIGNATION OF CENTERS OF EXCELLENCE IN OCCUPATIONAL HEALTH.

(a) IN GENERAL.—A State shall, in consultation with a panel consisting of representatives of organized labor and representatives of employers in equal numbers, designate at least one center of excellence in occupational health for each community-rating area in the State. A State may designate such a center of excellence for a community-rating area that is not located in the area or the State. Injured workers and certified health plans may elect to receive workers' compensation services through such centers under section 13001(a)(4).

(b) QUALIFICATIONS.—A State shall not designate a center of excellence under subsection (a) unless the State finds that the center meets the following requirements:

(1) The center includes, as staff members or contractors, physicians and other health providers with significant experience and training in the diagnosis, management, and treatment of occupational injuries and illnesses, including the diagnosis of chronic diseases of occupational origin.

(2) The center has the ability to serve as a technical resource to providers serving certified health plans on issues relating to occupational injury and illness.

(3) The center provides an interdisciplinary range of specialized services, including independent evaluation of occupational injuries and illnesses, assessment and control of the causes of such injuries and illnesses, methods to educate workers in the prevention of such injuries and illnesses, and rehabilitative care and other treatment to facilitate the return to work of an injured worker.

(c) PUBLICATION.—Each State shall publish a list of centers of excellence designated under subsection (a).

(d) TRAVEL PAID BY CARRIER.—Injured workers shall be reimbursed by workers' compensation carriers for reasonable expenses related to travel to centers of excellence designated under subsection (a).

SEC. 13012. DEVELOPMENT OF SUPPLEMENTAL SCHEDULES.

Each State shall develop a fee schedule applicable to payment for workers' compensation services not included in the guaranteed national benefit package, including a separate schedule for services of a case manager under section 13001(c) and the preparation of reports relating to workers' compensation medical benefits.

SEC. 13013. PROVISION OF WORKERS' COMPENSATION DATA.

Each State shall make available to the Secretary of Labor, in such form as the Secretary shall require, injury and illness data collected as part of the State's workers' compensation program.

Such a State is not required to make available personally identifiable information with respect to a worker. The Secretary is authorized to reimburse the States for the cost of preparing and transmitting the data in the requested form.

SEC. 13014. EFFECT ON STATE WORKERS' COMPENSATION LAWS.

(a) IN GENERAL.—Except as provided in this subtitle, no State law shall have any effect that restricts the choice, or payment, of providers that may provide workers' compensation services for individuals enrolled in a certified health plan.

(b) DISPUTE RESOLUTION.—A State law may provide for a method for resolving disputes related to—

(1) an individual's entitlement to workers' compensation medical benefits under State law,

(2) the necessity and appropriateness of workers' compensation services provided to an injured worker, and

(3) subject to section 13002, the reasonableness of fees charged for workers' compensation services.

(c) CONSTRUCTION.—Nothing in this subtitle shall be construed as altering—

(1) the effect of a State workers' compensation law as the exclusive remedy for work-related injuries or illnesses,

(2) the determination of whether or not a person is an injured worker and entitled to workers' compensation medical benefits under State law,

(3) the scope of items and services available to injured workers entitled to workers' compensation medical benefits under State law, including protocols approved under such a law relating to provision of workers' compensation services, or

(4) the eligibility of any individual or class of individuals for workers' compensation medical benefits under State law.

(d) INTEGRATION.—Nothing in this subtitle shall prevent a State from integrating or otherwise coordinating the payment for workers' compensation medical benefits with payment for benefits under health insurance or health benefit plans.

SEC. 13015. PROTECTION AGAINST FRAUD.

A State workers' compensation law may disqualify or suspend a health provider from providing workers' compensation services if the provider is determined to have violated protocols or standards of care, to have provided unnecessary or inappropriate services, to have billed in violation of law, or to have engaged in another prohibited practice with respect to workers' compensation services.

PART 3—APPLICATION OF INFORMATION PRACTICES REQUIREMENTS; EFFECT ON PREMIUMS

SEC. 13021. APPLICATION OF INFORMATION PRACTICES REQUIREMENTS.

(a) IN GENERAL.—The provisions of subtitle C of title IX apply to the provision of workers' compensation services.

(b) RULES.—The Secretary of Health and Human Services, in consultation with the Secretary of Labor, shall promulgate rules to clarify the responsibilities of certified health plans and workers' compensation carriers in carrying out the provisions referred to in subsection (a).

SEC. 13022. REPORT ON EFFECT ON WORKERS' COMPENSATION PREMIUMS.

(a) STUDY AND REPORT.—

(1) STUDY.—The Secretary of Labor shall provide for a study of the impact of the provisions of this subtitle on the premium rates charged to employers for workers' compensation insurance. Such study shall use information supplied by States relating to workers' compensation premiums and such other information as the Secretary of Labor finds appropriate.