(3) for benefits furnished by licensed or certified providers on compliance with conditions which are in addition to those required for licensure or certification under State law;

(4) for nursing facility services (if covered under the policy) only—

(A) to care provided in facilities which provide a specified level of care; or

(B) to care provided in facilities which provide for 24-hour or other nursing care not required in order to be licensed by the State; or

(5) for benefits on the continued payment of premiums during periods when long-term care is being received and for which claims under the policy are being filed.

(c) HOME AND COMMUNITY CARE SERVICES.—

(1) SERVICES INCLUDED.—Home and community care services under a long-term care insurance policy shall include—

(A) home-based services (described in paragraph (2)) which are provided in a place of residence used as the individual's home (or, in the case of services described in subparagraphs (C), (F), and (G) of that paragraph, which may be provided outside the individual's residence), and

(B) community-based services (described in paragraph (3)).

(2) HOME-BASED SERVICES.—The home-based services described in this paragraph are as follows:

(A) Nursing care provided by or under the supervision of a registered professional nurse.

(B) Services of a homemaker/home health aide who has successfully completed a training and competency evaluation program that meets minimum standards established by the Secretary under section 1891(a)(3)(D) of the Social Security Act.

(C) Personal assistance services furnished by an individual who has successfully completed a training and competency evaluation program that meets minimum standards established by the Secretary.

(D) Medical social services.

(E) Physical, occupational, or respiratory therapy or speech-language pathology.

(F) Medical supplies (other than drugs and biologicals), assistive technologies, and equipment that assist in the performance of activities of daily living.

(G) Patient and caregiver (including family caregiver) education and training to develop skills necessary to permit the individual to remain in the home setting.

(H) Such other home-based items and services as the Secretary may approve.

(3) COMMUNITY-BASED SERVICES.—The community-based services described in this paragraph are as follows:

(A) Adult day care services provided by an adult day care program that meets minimum standards (including the provision of at least 1 meal a day and the provision of necessary transportation) established by the Secretary.

(B) In the case of individuals with chronic mental illness, day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility), but only insofar as such services are equivalent to services described in subparagraph (A) and do not include individual therapy.

(C) Such other community-based items and services as the Secretary may approve.

(4) LIMITATIONS ON CONDITIONS.—If a long-term care insurance policy provides benefits for home and community care services, the policy—

(A) may not limit such benefits to services provided by registered nurses, licensed practical nurses, occupational, physical, or speech therapists, or social workers;

(B) may not require benefits for such services to be provided by a nurse or therapist that can be provided by a home health aide or licensed or certified home care worker acting within the scope of the worker's licensure or certification;

(C) may not limit such benefits to services provided by agencies or providers certified under title XVIII or XIX of the Social Security Act;

(D) may not limit or exclude benefits for such services (i) by requiring that the policyholder would need nursing care in a facility if home and community care services were not provided, or (ii) by requiring that the policyholder have an acute condition before home and community care services are covered; and

(E) must provide not less than 365 days of home-based services and community-based services.

(d) NURSING FACILITY SERVICES.—

(1) TYPES OF SERVICES.—Nursing facility services under a long-term care insurance policy shall include the following:

(A) Nursing care provided by or under the supervision of a registered professional nurse.

(B) Bed and board in connection with the furnishing of such nursing care.

(C) Physical, occupational, or respiratory therapy, or speech-language pathology, furnished by the facility or by others under arrangements with them made by the facility.

(D) Medical social services.

(E) Such drugs, biologicals, supplies, appliances, and equipment, furnished for use in the facility as are ordinarily furnished by such facility for the care and treatment of residents.

(F) Medical services provided by an intern or resident-in-training of a hospital with which the facility has in effect a transfer agreement (meeting the requirements of section 1861(l) of the Social Security Act), under a teaching program of such hospital approved as provided in the last sentence of section 1861(b) of such Act, and other diagnostic or therapeutic services provided by a hospital with which the facility has such an agreement in effect.

(G) Such other services necessary to the health of the residents as are generally provided by nursing facilities.

(2) MINIMUM DURATION.—If a long-term care insurance policy provides benefits for nursing facility services, the policy shall provide—

(A) such benefits with respect to all nursing facilities (as defined in section 1919(a) of the Social Security Act, and

(B) not less than 365 days of such benefits with respect to all such nursing facilities.

SEC. 10123. PROHIBITION OF DISCRIMINATION.

A long-term care insurance policy may not treat benefits under the policy for an individual with Alzheimer's disease, with any related progressive degenerative dementia of an organic origin, with any mental disorder of a demonstrable organic origin, or with HIV disease, differently from benefits for an individual having another medical condition for which benefits may be made available. For purposes of the previous sentence, the term "HIV disease" means infection with the human immunodeficiency virus, and includes any condition arising from acquired immune deficiency syndrome.

SEC. 10124. LIMITATION ON USE OF PREEXISTING CONDITION LIMITS.

(a) INITIAL ISSUANCE.—

(1) IN GENERAL.—Subject to paragraph (2), a long-term care insurance policy may not exclude or condition benefits based on a medical condition for which the policyholder received treatment or was otherwise diagnosed before the date of issuance of the policy.

(2) 6-MONTH LIMIT.—A long-term care insurance policy may exclude benefits under a policy, during its first 6 months, based on a condition for which the policyholder received treatment or was otherwise diagnosed during the 6 months before the policy became effective.

(3) REFERENCE TO MEDICAL DOCUMENTATION REQUIREMENT.—For provision requiring medical documentation for individuals 75 years or age or older at the time of policy issuance, see section 10147.

(b) REPLACEMENT POLICIES.—If a long-term care insurance policy replaces another long-term care insurance policy, the replacing policy shall waive any time periods (including waiting periods, elimination periods, and probationary periods) applicable to preexisting conditions in the new policy for similar benefits to the extent such time was spent under the original policy.

SEC. 10125. USE OF FUNCTIONAL ASSESSMENT.

(a) IN GENERAL.—If a long-term care insurance policy limits the eligibility for, or level of, benefits, the policy—

(1) shall specify that eligibility for, and the level of, benefits available under the policy based on a functional assessment (described in subsection (c)); and

(2) shall specify the level (or levels) of physical, cognitive, or mental impairment required under such an assessment to obtain benefits under the policy.

(b) CONDUCT OF ASSESSMENT.—Such assessment may not be conducted by an individual—

(1) who has a direct or indirect ownership or control interest in the carrier issuing the policy or an entity that provides services for which benefits are available under the long-term care insurance policy, or

(2) who has a direct or indirect affiliation or relationship with such a carrier or entity if there is a financial incentive that is related to the results of the assessment determination.

(c) UNIFORM ASSESSMENT INSTRUMENT AND UNIFORM FORMULAS.—Not later than July 1, 1995—

(1) the functional assessment referred to in subsection (a) must—

(A) be based on a professional assessment of the policyholder's physical, cognitive, and mental abilities, and

(B) be conducted in accordance with a standard, reproducible, uniform assessment instrument and methodology designated by the Secretary; and

(2) benefits shall be determined in accordance with an eligibility formula specified in the Standards and based on the assessment described in paragraph (1).

(d) APPEALS PROCESS.—Each long-term care insurance policy shall provide for an appeals process, meeting the Standards, for individuals who dispute the results of an assessment conducted under this section, including any determination of eligibility, level of functional impairment, or level of benefits.

SEC. 10126. REQUIREMENTS FOR PREMIUMS.

(a) INITIAL ISSUANCE.—The premiums charged for the initial issuance of a long-term care insurance policy shall be established in accordance with a system that ensures that premiums—

(1) accurately reflect the true lifetime cost of the policies (in order to minimize premium rate increases);

(2) are fully supported by an actuarial memorandum; and

(3) utilize lapse rates (in accordance with a table specified in the standards).

(b) RENEWALS.—Except as provided in subsection (c)—

(1) IN GENERAL.—The Standards shall provide limits on the increases in premiums that are allowable at the time of renewal. Such Standards shall be at least as stringent as the limitations contained in the succeeding paragraphs of this subsection.

(2) PROHIBITION ON INCREASES IN FIRST 4 YEARS.—No increase in premiums shall be granted during the first 4 years of a policy's duration.

(3) REQUIREMENTS FOR CERTAIN PREMIUM INCREASES FOR INDIVIDUALS UNDER AGE 70.—In the case of a policyholder or certificateholder of a long-term care insurance policy who is under the age of 70, a proposed premium increase for renewal of the policy that would result either—

(A) in the premium exceeding twice the original premium amount, or

(B) in a premium increase, over any 4-year period, exceeding 25 percent of the premium in effect at the beginning of such period,

shall not be granted.

(4) REQUIREMENTS FOR PREMIUM INCREASES FOR INDIVIDUALS BETWEEN 70 AND 80 YEARS OF AGE.—In the case of a policyholder or certificateholder of a long-term care insurance policy who is at least 70 years of age but under the age of 80, no proposed premium increase for renewal of the policy shall be granted if the proposed premium increase would result in a premium increase, over any 5-year period, exceeding 15 percent of the premium in effect at the beginning of the period.

(5) PROHIBITION ON PREMIUM INCREASES FOR INDIVIDUALS 80 YEARS OF AGE OR OLDER.—In the case of a policyholder or certificate holder of a long-term care insurance policy who is 80 years of age or older, the premiums for such policy may not be increased.

(c) SPECIAL RULES IN CASE OF INFLATION PROTECTION.—In the case of a policy that includes inflation protection benefits, the requirements of subsection (b) shall not apply to any proposed or expected premium increases if the increases are consistent with the increases attributable to such inflation protection as scheduled within the policy and were contained in the outline of coverage required under section 10136(b)(9).

SEC. 10127. INFLATION PROTECTION.

(a) REQUIREMENT TO OFFER.—An insurer offering for sale any long-term care insurance policy shall afford the purchaser the option to obtain coverage under such policy of annual increases in benefits (upon payment of increased premiums) at rates in accordance with subsection (b).

(b) RATE INCREASE IN BENEFITS.—For purposes of subsection (a), the benefits under a policy for each year shall be increased by a percentage of the full value of benefits under the policy for the previous year, which shall be not less than 5 percent of such value (or such other rate of increase as may be determined by the Secretary to be adequate to offset increases in the costs of long-term care services for which coverage is provided under the policy).

(c) REQUIREMENT OF WRITTEN REJECTION.—Inflation protection in accordance with subsection (b) may be excluded from the coverage under a policy only if the insured individual (or, if different, the person responsible for payment of premiums) has rejected in writing the option to obtain such coverage.

SEC. 10128. NONFORFEITURE.

(a) IN GENERAL.—Each long-term care insurance policy shall provide that if the policy lapses after the policy has been in effect for at least 3 years, the policy will provide without payment of any additional premiums benefits equal to a percentage (specified under the Standards) of the benefits otherwise available at term.

(b) STANDARDS.—The Standards may provide that the percentage under subsection (a) must increase based upon the period of time in which the policy was in effect.

SEC. 10129. DESIGNATION OF REPRESENTATIVES.

(a) IN GENERAL.—The carrier issuing a long-term care insurance policy—

(1) at the time of issuance of the policy shall require the applicant or policyholder either—

(A) to designate not more than 3 representatives whom the carrier shall notify in the event that the policyholder fails to pay premiums, or

(B) to provide a written waiver (signed and dated by the applicant or policyholder) of the right to make such designation; and

(2) shall permit the policyholder to make or alter such a designation not less frequently than annually at the time of renewal.

(b) NO LEGAL OBLIGATION TO PAY PREMIUMS.—An individual designated as a representative under subsection (a) is not under any legal obligation to pay for premiums or to otherwise act in the event of a notification under this section.

SEC. 10130. ISSUANCE, RENEWAL, AND CANCELLATION.

(a) IN GENERAL.—No long-term care insurance policy may be canceled or nonrenewed for any reason other than nonpayment of premium (subject to subsection (d) and any nonforfeiture rights under section 10128) or fraud or material misrepresentation (subject to section 10145(c)).

(b) CONTINUATION AND CONVERSION RIGHTS FOR GROUP POLICIES.—

(1) IN GENERAL.—Each group long-term care insurance policy shall provide covered individuals with a basis for continuation or conversion in accordance with this subsection.

(2) BASIS FOR CONTINUATION.—For purposes of paragraph (1), a policy provides a basis for continuation of coverage if the policy maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. A group policy which restricts provision of benefits and services to or contains incentives to use certain providers or facilities, may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy.

(3) BASIS FOR CONVERSION.—For purposes of paragraph (1), a policy provides a basis for conversion of coverage if the policy entitles each individual—

(A) whose coverage under the group policy would otherwise be terminated for any reason; and

(B) who has been continuously insured under the policy (or group policy which was replaced) for at least 6 months before the date of the termination;

to issuance of a policy providing benefits identical to, substantially equivalent to, or in excess of, those of the policy being terminated, without evidence of insurability.

(4) GUIDELINES FOR DETERMINATION OF SUBSTANTIAL EQUIVALENCE.—For the purpose of determining whether benefits under such policies are substantially equivalent under paragraphs (2) or (3), the Secretary shall establish guidelines for comparing long-term care insurance policies.

(5) GROUP REPLACEMENT OF POLICIES.—If a group long-term care insurance policy is replaced by another long-term care insurance policy purchased by the same policyholder, the succeeding carrier shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(6) PREMIUMS FOR REPLACEMENT OR CONVERSION.—In the case of a converted policy or a replacement policy issued by the same carrier that had issued a previous policy and issued to the same group or its successor, or issued to any individual

covered by the previous group policy, the premium shall be calculated on the basis of the insured's age at the inception of coverage under the earliest previous policy which became the basis for the converted or replaced policy in the case of benefits which are the same as benefits that were provided under any earlier policy.

(c) GUARANTEED ISSUANCE.—

(1) IN GENERAL.—A carrier that sells or issues long-term care insurance policies shall guarantee that such policies shall be sold or issued to an individual if such individual meets the minimum medical underwriting requirements of such policy as established in compliance with an age rating formula established by the Secretary.

(2) POLICY UPGRADES.—

(A) CURRENT POLICIES.—Each long-term care insurance policy in effect as of the effective date of the Standards established under section 10102 shall permit the policyholder to purchase a policy that meets all such standards and the carrier shall directly inform each such policyholder of the right to purchase an upgraded policy under this paragraph.

(B) FUTURE UPGRADES.—

(i) IN GENERAL.—If a carrier of a long-term care insurance policy provides for the issuance of policies with benefits that are greater than the benefits previously provided under such policies, the policyholder of a long-term care insurance policy previously issued by that carrier and still in force has the right to purchase a policy that provides for such upgraded benefits and the carrier shall directly inform each such policyholder of the existence of such an upgraded policy and the right to purchase an upgraded policy under this paragraph.

(ii) LIMITATION.—Clause (i) shall not apply to a policyholder who is eligible (or was eligible at any time within the previous 3 months) for benefits under the long-term care insurance policy.

(C) LIMITATION ON MEDICAL UNDERWRITING OF UPGRADED POLICIES REQUIRED UNDER FEDERAL OR STATE LAW.—With respect to a policy that offers upgraded benefits in accordance with a new Federal or State requirement, the carrier issuing the policy may not impose additional medical underwriting criteria, except that—

(i) the carrier may utilize an age rate for such policy based on the formula established by the Secretary under subsection (c)(1), and

(ii) the carrier may impose additional medical underwriting criteria in relation to benefits to the extent they were not included in the previously issued policy.

(D) LIMITATION ON MEDICAL UNDERWRITING ON OTHER UPGRADED POLICIES.—With respect to an upgraded long-term care insurance policy that offers benefits that are greater than the benefits required under Federal or State requirements, the carrier issuing the policy—

(i) except as provided in clause (ii), may not impose additional medical underwriting criteria in relation to benefits that are the same as the benefits under the previously issued policy and the premiums charged with respect to such benefits may not be greater than the premiums charged with respect to such benefits under the previously issued policy, but

(ii) may impose additional medical underwriting criteria in cases where the State insurance commissioner determines that the absence of such underwriting would result in adverse selection of insured risks.

(E) APPROVAL OF HIGHER PREMIUMS REQUIRED.—In the case of a carrier that intends to offer upgraded policies at premiums that are higher than the premiums charged for their existing policies, such carrier must have such higher premiums approved through the process specified in section 10164.

(F) CREDIT TOWARD NONFORFEITURE BENEFIT.—In the case that a policy is replaced with an upgraded policy, the upgraded policy shall provide for credit designed to assure retention of a policyholder's equity, according to a formula established by the Secretary, toward the nonforfeiture benefit for periods of coverage under the previous long-term care insurance policy issued by the same carrier.

(d) EFFECT OF INCAPACITATION.—

(1) IN GENERAL.—Except as provided in paragraph (2), a long-term care insurance policy may not be canceled for nonpayment if the policy holder is determined by a long-term care provider, physician or other health care provider, independent of the carrier issuing the policy, to be cognitively, mentally, or physically incapacitated.

(2) PERMITTED CANCELLATION.—A long-term care insurance policy may be canceled under paragraph (1) for nonpayment if—

(A) the period of such nonpayment is in excess of 30 days; and

(B) notice of intent to cancel (and right of reinstatement under paragraph (3)) is received by all designated representatives of the policyholder after the expiration of the period specified in subparagraph (A) and not less than 30 days prior to such cancellation.

(3) REINSTATEMENT.—If a long-term care insurance policy is canceled for nonpayment under this subsection, the policy may be reinstated without any loss in the policyholder's equity for purposes of a nonforfeiture benefit if the policyholder pays all premiums owing within a period (specified in the standards and of not less than 6 months) after the date of the cancellation.

Subpart B—Sales Practices

SEC. 10131. CERTIFICATION OF TRAINING OF SALES AGENTS.

A person may not sell or offer for sale a long-term care insurance policy unless the person has been certified under the State regulatory program or by the Secretary as having received training (in accordance with section 10106) with respect to such policies in accordance with the Standards.

SEC. 10132. DUTY OF GOOD FAITH AND FAIR DEALING.

(a) IN GENERAL.—Each person who is selling or offering for sale a long-term care insurance policy has the duty of good faith and fair dealing to the purchaser or potential purchaser of such a policy.

(b) PROHIBITED PRACTICES.—A person is considered to have violated subsection (a) if the person engages in any of the following practices:

(1) TWISTING.—Knowingly making any misleading representation or incomplete or fraudulent comparison of any long-term care insurance policy or carrier for the purpose of inducing, or tending to induce, any person to retain or effect a change with respect to a long-term care insurance policy.

(2) HIGH PRESSURE TACTICS.—Employing any method of marketing having the effect of, or intending to, induce the purchase of long-term care insurance policy through undue pressure.

(3) COLD LEAD ADVERTISING.—Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing

is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

(4) OTHERS.—Engaging in such other practices determined inappropriate under standards established by the Secretary.

(c) PROHIBITION OF COMPLETION OF MEDICAL HISTORIES.—A person who is selling or offering for sale a long-term care insurance policy may not complete the medical history portion of an application for any other individual (other than a relative of the person).

SEC. 10133. FINANCIAL GUIDELINES.

(a) DEVELOPMENT.—The Secretary, by July 1, 1995, shall develop recommended minimum financial guidelines (including both income and asset criteria) that an individual should meet before purchasing a long-term care insurance policy.

(b) CONSTRUCTION.—Nothing in such guidelines shall permit a person who is selling or offering for sale a long-term care insurance policy to compel a potential purchaser of such a policy (directly or indirectly) to provide financial information as a condition of purchasing such a policy.

SEC. 10134. PROHIBITION OF SALE OR ISSUANCE TO MEDICAID BENEFICIARIES.

A person may not knowingly sell or issue a long-term care insurance policy to an individual who is eligible for medical assistance (other than only as a qualified medicare beneficiary) under title XIX of the Social Security Act.

SEC. 10135. PROHIBITION OF SALE OR ISSUANCE OF DUPLICATE POLICIES.

A person may not sell or issue a long-term care insurance policy—

(1) knowing that the policy provides for coverage that duplicates coverage already provided in another long-term care insurance policy (unless the policy is intended to replace such other policy), or

(2) for the benefit of an individual unless the individual (or a representative of the individual) provides a written statement to the effect that the coverage under the new policy—

(A) does not duplicate other coverage in effect under a long-term care insurance policy,

(B) will replace another long-term care insurance policy, or

(C) is fully payable without regard to other long-term care services which may be provided to the individual.

SEC. 10136. PROVISION OF OUTLINE OF COVERAGE AND OTHER INFORMATION.

(a) OUTLINE OF COVERAGE.—A person may not sell or offer for a sale a long-term care insurance policy for the benefit of an individual without providing to the purchaser or potential purchaser (or representative), before such purchase, with—

(1) a copy of the guidelines developed under section 10133 and an explanation of such guidelines;

(2) an outline of coverage that includes the information required under subsection (b); and

(3) information (specified under the Standards) describing—

(A) the right of individuals to turn down the policy in 30 days, and

(B) the right of individuals to cancel a policy, and receive a refund on premiums paid, within 30 days after the date the policy is issued.

In applying this subsection in the case of a group long-term care insurance policy, the carrier issuing the policy is responsible for the provision of the outline and information to each certificate holder before the policy takes effect with respect to that certificate holder.

(b) CONTENTS OF OUTLINE OF COVERAGE.—The outline of coverage for each long-term care insurance policy shall be in a uniform format, utilizing simple, easily understood English, as prescribed in

guidelines issued by the Secretary. Each outline shall include (in accordance with the Standards) at least the following:

(1) A description of the principal benefits and coverage under the policy, how such benefits and coverage compare to the range of potential benefits and coverage available under such policies, and the eligibility criteria (if any) for such benefits.

(2) A statement of the principal exclusions, reductions, and limitations contained in the policy.

(3) A statement of the terms under which the policy (or certificate in the case of a group policy) may be continued in force or discontinued, the terms for continuation or conversion, and any reservation in the policy of a right to change premiums.

(4) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy (or master policy) contains the contractual provisions that govern.

(5) A description of the terms, specified in section 10140, under which a policy may be returned and the premium refunded.

(6) Information developed by the Secretary on national average nursing home lengths of stay and percentage of the population that requires nursing facility or home care services, broken down by age groups.

(7) Information on average costs (and variation in such costs) for nursing facility care (and such other care as the Secretary may specify) in the United States, information on the value of benefits relative to such costs, and a statement that this national average varies by geographic region.

(8) A comparison of benefits, over a period of at least 20 years, for policies with and without inflation protection.

(9) A declaration as to whether the amount of benefits will increase over time, and, if so, a statement of the type and amount of, any limitations on, and any premium increases for, such benefit increases.

For purposes of carrying out paragraph (7), the Secretary shall publish annually the national average costs of nursing facility care, home health care services, and other long-term care services as may be deemed appropriate by the Secretary.

(c) CERTIFICATES.—A certificate issued pursuant to a group long-term care insurance policy shall include—

(1) a description of the principal benefits and coverage provided in the policy;

(2) a statement of the principal exclusions, reductions, and limitations contained in the policy; and

(3) a statement that the group master policy determines governing contractual provisions.

(d) LONG-TERM CARE AS PART OF LIFE INSURANCE.—In the case of a long-term care insurance policy issued as a part of or a rider on a life insurance policy, at the time of policy delivery there shall be provided a policy summary that includes—

(1) an explanation of how the long-term care benefits interact with other components of the policy (including deductions from death benefits);

(2) an illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits (if any) for each covered person;

(3) principal exclusions, reductions, and limitations on benefits of long-term care; and

(4) a description of the tax consequences of redeeming the life insurance policy to pay for long-term care.

SEC. 10137. INFORMATION ON FINANCIAL ARRANGEMENTS WITH GROUPS.

A person may not sell or offer for sale a long-term care insurance policy with respect to a member of an organization with which the person (or the carrier issuing the policy) has a financial ar-

rangement of any type unless the person discloses (in accordance with the Standards) the nature of the financial arrangement.

Subpart C—Carrier Standards

SEC. 10141. REFUND OF PREMIUMS (FREE LOOK).

If an application for a long-term care insurance policy (or for a certificate under a group long-term care insurance policy) is denied or an applicant returns a policy or certificate within 30 days of the date of its issuance, the carrier shall refund directly to the applicant, not later than 30 days after the date of the denial or return, any premiums paid with respect to such a policy.

SEC. 10142. MAILING OF POLICY.

If an application for a long-term care insurance policy (or for a certificate under a group long-term care insurance policy) is approved, the carrier shall transmit to the applicant the policy of insurance not later than 30 days after the date of the approval.

SEC. 10143. PROMPT PAYMENT.

A carrier issuing a long-term care insurance policy shall make payment promptly to satisfy claims filed under such policy.

SEC. 10144. CLAIMS DENIALS.

(a) INFORMATION ON DENIALS OF CLAIMS.—If a claim under a long-term care insurance policy is denied or results in less than full payment, the carrier shall, within 30 days of the date of the denial or partial payment—

(1) provide to the person submitting the claim, and to the persons (if any) designated under section 10129, a written explanation of the reasons for the denial or partial payment;

(2) make available to such person all information directly relating to such denial or partial payment; and

(3) inform the individual of the process established under paragraph (3) for the appeal of the claim denial.

(b) LIMITATION ON BASIS FOR DENIAL.—

(1) FAILURE TO DISCLOSE INFORMATION.—No claim under such a policy may be denied on the basis of a failure to disclose information at the time of delivery (and issuance for delivery) of the policy if the application for the policy failed to request such information.

(2) TIMELY RESOLUTION OF INSURABILITY QUESTIONS.—Before issuing a long-term care insurance policy or certificate with respect to coverage of an individual, the carrier shall resolve all reasonable questions relating to the insurability of the individual (including, if the carrier underwrites such coverage, the completion of such underwriting).

(3) TREATMENT OF INDIVIDUALS 75 YEARS OF AGE OR OLDER.—In the case of a policyholder who was 75 years of age or older at the time of delivery (and issuance for delivery) of a long-term care insurance policy, no claim under such a policy may be denied on the basis of a failure to disclose information at the time of delivery (and issuance for delivery) of the policy if the policyholder truthfully disclosed documentation obtained under section 10147.

(c) APPEALS PROCESS.—A policyholder whose policy has been rescinded, canceled, or nonrenewed, or whose claim has been fully or partly denied, or whose claim has not been acted upon with reasonable promptness shall have the right to a review of such rescission, cancellation, nonrenewal, or denial under a process specified in the Standards and shall be granted an opportunity for a fair hearing by the carrier in any case where the amount in controversy is at least $500. The Standards may provide for an appeal to the State commissioner of insurance in an appropriate State.

SEC. 10145. LIMITATION ON RESCISSION, CANCELLATION, OR NONRENEWAL OR DENIAL OF CLAIMS.

(a) IN GENERAL.—A carrier may rescind, cancel, or nonrenew a long-term care insurance policy or certificate, or deny an other-

wise valid claim under such policy, only in accordance with this section.

(b) NONPAYMENT OF PREMIUMS.—A carrier may rescind, cancel, or nonrenew a long-term care insurance policy or certificate for nonpayment of premiums, except as provided in section 10130(d).

(c) FRAUD OR MISREPRESENTATION RELATING TO INSURABILITY.—A carrier may rescind, cancel, or nonrenew a long-term care insurance policy or certificate, or deny an otherwise valid claim under such policy based upon fraud or misrepresentation of facts relating to the insurability of the individual, only—

(1) based upon clear and convincing evidence—

(A) of fraud or misrepresentation of information material to the acceptance for coverage, and

(B) involve a chronic condition or dates of treatment before the date of the policy application; and

(2) if the carrier notifies the policyholder of the carrier's intention to rescind, terminate, or nonrenew the policy or deny the claim not later than—

(A) 60 days after the date the carrier discovers the fraud or misrepresentation; or

(B) 6 months (or 2 years in the case of clear and convincing evidence that the fraud or misrepresentation pertains to the condition for which benefits are sought) after the date of issuance of the policy,

whichever is earlier.

(d) FRAUD OR MISREPRESENTATION RELATING TO A GROUP POLICY.—In the case of a policyholder or certificate holder who is insured as part of a group, within 2 years after the date of issuance of the policy or certificate, a carrier may rescind, cancel, or nonrenew the policy or certificate, or deny an otherwise valid claim under such policy, based upon fraud or misrepresentation of facts relating to that individual's status as a member of the group or other relationship to that group at the time of initial coverage of that individual under the policy or certificate.

SEC. 10146. REPORTING OF INFORMATION; ACCESS TO INFORMATION.

(a) REPORTING OF INFORMATION.—Each carrier issuing a long-term care insurance policy shall periodically (not less often than annually) report to the State commissioner of insurance of each State in which the policy is sold, and shall make available to the Secretary, upon request, information respecting the following:

(1) The long-term care insurance policies of the carrier that are in force.

(2) Utilization of benefits and payment of claims under the policy.

(3) The ages of individuals purchasing the policy.

(4) Advertising and other marketing material utilized in connection with the sale of such policies, including a copy of each such item.

(5) Total premiums written and premiums earned in the previous year.

(6) The most recent premiums for such policies and the premiums imposed for such policies during the previous 5-year period.

(7) The lapse rates, replacement rates, and rescission rates for policies (by agent). For purposes of this paragraph, there shall not be included as a lapse of policy such a lapse due to the death of the policyholder.

(8) The claims denied (as a percentage of claims submitted) for such policies. For purposes of this paragraph, there shall not be included as a denied claim such a claim that is denied solely because of the failure to meet a deductible, waiting period, or exclusionary period.

(9) Complaints received with respect to such policies, and the resolution of such complaints.

(10) The rate of appeal of denied claims (as a percentage of claims denied) for such policies.

(11) The rate of reversal of denied claims on appeal (as a percentage of claim denials appealed) for such policies.

(12) Such other information as is specified in the Standards.

Information under this subsection shall be reported in a format specified in the Standards.

(b) ACCESS TO INFORMATION.—Each such carrier shall make available to the Secretary and the State commissioner of insurance of each State in which the policy is sold such additional information as the Secretary or Commissioner, may request.

(c) AVAILABILITY OF INFORMATION.—The State commissioner of insurance of each State shall make information under this section available, upon request, to the NAIC and, to the extent consistent with other laws, to other interested parties.

SEC. 10147. MEDICAL DOCUMENTATION FOR THE ELDERLY.

Each carrier issuing a long-term care insurance policy shall, with respect to an applicant who is 75 years of age or older, obtain one of the following before issuing the policy:

(1) A report of a contemporaneous physical examination.

(2) A contemporaneous assessment of functional capacity.

(3) Copies of contemporaneous medical records.

The carrier shall maintain the information obtained in its files.

SEC. 10148. LIMITS ON COMPENSATION FOR SALE OF POLICIES.

(a) IN GENERAL.—A carrier issuing a long-term care insurance policy may not provide a commission or other compensation to an agent or other representative for the sale of such a policy in an amount that exceeds a percentage of the commission or other compensation paid for selling or servicing such a policy in the second or subsequent year specified in the Standards.

(b) COMPENSATION DEFINED.—In subsection (a), the term "compensation" includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of the policy or certification, including deferred compensation, bonuses, gifts, prizes, awards, and finders fees.

PART 3—ENFORCEMENT OF STANDARDS

Subpart A—General Provisions

SEC. 10151. SECRETARIAL ENFORCEMENT AUTHORITY.

(a) IN GENERAL.—The Secretary shall exercise authority under this section—

(1) in the case of a State which does not an approved regulatory program;

(2) in the case of a State which has an approved regulatory State, to the extent specified by the Secretary (under a look-behind program), to determine whether or not individual long-term health care policies in the State have failed to comply with the applicable Standards required under part 2 and whether persons or entities are otherwise in compliance with the requirements of such part;

(3) in imposing sanctions under this subpart against any person who sells, offers for sale, or issues a long-term care insurance policy in violation of the Standards required under subpart B of part 2; and

(4) in imposing sanctions under this subpart against a carrier that violates the Standards required under subpart C of part 2.

(b) PLAN DISAPPROVED UNDER LOOK-BEHIND AUTHORITY.—If the Secretary determines under this subpart that a long-term care insurance policy does not meet the applicable requirements of part 2 on or after the date specified in section 10103, regardless of whether or not the State has taken any action with respect to such noncompliance, no new policies may be offered under the plan on or after the date of the determination.

(c) LOSS OF STATUS AS A LONG-TERM CARE PLAN.—If an association or its subsidiary or a carrier is determined under this section not to be in compliance with applicable Standards under part 2 and is not determined to have come into compliance with such applicable Standards at the end of the 6-month period beginning on the date of the initial determination of such noncompliance, any long-term care insurance policy issued, sold, or offered for sale by such association or its subsidiary or carrier shall be considered to be issued, sold, or offered for sale in violation of section 10101(a).

SEC. 10152. COMPLAINTS AND INVESTIGATIONS.

(a) IN GENERAL.—The Secretary shall establish procedures—

(1) for individuals and entities to file written, signed complaints respecting alleged violations of the Standards required under part 2,

(2) for responding on a timely basis to such complaints, and

(3) for the investigation of—

(A) those complaints which, on their face, have a substantial probability of validity, and

(B) such other alleged violations of the requirements of part 2 as the Secretary determines to be appropriate.

(b) CONDUCT OF INVESTIGATIONS.—In conducting investigations under this section, agents of the Secretary shall have reasonable access to examine evidence of any person or entity being investigated.

(c) TREATMENT OF CARRIER VIOLATIONS.—For purposes of this subpart, a carrier whose policy was sold, offered for sale, or issued by an agent in violation of the Standards under subpart B of part 2 and who had any reason to know of such violation but did not act immediately to correct such violation in good faith, shall be deemed to have violated the Standards of such subpart.

SEC. 10153. HEARINGS.

(a) IN GENERAL.—Before imposing an order described in section 10154 against a person or entity under this section for a violation of the Standards under part 2, the Secretary shall provide the person or entity with notice and, upon request made within a reasonable time (of not less than 30 days, as established by the Secretary) of the date of the notice, a hearing respecting the violation. If no hearing is so requested, the Secretary shall impose a final and unappealable order.

(b) CONDUCT OF HEARING.—Any hearing so requested shall be conducted before an administrative law judge under section 201 of the Social Security Act. If no hearing is so requested, the Secretary's imposition of the order shall constitute a final and unappealable order.

(c) AUTHORITY IN HEARINGS.—

(1) IN GENERAL.—In conducting hearings under this section—

(A) agents of the Secretary and administrative law judges shall have reasonable access to examine evidence of any person or entity being investigated, and

(B) administrative law judges, may, if necessary, compel by subpoena the attendance of witnesses and the production of evidence at any designated place or hearing.

(2) ENFORCEMENT OF SUBPOENAS.—In case of contumacy or refusal to obey a subpoena lawfully issued under this subsection and upon application of the Secretary, an appropriate district court of the United States may issue an order requiring compliance with such subpoena and any failure to obey such order may be punished by such court as a contempt thereof.

(d) ISSUANCE OF ORDERS.—If the administrative law judge determines, upon the preponderance of the evidence received, that a person or entity named in the complaint has violated the Standards required under part 2, the administrative law judge shall state the findings of fact and issue and cause to be served on such person or entity an order described in section 10154. Any order is-

sued under such section shall be provided to the agent, association or its subsidiary, or carrier and include the findings and the basis of the order.

SEC. 10154. CEASE AND DESIST ORDER WITH CIVIL MONEY PENALTY.

(a) CEASE AND DESIST ORDER.—

(1) IN GENERAL.—Subject to the succeeding provisions of this section, the order under this section—

(A) shall require the person or entity—

(i) to cease and desist from such violations, and

(ii) to pay a civil penalty in an amount not to exceed $25,000 (or $15,000 in the case of a violation by an agent) for each such violation; and

(B) may require the person or entity to take such other remedial action as is appropriate.

(2) AMOUNT OF CIVIL PENALTY.—The amount of a civil penalty under paragraph (1)(A)(ii) may take into account the penalties imposed by a State with respect to the same such violation.

(3) PROCEDURES FOR CIVIL PENALTY.—The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(b) CRIMINAL PENALTY FOR MULTIPLE AGENT VIOLATIONS.— In the case of an agent who has committed multiple violations of the Standards required under subpart B of part 2, such agent also may be imprisoned not more than 5 years, or fined in accordance with title 18, United States Code, or both.

(c) CORRECTIONS WITHIN 30 DAYS.—No order shall be imposed under this section by reason of any violation if the person or entity establishes to the satisfaction of the Secretary by clear and convincing evidence that—

(1) such violation was due to reasonable cause and was not intentional and was not due to willful neglect, and

(2) such violation is corrected within the 30-day period beginning on the earliest date the person or entity knew, or exercising reasonable diligence could have known, that such a violation was occurring.

(d) WAIVER BY SECRETARY.—In the case of a violation which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the civil money penalty imposed by subsection (a)(1)(A)(ii) to the extent that payment of such penalty would be grossly excessive relative to the violation involved and to the need for deterrence of violations.

(e) REVIEW BY THE SECRETARY.—The decision and order of an administrative law judge under this section shall become the final agency decision and order of the Secretary unless, within 30 days, the Secretary modifies or vacates the decision and order, in which case the decision and order of the Secretary shall become a final order under this section.

(f) JUDICIAL REVIEW.—A person or entity adversely affected by a final order issued under this section may, within 45 days after the date the final order is issued, file a petition in the Court of Appeals for the appropriate circuit for review of the order.

(g) ENFORCEMENT OF ORDERS.—If a person or entity fails to comply with a final order issued under this section against the person or entity after opportunity for judicial review under subsection (f), the Secretary shall file a suit to seek compliance with the order in any appropriate district court of the United States. In any such suit, the validity and appropriateness of the final order shall not be subject to review.

Subpart B—Standards for Approval of State Regulatory Programs

SEC. 10161. GENERAL REQUIREMENT.

(a) IN GENERAL.—The Secretary may not approve a State regulatory program for purposes of this subtitle, unless the Secretary determines that the program—

(1) provides for the application and enforcement of the Standards; and

(2) complies with the requirements of—

(A) section 10162 (relating to enforcement),

(B) section 10163 (relating to publication and public access to compliance information),

(C) section 10164 (relating to a process for the approval of premiums), and

(D) section 10165 (relating to annual reports).

(b) PERIODIC REVIEW OF STATE REGULATORY PROGRAMS.—The Secretary periodically shall review State regulatory programs to determine if they continue to meet the requirements for approval under subsection (a). If the Secretary determines that a State regulatory program no longer meets such standards and requirements or is no longer in compliance, before making a final determination that a State regulatory program no longer meets such requirements, the Secretary shall provide the State a hearing and an opportunity of 6 months (or, in the case in which State legislation is required in order for the State to be in compliance with such standards and requirements, such longer period as is necessary to enact such legislation) to adopt such a plan of correction as would permit the program to continue to meet such standards and requirements. If the Secretary makes a final determination that the State regulatory program, after such a hearing and opportunity, fails to meet such requirements, the Secretary shall assume responsibility under section 10101(b) with respect to certifying long-term care insurance policies in the State and shall exercise full authority under subpart A for persons and entities in the State.

SEC. 10162. ENFORCEMENT.

(a) IN GENERAL.—The enforcement process under each State regulatory program—

(1) shall be designed in a manner so as to secure compliance with the Standards within 30 days after the date of a finding of noncompliance with such Standards, and

(2) shall provide for notice to the Secretary in cases where such compliance is not secured within such 30-day period.

(b) PROCESS.—The enforcement process under each State regulatory program shall provide for—

(1) procedures for individuals and entities to file written, signed complaints respecting alleged violations of the Standards;

(2) responding on a timely basis to such complaints;

(3) the investigation of—

(A) those complaints which, on their face, have a substantial probability of validity, and

(B) such other alleged violations of the Standards as the program finds appropriate;

(4) notice and opportunity for a hearing before executing sanctions;

(5) the imposition of appropriate sanctions (which include, in appropriate cases, the imposition of a civil money penalty) in the case of a person or entity determined to have violated the Standards; and

(6) an annual report to the Secretary on details concerning complaints filed under the process, including the disposition of, and actions resulting from, such complaints.

SEC. 10163. PUBLICATION AND PUBLIC ACCESS TO COMPLIANCE INFORMATION.

(a) PUBLICATION OF INFORMATION.—Each State regulatory program shall publish annually a summary—

(1) by carrier, of (A) the types of long-term health care policies issued and (B) the types of complaints filed concerning such policies, and

(2) of the information reported by policy under section 10146.

(b) ACCESS TO INFORMATION ON COMPLAINTS.—

(1) IN GENERAL.—Each State regulatory program shall provide for consumer access to complaints filed with the State commissioner of insurance with respect to long-term care insurance policies. Any such disclosure of complaint information shall be accompanied by a general disclaimer stating that no representations are being made as to the merits of such a complaint.

(2) CONFIDENTIALITY.—The access provided under paragraph (1) shall be limited to the extent required to protect the confidentiality of the identity of individual policyholders.

SEC. 10164. PROCESS FOR APPROVAL OF PREMIUMS.

(a) IN GENERAL.—Each State regulatory program shall—

(1) provide for a process for approving or disapproving proposed premium increases with respect to long-term care insurance policies, and

(2) establish a policy for receipt and consideration of public comments before approving such a premium increase.

(b) CONDITIONS FOR APPROVAL.—No such premium increase shall be approved (or deemed approved) unless the proposed increase is accompanied by an actuarial memorandum which—

(1) includes a description of the assumptions which justify the increase,

(2) fully supports the increase,

(3) contains such information as may be required under the Standards, and

(4) is made available to the public.

(c) SECRETARIAL AUTHORITY.—In the case of a State without an approved regulatory program, the Secretary shall provide for the activities described in subsections (a) and (b).

SEC. 10165. ANNUAL REPORTS.

Each State regulatory program shall provide for annual reports to the Secretary on the implementation and enforcement of the Standards in the State.

SEC. 10166. INCREASE IN FUNDING FOR LONG-TERM CARE INSURANCE, INFORMATION, COUNSELING, AND ASSISTANCE THROUGH STATE REGULATORY PROGRAMS.

In addition to amounts otherwise authorized to be appropriated, there are authorized to be appropriated, under section 4360(f) of the Omnibus Budget Reconciliation Act of 1990, $10,000,000 for fiscal year 1997 and each subsequent fiscal year, to fund grant programs under such section for the purpose of providing information, counseling, and assistance relating to long-term care benefits under this subtitle and the procurement of adequate and appropriate long-term care insurance.

PART 4—MISCELLANEOUS PROVISIONS

SEC. 10171. REPORTS AND STUDIES.

(a) REPORT ON SOLVENCY PROTECTION.—Not later than 2 years after the date of the enactment of this title, the Secretary shall prepare and submit to the appropriate committees of Congress a report on standards that may be applied under this subtitle to assure the solvency of carriers with respect to long-term care insurance policies.

(b) STUDY OF STANDARD MEASURE OF VALUE FOR LONG-TERM CARE INSURANCE POLICIES.—The Secretary shall provide for the

conduct of a study to develop a standard measure of value for long-term care insurance policies. Not later than 2 years after the date of the enactment of this Act, the Secretary shall prepare and submit to the appropriate committees of Congress a report concerning such study.

(c) STUDY OF LONG-TERM CARE INSURANCE RIDERS.—The Secretary shall review the applicability of the Standards to long-term care insurance riders. Not later than 2 years after the date of the enactment of this Act, the Secretary shall prepare and submit to the appropriate committees of Congress a report concerning such study.

(d) STUDY OF COORDINATION WITH PUBLIC PROGRAMS.—The Secretary shall review the coordination of coverage under long-term care insurance policies with benefits for long-term care services under the medicare program, medicare part C, the medicaid program, the long-term care program for home and community-based services under subtitle A, and other public programs. Not later than 2 years after the date of the enactment of this Act, the Secretary shall prepare and submit to the appropriate committees of Congress a report concerning such study. The Secretary shall include in the report such recommendations concerning rules for such coordination as the Secretary deems appropriate.

SEC. 10172. WAIVER OF PAPERWORK REQUIREMENTS.

Chapter 35 of title 44, United States Code, and Executive Order 12291 shall not apply to information and regulations required for purposes of carrying out this subtitle.

Subtitle C—Worker Redeployment in Long-Term Care Programs

SEC. 10201. REQUIREMENT REGARDING REDEPLOYMENT OF HEALTH CARE WORKERS UNDER LONG-TERM CARE PROGRAM.

With respect to the plan required in section 10004(c) (for the long-term care program for home and community-based services under subtitle A), the plan shall, in addition to requirements under such subtitle, provide for the following:

(1) Prior to implementing the program under such plan, negotiations will be commenced with labor organizations representing the employees of the affected hospitals or other facilities providing such services.

(2) Negotiations under paragraph (1) will address the following:

(A) The impact of the implementation of the program upon the workforce.

(B) Methods to redeploy workers to positions in the proposed program or other public or private settings, in the case of workers affected by the program.

(3) The plan will provide evidence that there has been compliance with paragraphs (1) and (2).

TITLE XI—REVENUE PROVISIONS

TABLE OF CONTENTS OF TITLE

SEC. 11001. AMENDMENT OF 1986 CODE.

Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

Subtitle A—Increase In Excise Taxes On Tobacco Products

SEC. 11101. INCREASE IN EXCISE TAXES ON TOBACCO PRODUCTS.

(a) CIGARETTES.—Subsection (b) of section 5701 is amended by striking paragraph (1) and all that follows and inserting the following:

"(1) SMALL CIGARETTES.—On cigarettes, weighing not more than 3 pounds per thousand, the amount per thousand determined under the following table:

"In the case of cigarettes removed—	The tax per thousand is—
After July 31, 1995, and before January 1, 1997	$19.50
During 1997	$24.50
During 1998	$29.50
After December 31, 1998	$34.50

"(2) LARGE CIGARETTES.—On cigarettes, weighing more than 3 pounds per thousand, removed at any time, an amount per thousand equal to 2.1 times the tax per thousand imposed by paragraph (1) on cigarettes removed at such time; except that, if more than 6½ inches in length, they shall be taxable at the rate prescribed for cigarettes weighing not more than 3 pounds per thousand, counting each 2¾ inches, or fraction thereof, of the length of each as one cigarette."

(b) CIGARS.—Paragraphs (1) and (2) of section 5701(a) are amended to read as follows:

"(1) SMALL CIGARS.—On cigars, weighing not more than 3 pounds per thousand, the amount per thousand determined under the following table:

"In the case of cigars removed—	The tax per thousand is—
After July 31, 1995, and before January 1, 1997	$1.83
During 1997	$2.30
During 1998	$2.77
After December 31, 1998	$3.23

"(2) LARGE CIGARS.—On cigars, weighing more than 3 pounds per thousand, the applicable percentage (determined under the following table) of the price for which sold but not more than the applicable limitation (determined under such table) per thousand:

In the case of cigars removed—	The applicable percentage is—	The limitation is—
After July 31, 1995 and before January 1, 1997	21 percent	$48.75
During 1997	26 percent	$61.26
During 1998	31 percent	$73.74
After December 31, 1998	37 percent	$86.25."

(c) CIGARETTE PAPERS.—Subsection (c) of section 5701 is amended—

(1) by striking "0.75 cent (0.625 cent on cigarette papers removed during 1991 or 1992)" and inserting "the amount determined in accordance with the following table", and

(2) by adding at the end the following:

"In the case of cigarette papers removed—	The tax for each 50 papers is—
After July 31, 1995 and before January 1, 1997	1.22 cents
During 1997	1.53 cents
During 1998	1.84 cents
After December 31, 1998	2.16 cents."

(d) CIGARETTE TUBES.—Subsection (d) of section 5701 is amended—

(1) by striking "1.5 cents (1.25 cents on cigarette tubes removed during 1991 or 1992)" and inserting "the amount determined in accordance with the following table", and

(2) by adding at the end the following:

"In the case of cigarette tubes removed—	The tax for each 50 tubes is—
After July 31, 1995 and before January 1, 1997	2.44 cents
During 1997	3.06 cents
During 1998	3.69 cents
After December 31, 1998	4.31 cents."

(e) SNUFF.—Paragraph (1) of section 5701(e) is amended—

(1) by striking "36 cents (30 cents on snuff removed during 1991 or 1992)" and inserting "the amount determined in accordance with the following table", and

(2) by adding at the end the following:

"In the case of snuff removed—	The tax per pound is—
After July 31, 1995 and before January 1, 1997	58.5 cents
During 1997	73.5 cents
During 1998	88.5 cents
After December 31, 1998	$1.03½."

(f) CHEWING TOBACCO.—Paragraph (2) of section 5701(e) is amended—

(1) by striking "12 cents (10 cents on chewing tobacco removed during 1991 or 1992)" and inserting "the amount determined in accordance with the following table", and

(2) by adding at the end the following:

"In the case of chewing tobacco removed—	The tax per pound is—
After July 31, 1995 and before January 1, 1997	19.5 cents
During 1997	24.5 cents
During 1998	29.5 cents
After December 31, 1998	34.5 cents."

(g) PIPE TOBACCO.—Subsection (f) of section 5701 is amended—

(1) by striking "67.5 cents (56.25 cents on pipe tobacco removed during 1991 or 1992)" and inserting "the amount determined in accordance with the following table", and

(2) by adding at the end the following:

"In the case of pipe tobacco removed—	The tax per pound is—
After July 31, 1995 and before January 1, 1997	$1.10
During 1997	$1.38
During 1998	$1.66
After December 31, 1998	$1.94."

(h) APPLICATION OF TAX INCREASE TO PUERTO RICO.—Section 5701 is amended by adding at the end the following new subsection:

"(h) APPLICATION OF TAXES TO PUERTO RICO.—Notwithstanding subsections (b) and (c) of section 7653 and any other provision of law—

"(1) IN GENERAL.—On tobacco products and cigarette papers and tubes, manufactured in or imported into the Commonwealth of Puerto Rico, there is hereby imposed a tax at the rate equal to the excess of—

"(A) the rate of tax applicable under this section to like articles manufactured in the United States, over

"(B) the rate referred to in subparagraph (A) as in effect on the day before the date of the enactment of the Guaranteed Health Insurance Act of 1994.

"(2) SHIPMENTS TO PUERTO RICO FROM THE UNITED STATES.—Only the rates of tax in effect on the day before the date of the enactment of the Guaranteed Health Insurance Act of 1994 shall be taken into account in determining the amount

of any exemption from, or credit or drawback of, any tax imposed by this section on any article shipped to the Commonwealth of Puerto Rico from the United States.

"(3) SHIPMENTS FROM PUERTO RICO TO THE UNITED STATES.—The rates of tax taken into account under section 7652(a) with respect to tobacco products and cigarette papers and tubes coming into the United States from the Commonwealth of Puerto Rico shall be the rates of tax in effect on the day before the date of the enactment of the Guaranteed Health Insurance Act of 1994.

"(4) REGULATIONS.—To the extent provided in regulations prescribed by the Secretary, references in this chapter (other than this section) to the United States shall be treating as including references to the Commonwealth of Puerto Rico to the extent appropriate to carry out the purposes of this subsection.

"(5) DISPOSITION OF REVENUES.—The provisions of section 7652(a)(3) shall not apply to any tax imposed by reason of this subsection."

(i) EFFECTIVE DATE.—The amendments made by this section shall apply to articles removed (as defined in section 5702(k) of the Internal Revenue Code of 1986, as amended by this Act) after July 31, 1995.

(j) FLOOR STOCKS TAXES.—

(1) IMPOSITION OF TAX.—On tobacco products and cigarette papers and tubes manufactured in or imported into the United States or the Commonwealth of Puerto Rico which are removed before any tax-increase date and held on such date for sale by any person, there is hereby imposed a tax in an amount equal to the excess of—

(A) the tax which would be imposed under section 5701 of the Internal Revenue Code of 1986 on the article if the article had been removed on such date, over

(B) the prior tax (if any) imposed under section 5701 or 7652 of such Code on such article.

(2) AUTHORITY TO EXEMPT CIGARETTES HELD IN VENDING MACHINES.—To the extent provided in regulations prescribed by the Secretary, no tax shall be imposed by paragraph (1) on cigarettes held for retail sale on any tax-increase date, by any person in any vending machine. If the Secretary provides such a benefit with respect to any person, the Secretary may reduce the $500 amount in paragraph (3) with respect to such person.

(3) CREDIT AGAINST TAX.—Each person shall be allowed as a credit against the taxes imposed by paragraph (1) on each tax-increase date an amount equal to $500. Such credit shall not exceed the amount of taxes imposed by paragraph (1) on such date for which such person is liable.

(4) LIABILITY FOR TAX AND METHOD OF PAYMENT.—

(A) LIABILITY FOR TAX.—A person holding any article on any tax-increase date to which any tax imposed by paragraph (1) applies shall be liable for such tax.

(B) METHOD OF PAYMENT.—The tax imposed by paragraph (1) shall be paid in such manner as the Secretary shall prescribe by regulations.

(C) TIME FOR PAYMENT.—The tax imposed by paragraph (1) on any tax-increase date shall be paid on or before the date which is 3 months after such tax-increase date.

(5) ARTICLES IN FOREIGN TRADE ZONES.—Notwithstanding the Act of June 18, 1934 (48 Stat. 998, 19 U.S.C. 81a) and any other provision of law, any article which is located in a foreign trade zone on any tax-increase date shall be subject to the taxes imposed by paragraph (1) if—

(A) internal revenue taxes have been determined, or customs duties liquidated, with respect to such article before such date pursuant to a request made under the 1st proviso of section 3(a) of such Act, or

(B) such article is held on such date under the supervision of a customs officer pursuant to the 2d proviso of such section 3(a).

(6) DEFINITIONS.—For purposes of this subsection—

(A) TAX-INCREASE DATE.—The term "tax-increase date" means August 1, 1995, January 1, 1997, January 1, 1998, and January 1, 1999.

(B) OTHER DEFINITIONS.—Terms used in this subsection which are also used in section 5702 of the Internal Revenue Code of 1986 shall have the respective meanings such terms have in such section, as amended by this Act.

(C) SECRETARY.—The term "Secretary" means the Secretary of the Treasury or his delegate.

(7) CONTROLLED GROUPS.—Rules similar to the rules of section 5061(e)(3) of such Code shall apply for purposes of this subsection.

(8) OTHER LAWS APPLICABLE.—All provisions of law, including penalties, applicable with respect to the taxes imposed by section 5701 of such Code shall, insofar as applicable and not inconsistent with the provisions of this subsection, apply to the floor stocks taxes imposed by paragraph (1), to the same extent as if such taxes were imposed by such section 5701. The Secretary may treat any person who bore the ultimate burden of the tax imposed by paragraph (1) as the person to whom a credit or refund under such provisions may be allowed or made.

SEC. 11102. MODIFICATIONS OF CERTAIN TOBACCO TAX PROVISIONS.

(a) EXEMPTION FOR EXPORTED TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES TO APPLY ONLY TO ARTICLES MARKED FOR SHIPMENT FROM THE UNITED STATES.—

(1) Subsection (b) of section 5704 is amended by adding at the end the following new sentence: "Tobacco products and cigarette papers and tubes may not be transferred or removed under this subsection unless such products or papers and tubes bear such marks, labels, or notices as the Secretary shall by regulations prescribe."

(2) Section 5761 is amended by redesignating subsections (c) and (d) as subsections (d) and (e), respectively, and by inserting after subsection (b) the following new subsection:

"(c) SALE OF TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES FOR EXPORT.—Except as provided in subsections (b) and (d) of section 5704—

"(1) every person who sells, relands, or receives within the jurisdiction of the United States any tobacco products or cigarette papers or tubes which have been labeled or shipped for exportation under this chapter,

"(2) every person who sells or receives such relanded tobacco products or cigarette papers or tubes, and

"(3) every person who aids or abets in such selling, relanding, or receiving,

shall, in addition to the tax and any other penalty provided in this title, be liable for a penalty equal to the greater of $1,000 or 5 times the amount of the tax imposed by this chapter. All tobacco products and cigarette papers and tubes relanded within the jurisdiction of the United States, and all vessels, vehicles, and aircraft used in such relanding or in removing such products, papers, and tubes from the place where relanded, shall be forfeited to the United States."

(3) Subsection (a) of section 5761 is amended by striking "subsection (b)" and inserting "subsection (b) or (c)".

(4) Subsection (d) of section 5761, as redesignated by paragraph (2), is amended by striking "The penalty imposed by subsection (b)" and inserting "The penalties imposed by subsections (b) and (c)".

(5)(A) Subchapter F of chapter 52 is amended by adding at the end the following new section:

"SEC. 5754. RESTRICTION ON IMPORTATION OF PREVIOUSLY EXPORTED TOBACCO PRODUCTS.

"(a) IN GENERAL.—Tobacco products and cigarette papers and tubes previously exported from the United States may be imported or brought into the United States only as provided in section 5704(d). For purposes of this section, section 5704(d), section 5761, and such other provisions as the Secretary may specify by regulations, references to exportation shall be treated as including a reference to shipment to the Commonwealth of Puerto Rico.

"(b) CROSS REFERENCE.—

"For penalty for the sale of tobacco products and cigarette papers and tubes in the United States which are labeled for export, see section 5761(c)."

(B) The table of sections for subchapter F of chapter 52 is amended by adding at the end thereof the following new item:

"Sec. 5754. Restriction on importation of previously exported tobacco products."

(b) IMPORTERS REQUIRED TO BE QUALIFIED.—

(1) Sections 5712, 5713(a), 5721, 5722, 5762(a)(1), and 5763(b) and (c) are each amended by inserting "or importer" after "manufacturer".

(2) The heading of subsection (b) of section 5763 is amended by inserting "QUALIFIED IMPORTERS," after "MANUFACTURERS,".

(3) The heading for subchapter B of chapter 52 is amended by inserting "**and Importers**" after "**Manufacturers**".

(4) The item relating to subchapter B in the table of subchapters for chapter 52 is amended by inserting "and importers" after "manufacturers".

(c) REPEAL OF TAX-EXEMPT SALES TO EMPLOYEES OF CIGARETTE MANUFACTURERS.—

(1) Subsection (a) of section 5704 is amended—

(A) by striking "EMPLOYEE USE OR" in the heading, and

(B) by striking "for use or consumption by employees or" in the text.

(2) Subsection (e) of section 5723 is amended by striking "for use or consumption by their employees, or for experimental purposes" and inserting "for experimental purposes".

(d) REPEAL OF TAX-EXEMPT SALES TO UNITED STATES.—Subsection (b) of section 5704 is amended by striking "and manufacturers may similarly remove such articles for use of the United States;".

(e) BOOKS OF 25 OR FEWER CIGARETTE PAPERS SUBJECT TO TAX.—Subsection (c) of section 5701 is amended by striking "On each book or set of cigarette papers containing more than 25 papers," and inserting "On cigarette papers,".

(f) STORAGE OF TOBACCO PRODUCTS.—Subsection (k) of section 5702 is amended by inserting "under section 5704" after "internal revenue bond".

(g) AUTHORITY TO PRESCRIBE MINIMUM MANUFACTURING ACTIVITY REQUIREMENTS.—Section 5712 is amended by striking "or" at the end of paragraph (1), by redesignating paragraph (2) as paragraph (3), and by inserting after paragraph (1) the following new paragraph:

"(2) the activity proposed to be carried out at such premises does not meet such minimum capacity or activity requirements as the Secretary may prescribe; or".

(h) LIMITATION ON COVER OVER OF TAX ON TOBACCO PRODUCTS.—Section 7652 is amended by adding at the end thereof the following new subsection:

"(h) LIMITATION ON COVER OVER OF TAX ON TOBACCO PRODUCTS.—For purposes of this section, with respect to taxes imposed under section 5701 or this section on any tobacco product or cigarette paper or tube, the amount covered into the treasuries of Puerto Rico and the Virgin Islands shall not exceed the rate of tax

under section 5701 in effect on the article on the day before the date of the enactment of the Guaranteed Health Insurance Act of 1994."

(i) EFFECTIVE DATE.—The amendments made by this section shall apply to articles removed (as defined in section 5702(k) of the Internal Revenue Code of 1986, as amended by this Act) after July 31, 1995.

SEC. 11103. IMPOSITION OF EXCISE TAX ON MANUFACTURE OR IMPORTATION OF ROLL-YOUR-OWN TOBACCO.

(a) IN GENERAL.—Section 5701 (relating to rate of tax), as amended by section 11101, is amended by redesignating subsections (g) and (h) as subsections (h) and (i), respectively, and by inserting after subsection (f) the following new subsection:

"(g) ROLL-YOUR-OWN TOBACCO.—On roll-your-own tobacco, manufactured in or imported into the United States, there shall be imposed a tax of the amount determined in accordance with the following table per pound (and a proportionate tax at the like rate on all fractional parts of a pound).

"In the case of roll-your-own tobacco removed—	The tax per pound is—
After July 31, 1995 and before January 1, 1997	$1.10
During 1997	$1.38
During 1998	$1.66
After December 31, 1998	$1.94."

(b) ROLL-YOUR-OWN TOBACCO.—Section 5702 (relating to definitions) is amended by adding at the end the following new subsection:

"(p) ROLL-YOUR-OWN TOBACCO.—The term 'roll-your-own tobacco' means any tobacco which, because of its appearance, type, packaging, or labeling, is suitable for use and likely to be offered to, or purchased by, consumers as tobacco for making cigarettes."

(c) TECHNICAL AMENDMENTS.—

(1) Subsection (c) of section 5702 is amended by striking "and pipe tobacco" and inserting "pipe tobacco, and roll-your-own tobacco".

(2) Subsection (d) of section 5702 is amended—

(A) in the material preceding paragraph (1), by striking "or pipe tobacco" and inserting "pipe tobacco, or roll-your-own tobacco", and

(B) by striking paragraph (1) and inserting the following new paragraph:

"(1) a person who produces cigars, cigarettes, smokeless tobacco, pipe tobacco, or roll-your-own tobacco solely for his own personal consumption or use, and".

(3) The chapter heading for chapter 52 is amended to read as follows:

"CHAPTER 52—TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES".

(4) The table of chapters for subtitle E is amended by striking the item relating to chapter 52 and inserting the following new item:

"Chapter 52. Tobacco products and cigarette papers and tubes."

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to roll-your-own tobacco removed (as defined in section 5702(k) of the Internal Revenue Code of 1986, as amended by this Act) after July 31, 1995.

(2) TRANSITIONAL RULE.—Any person who—

(A) on the date of the enactment of this Act is engaged in business as a manufacturer of roll-your-own tobacco or as an importer of tobacco products or cigarette papers and tubes, and

(B) before August 1, 1995, submits an application under subchapter B of chapter 52 of such Code to engage in such business,

may, notwithstanding such subchapter B, continue to engage in such business pending final action on such application. Pending such final action, all provisions of such chapter 52 shall apply to such applicant in the same manner and to the same extent as if such applicant were a holder of a permit under such chapter 52 to engage in such business.

Subtitle B—Treatment of Employer-Provided Health Care

SEC. 11201. HEALTH BENEFITS MAY NOT BE PROVIDED UNDER CAFETERIA PLANS OR FLEXIBLE SPENDING ARRANGEMENTS OTHER THAN MEDICAL SAVINGS ACCOUNTS.

(a) CAFETERIA PLANS.—

(1) IN GENERAL.—Subsection (f) of section 125 (defining qualified benefits) is amended by adding at the end the following new sentence: "Such term shall not include any benefits or coverage under an accident or health plan."

(2) CONFORMING AMENDMENT.—Subsection (g) of section 125 is amended by striking paragraph (2) and redesignating paragraphs (3) and (4) as paragraphs (2) and (3), respectively.

(b) FLEXIBLE SPENDING ARRANGEMENTS.—The text of section 106 (relating to contributions by employer to accident and health plans) is amended to read as follows:

"(a) GENERAL RULE.—Except as provided in subsection (b), gross income of an employee does not include employer-provided coverage under an accident or health plan.

"(b) NO EXCLUSION FOR COVERAGE PROVIDED UNDER FLEXIBLE SPENDING ARRANGEMENTS.—

"(1) IN GENERAL.—Subsection (a) shall not apply to coverage provided through a flexible spending or similar arrangement.

"(2) FLEXIBLE SPENDING ARRANGEMENT.—For purposes of this subsection, a flexible spending arrangement is a benefit program which provides employees with coverage under which—

"(A) specified incurred expenses may be reimbursed (subject to reimbursement maximums and other reasonable conditions), and

"(B) the maximum amount of reimbursement which is reasonably available to a participant for such coverage is less than 500 percent of the cost of such coverage.

In the case of an insured plan, the maximum amount reasonably available shall be determined on the basis of the underlying coverage.

"(c) CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

"(1) IN GENERAL.—Notwithstanding subsection (b), gross income of an eligible employee does not include amounts contributed by an employer to any medical savings account of such employee to the extent such contributions are required to be made to such account by such employer under section 1104(d)(2)(C) of the Guaranteed Health Insurance Act of 1994. For purposes of the preceding sentence, the terms 'eligible employee' and 'medical savings account' have the respective meanings given such terms by section 7705.

"(2) NO CONSTRUCTIVE RECEIPT.—No amount shall be included in the gross income of any employee solely because the employee may choose between the contributions referred to in paragraph (1) and employer contributions to another health plan of the employer."

(c) MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Chapter 79 is amended by adding at the end the following new section:

"SEC. 7705. MEDICAL SAVINGS ACCOUNTS.

"(a) GENERAL RULE.—For purposes of this title, the term 'medical savings account' means a trust created or organized in the United States for the exclusive benefit of an individual or his beneficiaries, but only if the written instrument creating the trust meets the following requirements:

"(1) Except in the case of a rollover contribution described in subsection (d)(3), no contribution will be accepted unless—

"(A) it is in cash, and

"(B) such individual is an eligible employee for the period for which such contribution is made.

"(2) The trustee is a bank (as defined in section 408(n)), insurance company (as defined in section 816), or such other person who demonstrates to the satisfaction of the Secretary that the manner in which such other person will administer the trust will be consistent with the requirements of this section.

"(3) No part of the trust funds will be invested in life insurance contracts.

"(4) The interest of an individual in the balance of the account is nonforfeitable.

"(5) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

"(b) ELIGIBLE EMPLOYEE.—For purposes of this section—

"(1) IN GENERAL.—The term 'eligible employee' means any employee who is covered under a high deductible plan (as defined in section 5504(5) of the Guaranteed Health Insurance Act of 1994) of his employer.

"(2) EXCEPTION.—An employee shall be treated as not being an eligible employee for any calendar year if—

"(A) for any month during such year, it is reasonably expected that such employee will be eligible for subsidies under part A of title XXII of the Social Security Act, or

"(B) it is reasonably expected that, if the employee were a medicare part C covered individual for any month during such year, the amount of tax imposed by section 59B (if any) on such employee would be determined under section 59B(b).

"(c) TAX TREATMENT OF ACCOUNTS.—

"(1) ACCOUNT TAXED AS GRANTOR TRUST.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the account beneficiary of a medical savings account shall be treated for purposes of this title as the owner of such account and shall be subject to tax thereon in accordance with subpart E of part I of subchapter J of this chapter (relating to grantors and others treated as substantial owners).

"(B) TREATMENT OF CAPITAL LOSSES.—With respect to assets held in a medical savings account, any capital loss for a taxable year from the sale or exchange of such an asset shall be allowed only to the extent of capital gains from such assets for such taxable year. Any capital loss which is disallowed under the preceding sentence shall be treated as a capital loss from the sale or exchange of such an asset in the next taxable year. For purposes of this subparagraph, all medical savings accounts of the account beneficiary shall be treated as 1 account.

"(2) ACCOUNT TERMINATES IF INDIVIDUAL ENGAGES IN PROHIBITED TRANSACTION.—

"(A) IN GENERAL.—If, during any taxable year of the account beneficiary, such beneficiary engages in any transaction prohibited by section 4975 with respect to the account, the account shall cease to be a medical savings account as of the first day of such taxable year.

"(B) ACCOUNT TREATED AS DISTRIBUTING ALL ITS ASSETS.—In any case in which any account ceases to be a

medical savings account by reason of subparagraph (A) on the first day of any taxable year, subsection (d) shall be applied as if—

"(i) there were a distribution on such first day in an amount equal to the fair market value (on such first day) of all assets in the account (on such first day), and

"(ii) no portion of such distribution were used to pay qualified medical expenses.

"(3) EFFECT OF PLEDGING ACCOUNT AS SECURITY.—If, during any taxable year, the account beneficiary uses the account or any portion thereof as security for a loan, the portion so used is treated as distributed and not used to pay qualified medical expenses.

"(d) TAX TREATMENT OF DISTRIBUTIONS.—

"(1) INCLUSION OF AMOUNTS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

"(A) IN GENERAL.—Any amount paid or distributed out of a medical savings account which is not used exclusively to pay the qualified medical expenses of the account beneficiary or of the spouse or young dependents (as defined in section 1003(b)(1) of the Guaranteed Health Insurance Act of 1994) of such beneficiary shall be included in the gross income of such beneficiary to the extent such amount does not exceed the excess of—

"(i) the aggregate contributions to such account which were not includible in gross income by reason of section 106(c), over

"(ii) the aggregate prior payments or distributions from such account which were includible in gross income under this paragraph.

"(B) SPECIAL RULES.—For purposes of subparagraph (A)—

"(i) all medical savings accounts of the account beneficiary shall be treated as 1 account,

"(ii) all payments and distributions during any taxable year shall be treated as 1 distribution, and

"(iii) any distribution of property shall be taken into account at its fair market value on the date of the distribution.

"(2) PENALTY FOR DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

"(A) IN GENERAL.—The tax imposed by chapter 1 on the account beneficiary for any taxable year in which there is a payment or distribution from a medical savings account of such beneficiary which is includible in gross income under paragraph (1) shall be increased by 100 percent of the amount which is so includible.

"(B) EXCEPTION FOR DISTRIBUTIONS AFTER AGE 65.—Subparagraph (A) shall not apply to any payment or distribution after the date on which the account beneficiary attains age 65.

"(C) EXCEPTION FOR DISABILITY OR DEATH.—Subparagraph (A) shall not apply if the payment or distribution is made after the account beneficiary becomes disabled within the meaning of section 72(m)(7) or dies.

"(3) ROLLOVER CONTRIBUTION.—An amount is described in this paragraph as a rollover contribution if it meets the requirements of subparagraphs (A) and (B).

"(A) IN GENERAL.—Paragraph (1) shall not apply to any amount paid or distributed from a medical savings account to the account beneficiary to the extent the amount received is paid into a medical savings account for the benefit of such beneficiary not later than the 60th day after the day on which he receives the payment or distribution.

"(B) LIMITATION.—This paragraph shall not apply to any amount described in subparagraph (A) received by an individual from a medical savings account if, at any time during the 1-year period ending on the day of such receipt, such individual received any other amount described in subparagraph (A) from a medical savings account which was not includible in his gross income because of the application of this paragraph.

"(4) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—For purposes of section 213, any payment or distribution out of a medical savings account for qualified medical expenses shall not be treated as an expense paid for medical care to the extent of the amount of such payment or distribution which is excludable from gross income solely by reason of paragraph (1)(A).

"(e) DEFINITIONS.—For purposes of this section—

"(1) QUALIFIED MEDICAL EXPENSES.—The term 'qualified medical expenses' means any expense for medical care (as defined in section 213(d)); except that such term shall not include any expense for insurance.

"(2) ACCOUNT BENEFICIARY.—The term 'account beneficiary' means the individual for whose benefit the medical savings account is maintained.

"(f) CUSTODIAL ACCOUNTS.—For purposes of this section, a custodial account shall be treated as a trust if—

"(1) the assets of such account are held by a bank (as defined in section 408(n)), insurance company (as defined in section 816), or another person who demonstrates to the satisfaction of the Secretary that the manner in which he will administer the account will be consistent with the requirements of this section, and

"(2) the custodial account would, except for the fact that it is not a trust, constitute a medical savings account described in subsection (a).

For purposes of this title, in the case of a custodial account treated as a trust by reason of the preceding sentence, the custodian of such account shall be treated as the trustee thereof.

"(g) REPORTS.—The trustee of a medical savings account shall keep such records and make such reports regarding such account to the Secretary and to the account beneficiary with respect to contributions, distributions, and such other matters as the Secretary may require under regulations. The reports required by this subsection shall be filed at such time and in such manner and furnished to such individuals at such time and in such manner as may be required by such regulations."

(2) EMPLOYER PAYMENTS EXCLUDED FROM EMPLOYMENT TAX BASE.—

(A) SOCIAL SECURITY TAXES.—

(i) Subsection (a) of section 3121 is amended by striking "or" at the end of paragraph (20), by striking the period at the end of paragraph (21) and inserting ", or", and by inserting after paragraph (21) the following new paragraph:

"(22) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(c)."

(ii) Subsection (a) of section 209 of the Social Security Act is amended by striking "or" at the end of paragraph (18), by striking the period at the end of paragraph (19) and inserting "; or", and by inserting after paragraph (19) the following new paragraph:

"(20) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from

income under section 106(c) of the Internal Revenue Code of 1986."

(B) RAILROAD RETIREMENT TAX.—Subsection (e) of section 3231 is amended by adding at the end the following new paragraph:

"(10) MEDICAL SAVINGS ACCOUNT CONTRIBUTIONS.—The term 'compensation' shall not include any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(c)."

(C) UNEMPLOYMENT TAX.—Subsection (b) of section 3306 is amended by striking "or" at the end of paragraph (15), by striking the period at the end of paragraph (16) and inserting "; or", and by inserting after paragraph (16) the following new paragraph:

"(17) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(c)."

(D) WITHHOLDING TAX.—Subsection (a) of section 3401 is amended by striking "or" at the end of paragraph (19), by striking the period at the end of paragraph (20) and inserting "; or", and by inserting after paragraph (20) the following new paragraph:

"(21) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(c)."

(3) TAX ON PROHIBITED TRANSACTIONS.—Section 4975 (relating to prohibited transactions) is amended—

(A) by adding at the end of subsection (c) the following new paragraph:

"(4) SPECIAL RULE FOR MEDICAL SAVINGS ACCOUNTS.—An individual for whose benefit a medical savings account (within the meaning of section 7705) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a medical savings account by reason of the application of section 7705(c)(2)(A) to such account.", and

(B) by inserting "or a medical savings account described in section 7705" in subsection (e)(1) after "described in section 408(a)".

(4) FAILURE TO PROVIDE REPORTS ON MEDICAL SAVINGS ACCOUNTS.—Section 6693 (relating to failure to provide reports on individual retirement account or annuities) is amended—

(A) by inserting "or on medical savings accounts" after "annuities" in the heading of such section, and

(B) by adding at the end of subsection (a) the following: "The person required by section 7705(g) to file a report regarding a medical savings account at the time and in the manner required by such section shall pay a penalty of $50 for each failure unless it is shown that such failure is due to reasonable cause."

(5) CLERICAL AMENDMENTS.—

(A) The table of sections for chapter 79 is amended by adding at the end the following:

"Sec. 7705. Medical savings accounts."

(B) The table of sections for subchapter B of chapter 68 is amended by inserting "or on medical savings accounts" after "annuities" in the item relating to section 6693.

(d) EMPLOYMENT TAX TREATMENT OF AMOUNT NOT EXCLUDED UNDER SECTION 106.—

(1) SOCIAL SECURITY TAX.—

(A) Subsection (a) of section 3121 is amended by inserting after paragraph (22) the following new sentence:

"Nothing in paragraph (2) shall exclude from the term 'wages' any amount which is required to be included in gross income under section 106(b)."

(B) Subsection (a) of section 209 of the Social Security Act is amended by inserting after paragraph (20) the following new sentence:

"Nothing in paragraph (2) shall exclude from the term 'wages' any amount which is required to be included in gross income under section 106(b) of the Internal Revenue Code of 1986."

(2) RAILROAD RETIREMENT TAX.—Paragraph (1) of section 3231(e) is amended by adding at the end thereof the following new sentence: "Nothing in clause (i) of the second sentence of this paragraph shall exclude from the term 'compensation' any amount which is required to be included in gross income under section 106(b)."

(3) UNEMPLOYMENT TAX.—Subsection (b) of section 3306 is amended by inserting after paragraph (17) the following new sentence:

"Nothing in paragraph (2) shall exclude from the term 'wages' any amount which is required to be included in gross income under section 106(b)."

(4) WAGE WITHHOLDING.—Subsection (a) of section 3401 is amended by adding at the end thereof the following new sentence:

"Nothing in the preceding provisions of this subsection (other than paragraph (21)) shall exclude from the term 'wages' any amount which is required to be included in gross income under section 106(b)."

(e) EFFECTIVE DATE.—

(1) PROVISIONS OTHER THAN MEDICAL SAVINGS ACCOUNTS.—

(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the amendments made by subsections (a) and (d), and so much of the amendment made by subsection (b) as relates to section 106(b) of the Internal Revenue Code of 1986, shall take effect on January 1, 1995.

(B) BENEFITS PROVIDED PURSUANT TO COLLECTIVE BARGAINING AGREEMENTS.—In the case of a cafeteria plan or flexible spending arrangement maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers which was ratified before June 30, 1994, the amendments referred to in subparagraph (A) shall not apply to benefits pursuant to any such agreement provided before the date on which the last of such agreements terminate (determined without regard to any extension thereof on or after June 30, 1994). The preceding sentence shall cease to apply with respect to any such agreement on the effective date of any modification of such agreement on or after June 30, 1994.

(C) STATE AND LOCAL EMPLOYEES COVERED BY COLLECTIVE BARGAINING AGREEMENTS.—In the case of employees of a State or political subdivision thereof—

(i) who are not entitled to the benefits of subparagraph (B),

(ii) who are covered by 1 or more collective bargaining agreements with such State or political subdivision which was ratified before June 30, 1994, and

(iii) who are eligible to participate in a cafeteria plan or flexible spending arrangement which was established by State or local law and which is in effect on such date,

the amendments referred to in subparagraph (A) shall not apply to benefits provided under such plan or arrangement (as in effect on such date) before January 1, 1999.

(2) MEDICAL SAVINGS ACCOUNTS.—The amendments made by this section (other than the amendments referred to in paragraph (1)(A)) shall take effect on January 1, 1999.

SEC. 11202. DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS INCREASED AND MADE PERMANENT.

(a) PROVISION MADE PERMANENT.—

(1) IN GENERAL.—Subsection (l) of section 162 (relating to special rules for health insurance costs of self-employed individuals) is amended by striking paragraph (6).

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to taxable years beginning after December 31, 1993.

(b) DEDUCTION INCREASED TO 80 PERCENT.—

(1) IN GENERAL.—Paragraph (1) of section 162(l) is amended by striking "25 percent" and inserting "80 percent".

(2) OTHER COVERAGE.—Subparagraph (B) of section 162(l)(2) is amended to read as follows:

"(B) OTHER COVERAGE.—Paragraph (1) shall not apply to any taxpayer for any calendar month for which the taxpayer or the taxpayer's spouse—

"(i) is normally employed by an employer for at least 25 hours per week, or

"(ii) is eligible to participate in a subsidized health plan maintained by any employer of such taxpayer or spouse."

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning after December 31, 1998.

SEC. 11203. LIMITATION ON PREPAYMENT OF MEDICAL INSURANCE PREMIUMS.

(a) GENERAL RULE.—Subsection (d) of section 213 is amended by adding at the end the following new paragraph:

"(10) LIMITATION ON PREPAYMENTS.—If the taxpayer pays a premium or other amount which constitutes medical care under paragraph (1), to the extent such premium or other amount is properly allocable to insurance coverage or care to be provided during periods more than 12 months after the month in which such payment is made, such premium shall be treated as paid ratably over the period during which such insurance coverage or care is to be provided. The preceding sentence shall not apply to any premium to which paragraph (7) applies."

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to amounts paid after December 31, 1994.

Subtitle C—Extending Medicare Coverage of, and Application of Hospital Insurance Tax to, All State And Local Government Employees.

SEC. 11301. EXTENDING MEDICARE COVERAGE OF, AND APPLICATION OF HOSPITAL INSURANCE TAX TO, ALL STATE AND LOCAL GOVERNMENT EMPLOYEES.

(a) IN GENERAL.—

(1) APPLICATION OF HOSPITAL INSURANCE TAX.—Section 3121(u)(2) is amended by striking subparagraphs (C) and (D).

(2) COVERAGE UNDER MEDICARE.—Section 210(p) of the Social Security Act (42 U.S.C. 410(p)) is amended by striking paragraphs (3) and (4).

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to services performed after December 31, 1996.

(b) PHASEIN OF AMOUNT OF TAX WITH RESPECT TO EMPLOYEES NEWLY SUBJECT TO TAX.—Subsection (u) of section 3121 is amended by adding at the end the following new paragraph:

"(4) PHASEIN OF AMOUNT OF TAX WITH RESPECT TO CERTAIN EMPLOYEES.—If the wages paid to any individual during any period before January 1, 2000, would not be subject to tax under sections 3101(b) and 3111(b) but for the repeal of subparagraphs (C) and (D) of paragraph (2), the rates of the taxes imposed by such sections with respect to such wages paid during such period shall be—

"(A) 0.3625 percent in the case of wages paid during 1997,

"(B) 0.725 percent in the case of wages paid during 1998, and

"(C) 1.0875 percent in the case of wages paid during 1999."

(c) TRANSITION IN BENEFITS FOR STATE AND LOCAL GOVERNMENT EMPLOYEES AND FORMER EMPLOYEES.—

(1) IN GENERAL.—

(A) EMPLOYEES NEWLY SUBJECT TO TAX.—For purposes of sections 226, 226A, and 1811 of the Social Security Act, in the case of any individual who performs services during the calendar quarter beginning January 1, 1997, the wages for which are subject to the tax imposed by section 3101(b) of the Internal Revenue Code of 1986 only because of the amendments made by subsection (a), the individual's medicare qualified State or local government employment (as defined in subparagraph (B)) performed before January 1, 1997, shall be considered to be "employment" (as defined for purposes of title II of such Act), but only for purposes of providing the individual (or another person) with entitlement to hospital insurance benefits under part A of title XVIII of such Act for months beginning with January 1997.

(B) MEDICARE QUALIFIED STATE OR LOCAL GOVERNMENT EMPLOYMENT DEFINED.—In this paragraph, the term "medicare qualified State or local government employment" means medicare qualified government employment described in section 210(p)(1)(B) of the Social Security Act (determined without regard to section 210(p)(3) of such Act, as in effect before its repeal under subsection (a)(2)).

(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Federal Hospital Insurance Trust Fund from time to time such sums as the Secretary of Health and Human Services deems necessary for any fiscal year on account of—

(A) payments made or to be made during such fiscal year from such Trust Fund with respect to individuals who are entitled to benefits under title XVIII of the Social Security Act solely by reason of paragraph (1),

(B) the additional administrative expenses resulting or expected to result therefrom, and

(C) any loss in interest to such Trust Fund resulting from the payment of those amounts, in order to place such Trust Fund in the same position at the end of such fiscal year as it would have been in if this subsection had not been enacted.

(3) INFORMATION TO INDIVIDUALS WHO ARE PROSPECTIVE MEDICARE BENEFICIARIES BASED ON STATE AND LOCAL GOVERNMENT EMPLOYMENT.—Section 226(g) of the Social Security Act (42 U.S.C. 426(g)) is amended—

(A) by redesignating paragraphs (1) through (3) as subparagraphs (A) through (C), respectively,

(B) by inserting "(1)" after "(g)", and

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

"(2) The Secretary, in consultation with State and local governments, shall provide procedures designed to assure that individuals who perform medicare qualified government employment by virtue of service described in section 210(a)(7) are informed with respect to (A) their eligibility or potential eligibility for hospital insurance benefits (based on such employment) under part A of title XVIII, (B) the requirements for, and conditions of, such eligibility, and (C) the necessity of timely application as a condition of becoming entitled under subsection (b)(2)(C), giving particular attention to individuals who apply for an annuity or retirement benefit and whose eligibility for such annuity or retirement benefit is based on a disability."

(c) TECHNICAL AMENDMENTS.—

(1) Subparagraph (A) of section 3121(u)(2) is amended by striking "subparagraphs (B) and (C)," and inserting "subparagraph (B),".

(2) Subparagraph (B) of section 210(p)(1) of the Social Security Act (42 U.S.C. 410(p)(1)) is amended by striking "paragraphs (2) and (3)." and inserting "paragraph (2)."

(3) Section 218 of the Social Security Act (42 U.S.C. 418) is amended by striking subsection (n).

(4) The amendments made by this subsection shall apply after December 31, 1996.

Subtitle D—Treatment of Organizations Providing Health Care Services and Related Organizations

SEC. 11401. QUALIFICATION AND DISCLOSURE REQUIREMENTS FOR CERTAIN NONPROFIT HEALTH CARE ORGANIZATIONS.

(a) TREATMENT OF HOSPITALS AND OTHER ENTITIES PROVIDING HEALTH CARE SERVICES.—Section 501 (relating to exemption from tax on corporations, certain trusts, etc.) is amended by redesignating subsection (n) as subsection (o) and by inserting after subsection (m) the following new subsection:

"(n) QUALIFICATION OF HEALTH CARE ORGANIZATIONS AS EXEMPT ORGANIZATIONS.—

"(1) IN GENERAL.—An organization which is described in paragraph (3) or (4) of subsection (c) and the predominant activity of which is the provision of health care services shall be exempt from tax under subsection (a) only if—

"(A) such organization, with the participation of community representatives, annually—

"(i) assesses its community's needs for health care services and qualified outreach services, and

"(ii) prepares a written plan to meet those needs,

"(B) pursuant to such plan, such organization provides (directly or indirectly) significant qualified outreach services,

"(C) at least 80 percent of the members of the board of directors of such organization are independent members,

"(D) such organization does not discriminate against individuals in the provision of health care services on the basis of participation in a government-sponsored health plan,

"(E) such organization does not discriminate against individuals in the provision of emergency health care services on the basis of ability to pay, and

"(F) to the extent of such organization's financial ability, such organization does not discriminate against individuals in the provision of medically necessary health care services (other than emergency services) on the basis of ability to pay.

"(2) SPECIAL RULE FOR HEALTH MAINTENANCE ORGANIZATIONS.—A health maintenance organization shall not be treat-

ed as described in subsection (c)(3) unless substantially all of its primary care health services is provided as described in subsection (m)(6)(A).

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

"(A) QUALIFIED OUTREACH SERVICES.—The term 'qualified outreach services' means health care services (or preventive care, educational, or social services programs related thereto) which are provided—

"(i) in 1 or more medically underserved areas, or

"(ii) at below cost to individuals who are otherwise unable to afford such services.

Such term shall not include insurance described in subparagraph (B)(iii) unless such insurance is provided on a subsidized basis.

"(B) HEALTH CARE SERVICES.—The term 'health care services' means—

"(i) any activity of providing medical care (as defined in section 213(d)(1)(A)) to individuals,

"(ii) in the case of an organization described in subsection (c)(3), any activity which is treated as accomplishing an exempt purpose of the organization solely because it is carried on as part of an activity described in clause (i), and

"(iii) insurance (other than commercial-type insurance, as defined in subsection (m)) for the activities described in clauses (i) and (ii).

"(C) MEDICALLY UNDERSERVED AREA.—The term 'medically underserved area' means, with respect to a 'health care service, any area reasonably determined by the organization (in a manner not inconsistent with regulations prescribed by the Secretary) to have—

"(i) a shortage (relative to the number of individuals needing such service) of health professionals performing such service, or

"(ii) a population group experiencing such a shortage.

Such term includes a health professional shortage area (as defined in section 332 of the Public Health Service Act).

"(D) INDEPENDENT MEMBER.—The term 'independent member' means a member of the board of directors of an organization who receives no compensation (directly or indirectly)—

"(i) for medical services performed in connection with such organization, or

"(ii) for services as an officer of such organization (other than as a member of such board).

For purposes of clause (ii), the term 'officer' includes any individual having powers or responsibilities similar to those of officers.

"(4) EXCEPTION.—This subsection shall not apply to any organization which provides health care services exclusively on an uncompensated basis, regardless of ability to pay.

"(5) SAFE HARBOR FOR NURSING HOMES.—

"(A) IN GENERAL.—A nursing home shall be treated as meeting the requirement of paragraph (1)(D) if it accepts a proportion of Medicaid patients which meets a safe harbor prescribed by the Secretary for purposes of this paragraph.

"(B) DEFINITIONS.— For purposes of subparagraph (A)—

"(i) NURSING HOME.—The term 'nursing home' means any facility which is of a type which is traditionally considered a nursing home.

"(ii) MEDICAID PATIENT.—The term 'Medicaid patient' means any individual eligible to receive medical

assistance under a State plan approved under title XIX of the Social Security Act.

"(6) DISALLOWANCE OF CHARITABLE DEDUCTIONS.—No gift or bequest to an organization which is not exempt from tax by reason of this subsection shall be allowed as a deduction under section 170, 545(b)(2), 556(b)(2), 642(c), 2055, 2106(a)(2), or 2522.

"(7) REQUIREMENTS SUPPLEMENT OTHER REQUIREMENTS.—The requirements of this subsection are in addition to, and not in lieu of, the requirements otherwise applicable to an organization described in paragraph (3) or (4) of subsection (c)."

(b) REPORTING AND DISCLOSURE OF NEEDS ASSESSMENT AND PLAN.—

(1) REPORTING.—

(A) ORGANIZATIONS DESCRIBED IN SECTION 501(c)(3).—Subsection (b) of section 6033 (relating to certain organizations described in section 501(c)(3)) is amended by striking "and" at the end of paragraph (9), by redesignating paragraph (10) as paragraph (14), and by inserting after paragraph (9) the following new paragraphs:

"(10) in the case of an organization which prepares a plan described in section 501(n)(1)(A) (relating to community needs)—

"(A) a copy of such plan for the year, and

"(B) information on the implementation of such plan for the year (including unrecovered costs and revenues foregone in furtherance of such plan),

"(11)(A) the amount (if any) of tax paid by the organization during the year under section 4958 (relating to tax on failure to satisfy section 501(n)), and

"(B) the amount (if any) of tax imposed by section 4958 on the organization which was not assessed, or the assessment of which was abated, pursuant to section 4958(d),

"(12) such information as the Secretary may require with respect to any excess benefit transaction (as defined in section 4959(c)),

"(13) in the case of an applicable tax-exempt health care organization (as defined in section 4960), the respective amounts (if any) of the taxes paid by the organization during the year (and such other information as the Secretary may require with respect to the activities resulting in such taxes) under—

"(A) section 4911 (relating to tax on excess expenditures to influence legislation),

"(B) section 4912 (relating to tax on disqualifying lobbying expenditures of certain organizations), and

"(C) section 4955 (relating to taxes on political expenditures of section 501(c)(3) organizations), and".

(B) ORGANIZATIONS DESCRIBED IN SECTION 501(c)(4).—Section 6033 is amended by redesignating subsection (f) as subsection (g) and by inserting after subsection (e) the following new subsection:

"(f) CERTAIN ORGANIZATIONS DESCRIBED IN SECTION 501(c)(4).—Every organization described in section 501(c)(4) which is subject to the requirements of subsection (a) and which prepares a plan described in section 501(n)(1)(A) (relating to community needs) for the year—

"(1) shall include a copy of such plan with the return required under subsection (a) for the year, and

"(2) shall include on such return the information referred to in paragraphs (10)(B), (11), and (12) of subsection (b) with respect to such organization."

(2) DISCLOSURE.—

(A) IN GENERAL.—Subsection (e) of section 6104 (relating to public inspection of certain annual returns and ap-

plications for exemption) is amended by adding at the end the following new paragraph:

"(3) COMMUNITY HEALTH CARE NEEDS ASSESSMENT AND PLAN AND APPLICATION FOR EXEMPTION.—

"(A) IN GENERAL.—Every organization which is required to prepare a plan described in section 501(n)(1)(A) (relating to community needs)—

"(i) shall make a copy of such plan (and the assessment on which such plan is based) available for inspection during regular business hours by any individual at the principal office of such organization and, if such organization regularly maintains 1 or more regional or district offices having 3 or more employees, at each such regional or district office, and

"(ii) upon request of an individual made at such principal office or such a regional or district office, shall provide—

"(I) a copy of such plan (and assessment),

"(II) a copy of the annual return filed under section 6033, and

"(III) a copy of the application, papers, letters, and other documents referred to in paragraph (2)(A)(ii),

to such individual without charge other than a reasonable fee for any reproduction and mailing costs. If the request under clause (ii) is made in person, such copies shall be provided immediately and, if made other than in person, shall be provided within 30 days.

"(B) PERIOD OF AVAILABILITY.—Subparagraph (A) shall apply—

"(i) with respect to any plan (and assessment) during the 3-year period after the close of the year for which such plan is prepared,

"(ii) with respect to any return, during the 3-year period beginning on the filing date (as defined in paragraph (1)(D)), and

"(iii) with respect to the material referred to in subparagraph (A)(ii)(III), at any time.

"(C) LIMITATION.—Subparagraph (A)(ii) shall not apply to any request if the Secretary determines, upon application by an organization, that such request is part of a harassment campaign and that compliance with such request is not in the public interest."

(B) TECHNICAL AMENDMENT.—The heading for subsection (e) of section 6104 is amended by striking "AND APPLICATIONS FOR EXEMPTION" and inserting ", APPLICATIONS FOR EXEMPTION, AND COMMUNITY NEEDS ASSESSMENT AND PLAN FOR HEALTH AND OUTREACH SERVICES".

(c) FUNDRAISING SOLICITATIONS REQUIRED TO DISCLOSE AVAILABILITY OF ANNUAL RETURN.—

(1) Paragraph (1) of section 6104(e) is amended by adding at the end the following new subparagraph:

"(E) FUNDRAISING SOLICITATIONS OF CERTAIN HEALTH CARE ORGANIZATIONS REQUIRED TO DISCLOSE AVAILABILITY OF ANNUAL RETURN.—In the case of an applicable tax-exempt health care organization (as defined in section 4960), each fundraising solicitation (as defined in section 6113(c)) by (or on behalf of) such organization shall contain an express statement (in a conspicuous and easily recognizable format) that such return shall be provided to individuals upon request."

(2) PENALTY.—

(A) Section 6710 is amended by striking "section 6113" each place it appears and inserting "section 6113 or 6104(e)(1)(E)".

(B) Subsection (a) of section 6710 is amended by inserting "($100 in the case of a failure to meet the requirements of section 6104(e)(1)(E))" after "$1,000".

(C) The section heading of section 6710 is amended by inserting before the period "; failure by certain health care organizations to disclose availability of annual return".

(D) The table of sections for part I of subchapter B of chapter 68 is amended by inserting before the period at the end of the item relating to section 6710 the following: "; failure by certain health care organizations to disclose availability of annual return".

(E) Subparagraph (C) of section 6652(c)(1) is amended by striking "(e)(1)" and inserting "(e)(1) (other than subparagraph (E))".

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by this section shall take effect on January 1, 1995.

(2) REQUIREMENT OF INDEPENDENT BOARD OF DIRECTORS.—Subparagraph (C) of section 501(n)(1) of the Internal Revenue Code of 1986, as added by this section, shall take effect on January 1, 1997.

(3) HMO SERVICE REQUIREMENT.—So much of the amendments made by this section as relate to section 501(n)(2) of such Code, as added by this section, shall take effect on the date of the enactment of this Act.

SEC. 11402. EXCISE TAXES FOR FAILURE BY TAX-EXEMPT HEALTH CARE ORGANIZATIONS TO MEET CERTAIN QUALIFICATION REQUIREMENTS.

(a) IN GENERAL.—Chapter 42 (relating to private foundations and certain other tax-exempt organizations) is amended by redesignating subchapter D as subchapter E and by inserting after subchapter C the following new subchapter:

"Subchapter D—Failure By Tax-Exempt Health Care Organizations To Meet Certain Qualification Requirements

"SEC. 4958. TAX ON FAILURE TO SATISFY SECTION 501(n).

"(a) IMPOSITION OF TAX.—There is hereby imposed on any applicable tax-exempt health care organization which fails to meet 1 or more of the requirements of section 501(n)(1) during any taxable year a tax equal to the greater of—

"(1) $25,000, or

"(2) 5 percent of the organization's net investment income for such taxable year.

"(b) PAYMENT OF TAX.—The tax imposed by this section shall be paid by the organization.

"(c) DETERMINATION OF NET INVESTMENT INCOME.—For purposes of this section—

"(1) IN GENERAL.—The net investment income of an applicable tax-exempt health care organization shall include the net investment income of—

"(A) each organization which would be described in subparagraph (A) or (B) of section 509(a)(3) or in section 509(a)(4) with respect to such health care organization if such health care organization were described in section 509(a)(2), and

"(B) each organization which is organized and operated for the benefit of, and which directly or indirectly is controlled by, such health care organization.

"(2) NET INVESTMENT INCOME.—The term 'net investment income' has the meaning given such term by section 4940.

"(d) WAIVER.—If it is established to the satisfaction of the Secretary that—

"(1) a failure was due to reasonable cause and not to willful neglect, and

"(2) the organization has established safeguards to prevent future such failures (and has taken such additional corrective action as is prescribed by the Secretary by regulations),

then the tax imposed by subsection (a) (including interest) by reason of such failure shall not be assessed and, if assessed, the assessment shall be abated and, if collected, shall be credited or refunded as an overpayment.

"SEC. 4959. TAXES ON EXCESS BENEFIT TRANSACTIONS.

"(a) INITIAL TAXES.—

"(1) ON THE DISQUALIFIED PERSON.—There is hereby imposed on each excess benefit transaction a tax equal to 25 percent of the excess benefit. The tax imposed by this paragraph shall be paid by any disqualified person referred to in subsection (e)(1) with respect to such transaction.

"(2) ON THE MANAGEMENT.—In any case in which a tax is imposed by paragraph (1), there is hereby imposed on the participation of any organization manager in the excess benefit transaction, knowing that it is such a transaction, a tax equal to 10 percent of the excess benefit, unless such participation is not willful and is due to reasonable cause. The tax imposed by this paragraph shall be paid by any organization manager who participated in the excess benefit transaction.

"(b) ADDITIONAL TAX ON THE DISQUALIFIED PERSON.—In any case in which an initial tax is imposed by subsection (a)(1) on an excess benefit transaction and the excess benefit involved in such transaction is not corrected within the taxable period, there is hereby imposed a tax equal to 200 percent of the excess benefit involved. The tax imposed by this subsection shall be paid by any disqualified person referred to in subsection (e)(1) with respect to such transaction.

"(c) EXCESS BENEFIT TRANSACTION; EXCESS BENEFIT.—For purposes of this section—

"(1) EXCESS BENEFIT TRANSACTION.—

"(A) IN GENERAL.—The term 'excess benefit transaction' means any transaction in which an economic benefit is provided by an applicable tax-exempt health care organization to or for the use of any disqualified person if the value of the economic benefit provided exceeds the value of the consideration (including the performance of services) received for providing such benefit.

"(B) LOANS AND CERTAIN PRIVATE INUREMENT INCLUDED.—The term 'excess benefit transaction' includes—

"(i) any loan of money or other extension of credit by an applicable tax-exempt health care organization to or for the use of a disqualified person described in subsection (e)(1)(A)(i), and

"(ii) any transaction in which the amount of any 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 1 or more activities of the organization but only if such transaction results in inurement not permitted under paragraph (3) or (4) of section 501(c), as the case may be.

"(2) EXCESS BENEFIT.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'excess benefit' means the excess referred to in paragraph (1)(A).

"(B) LOANS AND PRIVATE INUREMENT INCLUDED.—The term 'excess benefit' means—

"(i) in the case of a loan or extension of credit described in paragraph (1)(B)(i), the amount of the loan or the credit extended, and

"(ii) in the case of a transaction described in paragraph (1)(B)(ii), the amount of the inurement.

"(3) EXCEPTION FOR ORGANIZATIONS SUBJECT TO PRIVATE FOUNDATION RULES.—For purposes of this section, the term 'applicable tax-exempt health care organization' shall not include a private foundation (as defined in section 509(a)).

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

"(1) JOINT AND SEVERAL LIABILITY.—If more than 1 person is liable for any tax imposed by subsection (a) or subsection (b), all such persons shall be jointly and severally liable for such tax.

"(2) LIMIT FOR MANAGEMENT.—With respect to any 1 excess benefit transaction, the maximum amount of the tax imposed by subsection (a)(2) shall not exceed $10,000.

"(e) OTHER DEFINITIONS.—For purposes of this section—

"(1) DISQUALIFIED PERSON.—The term 'disqualified person' means, with respect to any transaction—

"(A) any person who was, at any time during the 5-year period ending on the date of such transaction—

"(i) an organization manager, or

"(ii) an individual (other than an organization manager) in a position to exercise substantial influence over the affairs of the organization,

"(B) a member of the family of an individual described in subparagraph (A), and

"(C) a 35-percent controlled entity.

"(2) ORGANIZATION MANAGER.—The term 'organization manager' means, with respect to any applicable tax-exempt health care organization, any officer, director, or trustee of such organization (or any individual having powers or responsibilities similar to those of officers, directors, or trustees of the organization).

"(3) 35-PERCENT CONTROLLED ENTITY.—

"(A) IN GENERAL.—The term '35-percent controlled entity' means—

"(i) a corporation in which persons described in subparagraph (A) or (B) of paragraph (1) own more than 35 percent of the total combined voting power,

"(ii) a partnership in which such persons own more than 35 percent of the profits interest, and

"(iii) a trust or estate in which such persons own more than 35 percent of the beneficial interest.

"(B) CONSTRUCTIVE OWNERSHIP RULES.—Rules similar to the rules of paragraphs (3) and (4) of section 4946(a) shall apply for purposes of this paragraph.

"(4) FAMILY MEMBERS.—The members of an individual's family shall be determined under section 4946(d); except that such members also shall include the brothers and sisters (whether by the whole or half blood) of the individual and their spouses.

"(f) TREATMENT OF PREVIOUSLY EXEMPT ORGANIZATIONS.—

"(1) IN GENERAL.—For purposes of this section, the status of any organization as an applicable tax-exempt health care organization shall be terminated only if—

"(A)(i) such organization notifies the Secretary (at such time and in such manner as the Secretary may by regulations prescribe) of its intent to accomplish such termination, or

"(ii) there is a final determination by the Secretary that such status has terminated, and

"(B)(i) such organization pays the tax imposed by paragraph (2) (or any portion not abated pursuant to paragraph (3)), or

"(ii) the entire amount of such tax is abated pursuant to paragraph (3).

"(2) IMPOSITION OF TAX.—There is hereby imposed on each organization referred to in paragraph (1) a tax equal to the lesser of—

"(A) the amount which the organization substantiates by adequate records or other corroborating evidence as the aggregate tax benefit resulting from its exemption from tax under section 501(a), or

"(B) the value of the net assets of such organization.

"(3) ABATEMENT OF TAX.—The Secretary may abate the unpaid portion of the assessment of any tax imposed by paragraph (2), or any liability in respect thereof, if the applicable tax-exempt health care organization distributes all of its net assets to 1 or more organizations each of which has been in existence, and described in section 501(c)(3), for a continuous period of at least 60 calendar months. If the distributing organization is described in section 501(c)(4), the preceding sentence shall be applied by treating the reference to section 501(c)(3) as including a reference to section 501(c)(4).

"(4) CERTAIN RULES MADE APPLICABLE.—Rules similar to the rules of subsections (d), (e), and (f) of section 507 shall apply for purposes of this subsection.

"SEC. 4960. OTHER DEFINITIONS.

"(a) APPLICABLE TAX-EXEMPT HEALTH CARE ORGANIZATION.—For purposes of this subchapter, the term 'applicable tax-exempt health care organization' means any organization—

"(1) the predominant activity of which is the provision of health care services (as defined in section 501(n)(3)), and

"(2) which (without regard to any failure to meet any requirement of section 501(n) or any excess benefit) would be described in paragraph (3) or (4) of section 501(c) and exempt from tax under section 501(a).

"(b) TAXABLE PERIOD; CORRECTION.—For purposes of this subchapter—

"(1) TAXABLE PERIOD.—The term 'taxable period' means, with respect to any excess benefit transaction, the period beginning with the date on which the transaction occurs and ending on the earliest of—

"(A) the date of mailing a notice of deficiency under section 6212 with respect to the tax imposed by subsection (a)(1) of section 4959, or

"(B) the date on which the tax imposed by such subsection (a)(1) is assessed.

"(2) CORRECTION.—The terms 'correction' and 'correct' mean, with respect to any excess benefit transaction, 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 is prescribed by the Secretary by regulations."

(b) APPLICATION OF PRIVATE INUREMENT RULE TO TAX-EXEMPT HEALTH CARE ORGANIZATIONS DESCRIBED IN SECTION 501(c)(4).—Paragraph (4) of section 501(c) is amended by inserting "(A)" after "(4)" and by adding at the end the following:

"(B) Subparagraph (A) shall not apply to an entity the predominant activity of which is the provision of health care services (as defined in subsection (n)(3)) unless no part of the net earnings of such entity inures to the benefit of any private shareholder or individual."

(c) TECHNICAL AND CONFORMING AMENDMENTS.—

(1) Subsection (e) of section 4955 is amended—

(A) by striking "SECTION 4945" in the heading and inserting "SECTIONS 4945 and 4959", and

(B) by inserting before the period "or an excess benefit for purposes of section 4959".

(2) Subsections (a), (b), and (c) of section 4963 are each amended by inserting "4959," after "4955,".

(3) Subsection (e) of section 6213 is amended by inserting "4959 (relating to private excess benefit)," before "4971".

(4) Paragraphs (2) and (3) of section 7422(g) are each amended by inserting "4959," after "4955,".

(5) Subsection (b) of section 7454 is amended by inserting "or whether an organization manager (as defined in section 4959(e)(2)) has 'knowingly' participated in an excess benefit transaction (as defined in section 4959(c))," after "section 4912(b),".

(6) The table of subchapters for chapter 42 is amended by striking the last item and inserting the following:

"Subchapter D. Failure by tax-exempt health care organizations to meet certain qualification requirements.
"Subchapter E. Abatement of first and second tier taxes in certain cases."

(d) EFFECTIVE DATES.—

(1) SECTION 501(n) REQUIREMENTS.—The amendments made by this section, to the extent related to section 4958 of the Internal Revenue Code of 1986 (as added by this section), shall take effect on January 1, 1995.

(2) EXCESS BENEFIT TRANSACTION RULES.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by this section, to the extent related to section 4959 of such Code (as added by this section), shall apply to excess benefit transactions occurring on or after June 30, 1994.

(B) BINDING CONTRACTS FOR PERSONAL SERVICES.—The amendments referred to in subparagraph (A) shall not apply to any transaction pursuant to any written contract for the performance of personal services which was binding on June 29, 1994, and at all times thereafter before such transaction occurred.

(3) APPLICATION OF PRIVATE INUREMENT RULE TO TAX-EXEMPT HEALTH CARE ORGANIZATIONS DESCRIBED IN SECTION 501(c)(4).—

(A) IN GENERAL.—The amendment made by subsection (b) shall apply to inurement occurring on or after June 30, 1994.

(B) BINDING CONTRACTS.—The amendment made by subsection (b) shall not apply to any inurement occurring before July 1, 1996, pursuant to a written contract which was binding on June 29, 1994, and at all times thereafter before such inurement occurred.

SEC. 11403. TREATMENT OF NONPROFIT HEALTH CARE ORGANIZATIONS.

(a) INSURANCE PROVIDED BY HEALTH MAINTENANCE ORGANIZATIONS.—Section 501(m) (relating to certain organizations providing commercial-type insurance not exempt from tax) is amended by adding at the end the following new paragraph:

"(6) CERTAIN ACTIVITIES PROVIDED BY HEALTH MAINTENANCE ORGANIZATIONS NOT TREATED AS COMMERCIAL-TYPE INSURANCE.—For purposes of this subsection, the provision of (or the arranging for the provision of) medical care on a prepaid basis by a health maintenance organization shall not be treated as commercial-type insurance if (and only if) such care is—

"(A) care provided by such organization to its members at its own facilities through health care professionals who do not provide substantial health care services other than on behalf of such organization,

"(B) care provided by a health care professional to a member of such organization on a basis under which substantially all of the risks of the rates of utilization is assumed by the provider of such care, or

"(C) care (other than primary care) provided to a member of such organization pursuant to a referral by such organization, or

"(D) emergency care provided to a member of such organization at a location outside such member's area of residence."

(2) TECHNICAL AMENDMENTS.—

(A) Paragraph (3) of section 501(m) is amended by striking subparagraph (B) and by redesignating subparagraphs (C), (D), and (E) as subparagraphs (B), (C), and (D), respectively.

(B) Paragraph (5) of section 501(m) is amended by striking "paragraph (3)(E)" and inserting "paragraph (3)(D)".

(b) TREATMENT OF PARENT ORGANIZATIONS OF HEALTH CARE PROVIDERS.—Section 509(a) (defining private foundation) is amended by striking "and" at the end of paragraph (3), by redesignating paragraph (4) as paragraph (5), and by inserting after paragraph (3) the following new paragraph:

"(4) an organization which is organized and operated for the benefit of, and which directly or indirectly controls, an organization described in section 170(b)(1)(A)(iii); and".

(c) CONSUMER PURCHASING COOPERATIVES EXEMPT FROM TAX.—

(1) IN GENERAL.—Subsection (c) of section 501 (relating to exemption from tax on corporations, certain trusts, etc.) is amended by adding at the end the following new paragraph:

"(26)(A) Any consumer purchasing cooperative described in subtitle E of title V of the Guaranteed Health Insurance Act of 1994.

"(B) Such a cooperative shall not be exempt from tax pursuant to any provision other than this paragraph.

"(C) Such a cooperative shall not be exempt from tax unless—

"(i) no part of the net earnings of such cooperative inures to the benefit of any private shareholder or individual,

"(ii) no substantial part of the activities of such cooperative is carrying on propaganda, or otherwise attempting, to influence legislation (except as otherwise provided in subsection (h)), and

"(iii) such cooperative does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office."

(2) CERTAIN PROVISIONS APPLICABLE TO ORGANIZATIONS DESCRIBED IN SECTION 501(C)(3) MADE APPLICABLE TO CONSUMER PURCHASING COOPERATIVES.—Section 501 is amended by redesignating subsection (o) as subsection (p) and by inserting after subsection (n) the following new subsection:

"(o) CERTAIN PROVISIONS MADE APPLICABLE TO CONSUMER PURCHASING COOPERATIVES.—A consumer purchasing cooperative described in subsection (c)(26) shall be treated—

"(1) as described in subsection (c)(3) for purposes of applying subsection (h) (relating to expenditures by public charities to influence legislation), section 4955 (relating to taxes on political expenditures of section 501(c)(3) organizations), and section 4959 (relating to private inurement), and

"(2) as described in subsection (h)(4)."

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

SEC. 11404. TAX TREATMENT OF TAXABLE ORGANIZATIONS PROVIDING HEALTH INSURANCE AND OTHER PREPAID HEALTH CARE SERVICES.

(a) GENERAL RULE.—Section 831 is amended by redesignating subsection (c) as subsection (d) and by inserting after subsection (b) the following new subsection:

"(c) TREATMENT OF ORGANIZATIONS PROVIDING HEALTH INSURANCE AND OTHER PREPAID HEALTH CARE SERVICES.—

"(1) GENERAL RULE.—Any organization to which this subsection applies shall be taxable under this part in the same manner as if it were an insurance company other than a life insurance company.

"(2) ORGANIZATIONS TO WHICH SUBSECTION APPLIES.—This subsection shall apply to any organization—

"(A) which is not exempt from taxation under this subtitle,

"(B) which is not taxable as a life insurance company under part I of this subchapter,

"(C) which is not an organization to which section 833 applies, and

"(D) the primary and predominant business activity of which during the taxable year consists of 1 or more of the following:

"(i) Issuing accident and health insurance contracts or the reinsuring of risks undertaken by other insurance companies under such contracts.

"(ii) Operating as a health maintenance organization.

"(iii) Entering into arrangements under which—

"(I) fixed payments or premiums are received as consideration for the organization's agreement to provide or arrange for the provision of health care services, regardless of how the health care services are provided or arranged to be provided, and

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

In the case of an organization which has as a material business activity the issuing of accident and health insurance contracts or the reinsuring of risks undertaken by other insurance companies under such contracts, the administering of accident and health insurance contracts by such organization shall be treated as part of such business activity for purposes of subparagraph (D)(i)."

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by this section shall apply to taxable years beginning after December 31, 1994.

(2) TRANSITIONAL RULES.—

(A) ORGANIZATIONS TO WHICH PARAGRAPH APPLIES.—This paragraph shall apply to any organization to which section 831(c) of the Internal Revenue Code of 1986 (as added by subsection (a)) applies for such organization's first taxable year beginning after December 31, 1994; except that this paragraph shall not apply if—

(i) such organization treated itself as an insurance company taxable under part II of subchapter L of chapter 1 of such Code on its original Federal income tax return for its taxable year beginning in 1992 and for all of its taxable years thereafter beginning before January 1, 1995, or

(ii) such organization was exempt from tax under chapter 1 of such Code for such organization's last taxable year beginning before January 1, 1995.

(B) TREATMENT OF CURRENTLY TAXABLE COMPANIES.—In the case of any organization to which this paragraph applies—

(i) the amendments made by this section shall be treated as a change in the method of accounting, and

(ii) all adjustments required to be taken into account under section 481 of the Internal Revenue Code of 1986 shall be taken into account for such company's first taxable year beginning after December 31, 1994.

SEC. 11405. ORGANIZATIONS SUBJECT TO SECTION 833.

(a) IN GENERAL.—Section 833(c) (relating to organization to which section applies) is amended by adding at the end the following new paragraph:

"(4) TREATMENT AS EXISTING BLUE CROSS OR BLUE SHIELD ORGANIZATION.—

"(A) IN GENERAL.—Paragraph (2) shall be applied to an organization described in subparagraph (B) as if it were a Blue Cross or Blue Shield organization.

"(B) APPLICABLE ORGANIZATION.—An organization is described in this subparagraph if it—

"(i) is organized under, and governed by, State laws which are specifically and exclusively applicable to not-for-profit health insurance or health-service type organizations, and

"(ii) is not a Blue Cross or Blue Shield organization or health maintenance organization."

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 1986.

SEC. 11406. TAX EXEMPTION FOR HIGH-RISK INSURANCE POOLS.

(a) IN GENERAL.—Subsection (c) of section 501 (relating to list of exempt organizations) is amended by adding at the end the following new paragraph:

"(27) In the case of taxable years beginning before January 1, 1998, any corporation, association, or similar legal entity which is created by any State or political subdivision thereof to establish a risk pool to provide health insurance coverage to any person unable to obtain health insurance coverage in the private insurance market because of health conditions and no part of the net earnings of which inures to the benefit of any private shareholder, member, or individual."

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 1989.

Subtitle E—Treatment of Accelerated Death Benefits Under Life Insurance Contracts

SEC. 11501. TAX TREATMENT OF ACCELERATED DEATH BENEFITS UNDER LIFE INSURANCE CONTRACTS.

(a) GENERAL RULE.—Section 101 (relating to certain death benefits) is amended by adding at the end the following new subsection:

"(g) TREATMENT OF CERTAIN ACCELERATED DEATH BENEFITS.—

"(1) IN GENERAL.—For purposes of this section, any amount received under a life insurance contract on the life of an insured who is a terminally ill individual shall be treated as an amount paid by reason of the death of such insured.

"(2) NECESSARY CONDITIONS.—

"(A) IN GENERAL.—Paragraph (1) shall not apply to any amount received unless—

"(i) the total amount received is not less than the present value (determined under subparagraph (B)) of the reduction in the death benefit otherwise payable in the event of the death of the insured, and

"(ii) the percentage reduction by reason of the distribution in the cash surrender value of the contract does not exceed the percentage reduction by reason of such distribution in the death benefit payable under the contract.

For purposes of this subparagraph, any amount referred to in paragraph (1) that is received as a loan or lien shall be treated as a reduction, at the time of receipt, in the death benefit or the cash surrender value to the extent that the death benefit or cash surrender value, respectively, are encumbered (or can become encumbered) by the amount of such loan or lien (or amounts related thereto).

"(B) DETERMINATION OF PRESENT VALUE.—The present value of a reduction in the death benefit shall be determined by—

"(i) using a discount rate not to exceed the highest rate set forth in subparagraph (C), and

"(ii) assuming that the death benefit (or the portion thereof) would have been paid on the date which is 12 months after the date of the certification referred to in paragraph (3).

"(C) RATES.—The rates set forth in this subparagraph are the following:

"(i) the 90-day Treasury bill yield,

"(ii) the rate described as Moody's Corporate Bond Yield Average-Monthly Average Corporates, as published by Moody's Investors Service, Inc., or any successor thereto, for the calendar month ending 2 months before the date on which the rate is determined, and

"(iii) the rate used to compute the cash surrender values under the contract during the applicable period plus 1 percent per annum.

"(D) LIENS.—To the extent a lien is imposed against the death benefit in connection with the distribution, the rate of any interest charged may not exceed the highest rate set forth in subparagraph (C), and such lien may not encumber the cash surrender value such that the percentage amount of the cash surrender value that is encumbered exceeds the percentage amount of the death benefit that is encumbered.

"(3) TERMINALLY ILL INDIVIDUAL.—For purposes of this subsection, the term 'terminally ill individual' means an individual who the insurer has determined, after receipt of an acceptable certification by a licensed physician, has an illness or physical condition which is reasonably expected to result in death within 12 months after the date of certification.

"(4) EXCEPTION FOR BUSINESS-RELATED POLICIES.—This subsection shall not apply in the case of any amount paid to any taxpayer other than the insured if such taxpayer has an insurable interest with respect to the life of the insured by reason of the insured being a director, officer, or employee of the taxpayer or by reason of the insured being financially interested in any trade or business carried on by the taxpayer."

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendment made by subsection (a) shall apply to amounts received after the date of the enactment of this Act.

(2) DELAY IN APPLICATION OF DISCOUNTING RULES.—Clause (i) of section 101(g)(2)(A) of the Internal Revenue Code of 1986 (as added by this section) shall not apply to any amount received before January 1, 1995.

(3) ISSUANCE OF RIDER NOT TREATED AS MATERIAL CHANGE.—For purposes of applying sections 101(f), 7702, and 7702A of the Internal Revenue Code of 1986 to any contract, the issuance of a qualified accelerated death benefit rider (as