12. CBO Report

If alternative deficit reduction legislation has been enacted, or if the President has issued an executive order and the Secretary of Treasury has issued regulations making required reductions, the Congressional Budget Office must include in its January publication of the Economic and Budget Outlook, an analysis of whether the reductions are likely to be successful in eliminating the deficit overage.

Effective Date

Upon enactment.

C. MALPRACTICE REFORMS

Present Law

No provision.

Description of Proposal

1. Alternative Dispute Resolution (ADR) Procedures

Health plans would be required to establish ADR procedures and malpractice claims could not be brought in court until the claims had gone through and reached a final resolution under the plan's procedures. Each health plan would be required to adopt at least one of the specified dispute resolution methods for resolving medical malpractice claims arising from the provision of health care services to individuals enrolled in the plan. Acceptable ADR procedures would include arbitration; required mediation; and a process requiring parties to make early offers of settlement.

2. Actions in State Courts

After final resolution of an enrollee's claim under an ADR procedure, an enrollee dissatisfied with the resolution would be permitted to bring a cause of action to seek damages or other redress with respect to that claim, to the extent permitted under State law.

3. Contingency Fee Limits

Contingency fees paid to attorneys would be limited to a sliding-scale schedule. An attorney who represents a plaintiff in a medical malpractice action on a contingency fee basis would not be permitted to charge, demand, receive or collect more than a specified percentage of the total amount recovered by judgment or settlement in the action. This limitation would also apply to proceedings under any ADR procedure.

4. Collateral Source Offsets

Awards would be reduced by the amount of any payment for the same injury from another source. The reduction in damages would take into account the amount of past or future payment that the individual has received, or is eligible to receive, from other sources. Such sources include Federal or State disability or sickness programs; Federal, State or private health insurance programs; private disability insurance programs; employer wage continuation programs; and any other program, if the payment is intended to compensate the claimant for the same injury for which damages are awarded.

5. Periodic Payments

Payments of over $100,000 could be made on a periodic schedule determined by the court. At the request of any party to a medical malpractice liability action, the defendant would be permitted to make such payments periodically, based on a schedule that the court considers appropriate, taking into account the periods for which the injured party would need medical and other services.

6. Enterprise Liability Demonstrations

Demonstration projects for limiting liability to health plans rather than physicians would be authorized. The Secretary of Health and Human Services would be required to establish and fund a demonstration project in one or more States to demonstrate whether making the plan in which a physician participates, rather than the physician, liable for the physician's medical malpractice improves the quality of health care provided under the plan, reduces defensive medical practices, and improves risk management. To be eligible to participate in the demonstration project, a State would be required to enter into an agreement with a health plan under which the plan assumes legal liability for malpractice claims arising from the provision or failure to provider services under the plan by any participation physician. The State would also be required to provide by statute that physicians participating in such plans would not be liable for damages and would not be required to indemnify the plan for the value of any awards.

7. Medical Practice Guideline Demonstrations

Demonstration projects for adopting medical practice guidelines as the standard of care in medical liability actions would be authorized. The Secretary of HHS would establish and fund the demonstration projects at the State level. To be eligible to participate, the State would be required to provide assurances that under the law of the State, in a medical malpractice action alleging that the defendant was negligent in providing (or failing to provide) services, the appropriate medical practice guideline would establish the standard of care.

8. Preemption

Federal malpractice reforms would preempt inconsistent State laws except to the extent such laws imposed greater restrictions on attorney

fees or a person's liability, or permitted additional defenses to malpractice actions. The Federal provisions would apply in any malpractice liability action brought in any State or Federal court, with the exception of cases involving claims or actions for damages arising from an injury or death subject to resolution under other Federal laws.

9. No Right to Action in Federal Court

The Federal malpractice provisions would govern actions in State courts and would not establish a basis for bringing malpractice actions in Federal court.

Effective Date

Effective for causes of action arising on or after January 1, 1996.

D. ADMINISTRATIVE SIMPLIFICATION AND PAPERWORK REDUCTION

Present Law

Federal law does not regulate the collection of private sector health information except for Medicare claims, which are collected by the Health Care Financing Administration of the Department of Health and Human Services for a centralized database. The Omnibus Budget Reconciliation Act of 1993 also calls for a data bank of all insurance coverage from any source to be used for coordination of benefits to prevent Medicare and Medicaid from paying claims for which another insurer was responsible. This data bank has not yet been established.

Description of Proposal

1. Purpose

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

2. Requirements for the Secretary of HHS

The Secretary would be required to implement a national health information network by adopting standards for:

(a) representing the content and format of health information in both paper and electronic forms,
(b) transmitting health information over the network,
(c) conducting transactions using this information,
(d) certifying public or private entities to perform the intermediary functions which implement the network, and
(e) monitoring performance to assure compliance.

The Secretary would be required to establish expedited procedures to adopt health information standards that are already in common use or that are recommended by public or private standards setting organizations such as the American National Standards Institute.

The Secretary would be required to establish procedures for:
(a) adding codes to previously adopted standards;
(b) making changes to previously adopted standards; and
(c) developing, testing, and adopting new standards.

3. Establishment of a Health Information Advisory Committee

The Secretary would be required to consult with a Health Information Advisory Committee consisting of 15 members from the private sector including providers, consumers, and experts with practical experience in developing and applying health information and networking standards. The members would be appointed by the President and serve staggered, 5 year terms.

4. Requirements for Health Plans and Health Care Providers

All health plans, including Federal and State health programs, and all health care providers would be required to participate in the health information network either directly or through a contract with a certified health information network service. Plans and providers would be required to conduct transactions electronically over the health information network for:
(a) claims and claims attachments (or encounters in the case of providers who do not submit claims), and
(b) research and quality data inquiries.

In addition, plans would be required to conduct transactions electronically over the health information network for:
(a) enrollment;
(b) eligibility determination;
(c) claims status;
(d) payment and remittance advice;
(e) coordination of benefits;
(f) first report of injury; and
(g) referrals, certification, and authorization.

The Secretary may require other transactions to be conducted electronically, consistent with the goal of reducing administrative costs. In addition, plans and providers would be required to make certain standard data available electronically on the health information network to authorized inquiries.

5. Standards for Accessing Health Information

The Secretary would be required to establish technical standards for requesting standard health information from participants in the health information network which assure that a request for health information is

authorized under the Privacy and Confidentiality Part or that it requests health information that is not protected under the Privacy and Confidentiality Part because individuals cannot be identified using the information requested.

The Secretary would be required to establish standards for the appropriate release of health information to researchers and government agencies, including public health agencies. The Secretary would establish standards for the electronic identification of a request as one which comes from a person authorized to receive the requested health information under the Part on Privacy and Confidentiality.

6. Preemption of State "Quill Pen" Laws

Requirements of this Part would preempt State laws which conflict, including provisions that require health records to be maintained in written, rather than electronic, form. The Secretary would be required to establish standards for an electronic identifier which would serve the same function as a signature and its use would supersede State laws requiring a written signature.

7. Health Security Cards

The Secretary would be required to determine a standard format for a health security card which includes a form of the social security number to uniquely identify each individual. Using this standard, health plans will issue cards to individual enrollees.

8. Penalty for Failure to Comply

All participants would be required to comply with this section within a reasonable time unless specifically excluded or waived. The Secretary would be required to impose a penalty of not more than $1,000 for each violation of health information network standards and requirements. Additional penalties would be imposed for violation of the Part on Privacy and Confidentiality.

9. Health Information Continuity

To prevent the loss of health information due to bankruptcy of a health information network participant, the Secretary would be required to establish procedures for the rescue and reassignment of information held by participants who cease to function or who function in a manner that would threaten the continuous availability of their information.

10. Demonstration Projects for New Applications

The Secretary would be authorized to make grants for demonstration projects to promote the development and use of electronically integrated, community-based clinical information systems and computerized patient record systems.

11. Replacement of Medicare and Medicaid Coverage Data Bank

The function of the Medicare and Medicaid Coverage Data Bank would be replaced through the requirement on all health plans to ensure the electronic availability on the health information network of standardized enrollment and eligibility information on every covered individual.

In order to be certified, health information network services would be required to be capable of performing automated electronic coordination of benefits and responding to queries from health care providers and health plans, in standardized transactions as defined by the Secretary, regarding the enrollment and coverage for any individual under any health plan.

Effective Date

Upon enactment.

E. FRAUD

Present Law

1. Sanctions for Fraud that Affects Federal Outlays

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

2. Health Care Anti-Fraud Trust Fund

No provision.

Description of Proposal

1. Sanctions for Fraud that Affects Federal Outlays

a. The Secretary of HHS would be required to exclude from participation in a health plan for not less than five years an individual or entity convicted of violations described in section 1128(a) of the Social Security Act, as amended to include actions affecting Federal outlays under this Act. The Secretary would be authorized to exclude from participation in a health plan for periods of different duration an individual or entity convicted of violations described in specified subsections of section 1128(b) of the Social Security Act, as amended. The Secretary would be required to provide notice of exclusions to health plans, State health care administrative agencies, and State licensing agencies. Requirements with respect to notice, hearings, and judicial review of exclusions would be established.

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

c. A number of related amendments would be made to conform and strengthen the anti-fraud and abuse provisions under the Social Security Act.

2. Health Care Anti-Fraud Trust Fund

A health care anti-fraud trust fund would be created with a portion of administrative penalties and assessments imposed under the Social Security act, civil monetary penalties imposed under this Act, and other penalties paid for related violations and actions. Amounts in the trust fund would be available without appropriation and could be used by the Secretary and the Attorney General to cover the costs of combatting fraud affecting Federal outlays. Such funds would be supplementary to appropriated operating budgets of the agencies.

Effective Date

January 1, 1996.

VII. REVENUE PROVISIONS

A. INCREASE IN EXCISE TAXES ON TOBACCO PRODUCTS

Present Law

1. Tax rates

Excise taxes are imposed on the manufacture or importation of cigarettes, cigarette papers and tubes, snuff, chewing tobacco, and pipe tobacco. The present-law tax rates are as follows:

Cigarettes	
Small cigarettes (weighing no more than 3 pounds per thousand)[1].....	$12 per thousand (i.e., 24 cents per pack of 20 cigarettes)
Large cigarettes (weighing more than 3 pounds per thousand)[2].....	$25.20 per thousand
Cigars	
Small cigars (weighing no more than 3 pounds per thousand).....	$1.125 per thousand
Large cigars (weighing more than 3 pounds per thousand).....	12.75 percent of manufacturer's price (but not more than $30 per thousand)
Cigarette papers and tubes	
Cigarette papers[3].....	0.75 cent per 50 papers

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[1] Most taxable cigarettes are small cigarettes.

[2] Large cigarettes (measuring more than 6-1/2 inches in length) are taxed at the rate prescribed for small cigarettes, counting each 2-3/4 inches (or fraction thereof) as one cigarette.

[3] Cigarette papers measuring more than 6-1/2 inches in length are taxed at the rate prescribed, counting each 2-3/4 inches (or fraction thereof) as one cigarette paper. No tax is

Cigarette tubes[4].....	1.5 cents per 50 tubes

Snuff, chewing tobacco, pipe tobacco

Snuff.....	36 cents per pound
Chewing tobacco.....	12 cents per pound
Pipe tobacco.....	67.5 cents per pound

2. Exemptions; use of revenues

No tax is imposed on tobacco products exported from the United States. Exemptions also are allowed for (1) tobacco products furnished by manufacturers for employee use or experimental purposes; and (2) tobacco products to be used by the United States. In addition, no tax is imposed on tobacco to be used in "roll-your-own" cigarettes.

Revenues from the tobacco products excise taxes are retained in the general fund of the Treasury. Revenues from taxes on tobacco products brought into the United States from Puerto Rico and the American Virgin Islands are transferred ("covered over") to those possessions if the products satisfy a domestic content requirement with respect to the possession from which they are received.

Description of Proposal

1. Rate increases; extension of coverage

The proposal would increase the tax rate on small cigarettes by $88.00 per thousand ($1.76 per pack of 20 cigarettes) and on large cigarettes by $184.80 per thousand. The tax on other currently taxable tobacco products generally would be increased by $29.33 per pound of tobacco content and a $29.33 per pound tax would be imposed on "roll-your-own" tobacco.

The new tax rates on tobacco products would be--

Cigarettes

Small cigarettes (weighing no more than 3 pounds per thousand).....	$100.00 per thousand (i.e., $2.00 per pack of 20 cigarettes).

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imposed on a book or set of cigarette papers containing 25 or fewer papers.

[4] Cigarette tubes measuring more than 6-1/2 inches in length are taxed at the rate prescribed, counting each 2-3/4 inches (or fraction thereof) as one cigarette tube.

Large cigarettes (weighing more than 3 pounds per thousand).....	$210.00 per thousand.
<u>Cigars</u>	
Small cigars (weighing no more than 3 pounds per thousand).....	$89.13 per thousand.
Large cigars (weighing more than 3 pounds per thousand).....	106.21 percent of manufacturer's price (but not more than $249.90 per thousand).
<u>Cigarette papers and tubes</u>	
Cigarette papers.....	6.25 cents per 50 papers.
Cigarette tubes.....	12.50 cents per 50 tubes.
<u>Snuff, chewing tobacco, pipe tobacco, "roll-your-own" tobacco</u>	
Snuff.....	$29.69 per pound
Chewing tobacco.....	$29.45 per pound
Pipe tobacco.....	$30.00 per pound
"Roll-your-own" tobacco...	$29.33 per pound

Revenues from the increase in excise taxes on tobacco products provided for in the proposal would be paid into the Health Security Trust Fund.

The proposal would impose the increase in the excise tax rate on tobacco products to such products in Puerto Rico. Revenues from these taxes also would be paid into the Health Security Trust Fund.

2. Exemptions; administrative provisions

The proposal would repeal the present-law exemptions for tobacco products provided to employees of the manufacturer and for use by the United States, and would include administrative and compliance provisions. These provisions would--

(1) Limit the exemption for exports to products that are marked or

labelled under Treasury Department rules designed to prevent the diversion of such products into the domestic market.

(2) Prohibit the re-importation of tobacco products previously exported without payment of tax (other than for return to the manufacturer) and impose a new penalty, equal to the greater of $1,000 or five times the amount of tax on all parties involved in any prohibited re-importation. (All tobacco products and cigarette papers and tubes, as well as all vessels, vehicles, and aircraft used in such re-importations, would be subject to seizure by the United States.)

(3) Extend current manufacturer inventory maintenance, reporting requirements, criminal penalties, and forfeiture rules to importers of tobacco products.

(4) Repeal the present-law exemption for books or set of cigarette papers containing 25 or fewer papers.

(5) Limit the cover over of tobacco product revenues to Puerto Rico and the Virgin Islands to present-law tax levels.

Effective Date

The proposal generally would be effective for tobacco products removed after December 31, 1994. A floor stocks tax would be imposed on taxed tobacco products held on January 1, 1995.

B. ADDITIONAL MEDICARE PART B PREMIUMS FOR HIGH-INCOME INDIVIDUALS

Present Law

Medicare, authorized under Title XVIII of the Social Security Act, is a nationwide health insurance program for the aged and certain disabled persons. It consists of two parts: the hospital insurance (Part A) program and the supplementary medical insurance (Part B) program.

Most Americans age 65 or older are automatically entitled to coverage under Part A of Medicare. Part B of Medicare is voluntary. All persons age 65 or older may elect to enroll in Part B of Medicare by paying a flat monthly premium. The flat premium for 1994 is $41.10 per month. The premium rate is equal to 25 percent of estimated program costs for the coming year. Each individual who enrolls in Medicare Part B pays the same premium regardless of his or her income level. Benefits received under Part A and Part B of Medicare are excludable from the gross income of the recipient.

Description of Proposal

Under the proposal, taxpayers with modified adjusted gross income (AGI) above a threshold amount would be required to pay additional premiums for each month of coverage under Part B of Medicare. The maximum Medicare

Part B premium for high-income Medicare Part B enrollees would cover approximately 75 percent of estimated program costs, up from the current level of 25 percent.

For the purpose of these additional premiums, modified AGI would be AGI plus tax-exempt interest, certain foreign source income, and income from higher education U.S. savings bonds. The threshold amount would be $90,000 for unmarried taxpayers, $115,000 for married taxpayers filing joint returns, and $0 for married taxpayers filing separate returns. The amount of additional premiums would be phased in for taxpayers with modified AGI which exceeds the threshold amount by less than $15,000 ($30,000 for married taxpayers filing joint returns if each spouse is required to pay additional premiums).

Any additional Medicare Part B premiums imposed under this proposal would be treated as income taxes for purposes of subtitle F of the Code (relating to income tax procedure and administration) but would not be treated as income taxes for alternative minimum tax purposes (Code sec. 55), or for the purpose of determining the amount of other tax credits under the Code. Further, additional premiums imposed under this proposal would be deductible to the extent the premiums, when added to other medical expenses not otherwise deductible, exceed 7.5 percent of AGI.

Under the proposal, penalties for failure to pay estimated income tax would not be imposed on a taxpayer for any period prior to April 16, 1997, to the extent that the underpayment resulted from the failure to pay additional Medicare Part B premiums.

Proceeds from the collection of additional Medicare Part B premiums would be credited at least quarterly to the Supplemental Medical Insurance Trust Fund.

Effective Date

The proposal would be effective for taxable years beginning after December 31, 1995.

C. MODIFICATION TO SELF-EMPLOYMENT TAX TREATMENT OF CERTAIN S CORPORATION SHAREHOLDERS AND PARTNERS

Present Law

1. Employment taxes, in general

As part of the Federal Insurance Contributions Act (FICA), a tax is inposed on employees and employers up to a maximum amount of employee wages. The tax is composed of two parts: old-age, survivor, and disability insurance (OASDI) and Medicare hospital insurance (HI). For wages paid in 1993 to covered employees, the OASDI tax rate was 6.2 percent on both the employer and employee on the first $57,600 of wages and the HI tax rate was 1.45 percent on both the employer and employee on the first $135,000 of

wages. The cap on wages subject to the OASDI portion of FICA taxes is indexed to changes in the average wages in the economy. The cap on wages subject to the HI tax was repealed for wages and income received after December 31, 1993.

Similarly, under the Self-Employment Contributions Act (SECA), a tax is imposed on an individual's net earnings from self-employment (NESE). The SECA tax rate is the same as the total FICA rates for employers and employees (i.e., 12.4 percent for OASDI and 2.9 percent for HI) and the SECA base is capped and indexed in the same manner as is the FICA base. In general, the SECA tax is reduced to the extent the individual had wages for which FICA taxes were withheld during the year.

2. Treatment of partners and S corporation shareholders

The NESE of a partner in a partnership generally is the partner's distributive share from any trade or business of the partnership, adjusted for certain items of income that are passive in nature (e.g., rentals of real estate, dividends, and interest are excluded from NESE unless such amounts are received in the course of a trade or business of a dealer in the related property). However, the distributive share of a limited partner generally is excluded from NESE except to the extent the distributive share is a guaranteed payment for services actually rendered to or on behalf of the partnership.

Similar rules are not provided for shareholders in S corporations. Thus, shareholders are not required to include as NESE their pro rata share of the income of an S corporation. Rather, shareholders who perform services for the S corporation are subject to FICA taxes on the wages paid to them.[5]

Description of Proposal

1. In general

The proposal would: (1) amend the definition of NESE to include eighty percent of certain S corporation income of shareholder-service providers owning more than two percent of the stock of the S corporation; (2) modify the NESE rules applicable to limited partners in a partnership; and (3)

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[5] Furthermore, a shareholder of an S corporation may be subject to FICA tax even if the shareholder is not paid amounts denominated as "wages" by the corporation. In Rev. Rul. 74-44, 1974-1 C.B. 287, the IRS held that two shareholders who performed services for an S corporation but did not draw salaries were subject to FICA tax on dividend distributions from the corporation because the dividends represented reasonable compensation for the services performed. See, also, Spicer Accounting, Inc. v. U.S., 918 F2d 90 (9th Cir. 1990) and Dunn & Clark, P.A. v. U.S., No. CV 93-0108-E-EJL, (DC Idaho, 3/25/94) for similar results.

provide a special SECA exclusion for certain income derived from inventory for all taxpayers.

2. S corporation shareholders

Under the proposal, in the case of a "2-percent shareholder" of an S corporation for any taxable year who provides significant services to or on behalf of the corporation during the year, NESE would include 80 percent of the shareholder's pro rata share of taxable income or loss from "service-related businesses" carried on by the S corporation. A "2-percent shareholder" would be any shareholder that owns more than 2 percent of the stock of an S corporation at any time during the year (sec. 1372(b)). The shareholder's pro rata share of the income or loss of an S corporation would be determined pursuant to the general rules of subchapter S (sec. 1366). A "service-related business" would be any trade or business involving the performance of services in the fields of health (other than with respect to in-patient personal care facilities), law, engineering, architecture, accounting, actuarial services, performing arts, consulting, athletics, financial services (other than lending or brokerage services), or any trade or business where the Secretary of the Treasury determines that capital is an insignificant income-producing factor for the trade or business.

The present-law exclusions from NESE for certain passive income that apply to sole proprietors and partnerships would also apply to S corporations.

3. Limited partners

In the case of a limited partner of a partnership who provides significant services to or on behalf of the partnership during the year, NESE would include 80 percent of the partner's distributive share (other than guaranteed payments for services) of taxable income or loss from service-related businesses (as defined above) carried on by the partnership. The proposal would retain the present-law guaranteed payment rule for limited partners who provide services to or on behalf of the partnership. Thus, a limited partner who provides significant services to or on behalf of the partnership during the year would include in NESE: (1) 100 percent of any guaranteed payments received for services plus (2) 80 percent of any remaining distributive share of taxable income from service-related businesses carried on by the partnership.

4. Inventory income

The proposal would allow a taxpayer to reduce his or her NESE for the taxable year by a percentage of the lesser of: (1) the amount of the taxpayer's allocable share of inventory income or (2) the amount that the taxpayer's NESE for the year exceeds $135,000. For this purpose, "inventory income" generally would be gross profit from the sale of inventory, less the appropriate trade or business expenses allocable to such activity. In the case of a dealer in securities (as defined in sec. 475), inventory income generally would include interest, dividends, and

other income with respect to securities held as inventory (as generally defined in sec. 475). The $135,000 amount would be reduced by the amount of the taxpayer's wages that are subject to FICA and would be indexed to changes in the average wages in the economy.

5. Other

The proposal would make conforming amendments to the Social Security Act.

The proposal is not intended to change the present-law authority of the Internal Revenue Service to ascertain the reasonable compensation derived by a self-employed taxpayer (or a shareholder-employee) from his or her trade or business (or the trade or business of his or corporation) for payroll tax purposes.

Effective Date

The proposal would apply to taxable years of individuals beginning after December 31, 1995, and to taxable years of S corporations and partnerships ending with or within such taxable years of individuals.

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

Present Law

Under present law, State and local government employees hired before April 1, 1986, are not covered under Medicare unless a voluntary agreement providing for such coverage is in effect. Although the hospital insurance payroll tax does not apply to such employees, they may receive Medicare benefits, for example, through their spouse. Medicare coverage and the hospital insurance payroll tax is mandatory for State and local government employees hired on or after April 1, 1986, and for Federal employees.

For wages paid in 1994 to Medicare-covered employees, the total hospital insurance tax rate is 2.9 percent of total wages. One-half of the hospital insurance tax (1.45 percent) is imposed on the employee and one-half on the employer.

Description of Proposal

The proposal would extend Medicare coverage on a mandatory basis to all employees of State and local governments not otherwise covered under present law, without regard to their dates of hire. These employees and their employers would become liable for the hospital insurance tax, and the employees would earn credit toward Medicare eligibility.

In addition, the service of State and local government employees prior to October 1, 1995, would be considered covered employment for purposes of determining eligibility for Medicare coverage. The Department of the

Treasury would be required to reimburse the Federal Hospital Insurance Trust Fund for additional payments made, administrative expenses incurred, and any interest losses which occur as a result of the recognition of the prior service of State and local government employees for Medicare eligibility purposes.

Effective Date

The proposal would apply to services performed by State and local government employees after September 30, 1995.

E. CREDIT FOR HEALTH INSURANCE COSTS OF INDIVIDUALS NOT ELIGIBLE FOR SUBSIDIZED EMPLOYER-PROVIDED HEALTH CARE

Present Law

Under present law, individuals who itemize deductions may deduct amounts paid during the taxable year (if not reimbursed by insurance or otherwise) for medical care of the taxpayer, or the taxpayer's spouse and dependents, to the extent that the total of such expenses exceeds 7.5 percent of the taxpayer's adjusted gross income (AGI). For purposes of the deduction, medical care generally includes insurance premiums, as well as out-of-pocket medical expenses.

In addition, under present law, self-employed individuals cannot exclude the cost of health insurance from gross income. For this purpose, self-employed individuals include sole proprietors, partners in partnerships, and more than 2-percent shareholders of S corporations. Prior to January 1, 1994, a self-employed individual could deduct from gross income 25 percent of the health insurance costs of the individual and his or her spouse or dependents. The 25-percent deduction was not available for any month if the self-employed individual was eligible for employer-paid (i.e., employer subsidized) health benefits under a plan of an employer of the individual or the individual's spouse. In addition, no deduction was available to the extent that the deduction exceeded the taxpayer's earned income.

Description of Proposal

1. In general

The proposal would extend the 25-percent deduction for health insurance expenses of self-employed individuals, effective for taxable years beginning after December 31, 1993. For taxable years beginning on or after January 1, 1996, the proposal would provide a nonrefundable tax credit for health insurance costs of individuals (including self-employed individuals) who do not have employer-subsidized health coverage.

2. Credit for health insurance costs

The credit would equal 15 percent of premiums, net of any government

subsidies, paid by an individual (including a self-employed individual) for health insurance for the individual, or the individual's spouse or dependents, with respect to a certified standard health plan. In the case of an individual in the 15 percent rate bracket, the 15- percent credit is equivalent to a deduction for 100 percent of premiums. The credit is equivalent to a deduction for more than 50 percent of premiums in the case of an individual in the 28 percent rate bracket.

The credit would apply only to the cost of insurance with respect to a certified standard health plan. Thus, uninsured and out-of-pocket medical expenses (e.g., copayments, deductibles, and uncovered expenses), and premiums paid for supplemental or other nonstandard health insurance, would not be eligible for the credit, but would be deductible to the extent that total medical expenses exceed 7.5 percent of AGI. Expenses that are eligible for the credit would not be taken into account for purposes of determining whether total medical expenses exceed the 7.5 percent floor.

The credit would not be available for any month with respect to coverage of an individual if the individual is eligible to participate in a subsidized certified standard health plan maintained by an employer. For example, if an individual is eligible to participate in a subsidized health plan of an employer, but such plan does not offer subsidized coverage of dependents of the individual, then the credit would be available with respect to the purchase of dependent health insurance coverage. In such a case, the credit would apply only with respect to the additional cost of the dependent coverage.

Effective Date

The 25-percent deduction for self-employed individuals would be extended effective for taxable years beginning after December 31, 1993, and before January 1, 1996. The credit for insurance expenses would be effective for taxable years beginning on or after January 1, 1996.

F. LIMITATION ON PREPAYMENT OF MEDICAL INSURANCE PREMIUMS

Present Law

Under present law, individuals who itemize deductions may deduct amounts paid during the taxable year (if not reimbursed by insurance or otherwise) for medical care of the taxpayer, and the taxpayer's spouse and dependents to the extent that the total of such expenses exceeds 7.5 percent of the taxpayer's adjusted gross income (AGI).

Under a special rule, premiums paid during the taxable year by a taxpayer before he or she attains age 65 for insurance covering medical care for the taxpayer, or the taxpayer's spouse or a dependent, after the taxpayer attains age 65 are treated as expenses paid during the taxable year for insurance that constitutes medical care if premiums for the insurance are payable (on a level payment basis) under the contract for a period of 10 years or more or until the year in which the taxpayer attains

age 65 (but in no case for a period of less than five years).

A series of revenue rulings has held that, under certain circumstances, the portion of a fee paid for lifetime care that is properly allocable to medical expenses is deductible in the year paid, even though the medical services will not be performed until a future time, if at all. The Internal Revenue Service has recently issued a revenue ruling stating that the prior rulings should not be interpreted as allowing a current deduction of payments for future medical care (including medical insurance) extending substantially beyond the close of the taxable year in situations where the future care is not purchased in connection with obtaining lifetime care of the type described in the prior rulings. The recent revenue ruling states that it will not be applied to amounts paid before October 14, 1993, or to amounts paid on or after October 14, 1993, pursuant to the terms of a binding contract entered into before that date if such terms were in effect on that date.

Description of Proposal

The proposal would provide that, for purposes of the itemized deduction for medical expenses and the credit for health insurance costs of individuals not eligible for subsidized employer-provided health care, amounts paid during a taxable year that are allocable to insurance coverage or medical care to be provided more than 12 months after the month in which the payment is made would be treated as paid ratably over the period during which the coverage or care is to be provided. The proposal would not amend the special rule under present law for post-age 65 medical insurance.

Effective Date

The proposal would apply to amounts paid after December 31, 1994.

G. DEFINITION OF EMPLOYEE

Present Law

1. In general

In general, the determination of whether an employer-employee or independent contractor relationship exists for Federal tax purposes is made under a common-law test. Under this test, an employer-employee relationship generally exists if the person contracting for the services has the right to control not only the result of the services, but also the means by which that result is accomplished (Treas. Reg. sec. 31.3401(c)-(1)(b)). Whether the requisite control exists is determined based on the facts and circumstances. The Internal Revenue Service (IRS) uses a 20-factor test for this purpose. Rev. Rul. 87-41, 1987-1 C.B. 296. In addition to the common-law test, there are statutory provisions classifying certain employees as employees or independent contractors for certain purposes.

2. Section 530 of the Revenue Act of 1978

In the late 1960s, the IRS increased enforcement of the employment tax laws, and controversies developed between the IRS and taxpayers as to whether businesses had correctly classified certain employees as independent contractors rather than as employees. In response to this problem, Congress enacted section 530 of the Revenue Act of 1978 ("section 530"), which generally permits a taxpayer to treat an individual as not being an employee for employment tax purposes regardless of the individual's actual status under the common-law test, unless the taxpayer has no reasonable basis for such treatment and if certain additional requirements are satisfied. Section 530 does not apply in the case of an individual who, pursuant to an arrangement between the taxpayer and another person, provides services for such other person as an engineer, designer, drafter, computer programmer, systems analyst, or other similarly skilled employee engaged in a similar line of work.

Under section 530, a reasonable basis is deemed to exist for a period if the taxpayer reasonably relied on any of the following: (1) judicial precedent, published rulings, technical advice with respect to the taxpayer, or a letter ruling to the taxpayers; (2) a past IRS audit of the taxpayer in which there was no assessment attributable to the treatment (for employment tax purposes) of the individuals holding positions substantially similar to the position held by the individual in question; or (3) long-standing recognized practice of a significant segment of the industry in which such individual was engaged. These factors are a safe harbor, not the exclusive means of meeting the reasonable basis requirement.

Section 530 does not apply for income tax purposes. Thus, the determination of whether an individual is an employee for income tax purposes is made without regard to section 530.

Section 530 bars the Department of the Treasury (including the IRS) from publishing any regulation or revenue ruling classifying individuals for purposes of employment taxes under interpretations of the common law. Taxpayers may, however, obtain private letter rulings from the IRS regarding the status of employees.

Description of Proposal

The proposal would authorize the Department of the Treasury to issue regulations relating to the classification of workers as employees or independent contractors under the common-law test. Such regulations, which would apply only on a prospective basis, could not have the effect of repealing the ability of any taxpayer to utilize a safe harbor provision contained in section 530 of the Revenue Act of 1978. Thus, any taxpayer who relies on a safe harbor provision of section 530 under present law could continue to do so.

Effective Date

The proposal would be effective on the date of enactment.

H. INCREASE IN PENALTIES FOR FAILURE TO FILE CORRECT INFORMATION RETURNS WITH RESPECT TO NON-EMPLOYEES

Present Law

1. Information reporting requirements

Under sections 6041 and 6041A of the Internal Revenue Code, a person who makes payments of $600 or more to a person during a calendar year for services received in the course of a trade or business generally must file with the Internal Revenue Service (IRS) an information return reporting such payments, and the name, address, and taxpayer identification number of the payee. A similar statement must also be furnished to the payee.

2. Failure to file correct information returns

Any person that fails to file a correct information return with the IRS on or before the prescribed filing date is subject to a penalty that varies based on when, if at all, the correct information return is filed. If a person files a correct information return after the prescribed filing date but on or before the date that is 30 days after the prescribed filing date, the penalty is $15 per return, with a maximum penalty of $75,000 per calendar year. If a person files a correct information return more than 30 days after the prescribed filing date but on or before August 1 of the relevant year, the penalty is $30 per return, with a maximum penalty of $150,000 per calendar year. If a correct information return is not filed on or before August 1 of the relevant year, the amount of the penalty is $50 per return, with a maximum penalty of $250,000 per calendar year.

Special rules are applicable to certain small businesses and to incorrect information returns that are corrected on or before August 1 of the relevant year.

Description of Proposal

The proposal would modify the penalty for failure to file correct information returns under Code sections 6041 and 6041A with respect to services.[6] In general, the proposal would increase the penalty for failure to file correct information returns on or before August 1 of the relevant year from $50 for each return to the greater of $50 or 5 percent of the amount required to be reported correctly but not so reported.

The proposal would also provide an exception to this increase where substantial compliance has occurred. This exception would apply with respect to a calendar year if the aggregate amount that is timely and correctly reported under Code sections 6041 and 6041A with respect to services for that calendar year is at least 97 percent of the aggregate

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[6] The proposal would not apply to information returns required under section 6041 that are not with respect to payments for services.

amount required to be reported under these two sections of the Code for that calendar year. If this exception applies, the penalty of $50 for each return would continue to apply.

Effective Date

The proposal would apply to information returns the due date for which (without regard to extensions) is more than 30 days after the date of enactment.

I. TAX TREATMENT OF ACCELERATED DEATH BENEFITS UNDER LIFE INSURANCE CONTRACTS

Present Law

If a contract meets the definition of a life insurance contract, gross income does not include insurance proceeds that are paid pursuant to the contract by reason of the death of the insured. In addition, the undistributed investment income ("inside buildup") earned on premiums credited under the contract is not subject to current taxation to the owner of the contract. The exclusion from income applies regardless of whether the death benefits are paid as a lump sum or otherwise.

Amounts received under a life insurance contract (other than a modified endowment contract) prior to the death of the insured are includible in the gross income of the recipient to the extent that the amount received exceeds the taxpayer's investment in the contract (generally, the aggregate amount of premiums paid less amounts previously received that were excluded from gross income).

In contrast, if a contract fails to meet the definition of a life insurance contract, inside buildup on the contract is generally subject to tax. To qualify as a life insurance contract for Federal income tax purposes, a contract must be a life insurance contract under the applicable State or foreign law and must satisfy either of two alternative tests: (1) a cash value accumulation test, or (2) a test consisting of a guideline premium requirement and a cash value corridor requirement.

The Treasury Department has issued proposed regulations under which certain "qualified accelerated death benefits" paid to an insured because of his or her terminal illness would be treated as paid by reason of the death of the insured and therefore would qualify for the present-law exclusion from income.[7]

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[7] Under the proposed regulations, a benefit would qualify as a qualified accelerated death benefit only if it meets three requirements. First, the qualified accelerated death benefit can be payable only if the insured becomes terminally ill. Second, the amount of the benefit must equal or exceed the present value of the reduction in the death benefit otherwise payable. Third,

Description of Proposal

The proposal would provide an exclusion from gross income for certain amounts received under a life insurance contract[8] if the insured under the contract is terminally ill. For this purpose, an individual would be considered terminally ill if the insurer determines, after receipt of an acceptable certification by a licensed physician, that the individual has an illness or physical condition that is reasonably expected to result in death within 12 months of the certification.

The exclusion under the proposal would be applicable only if two requirements are met. First, the amount received must equal or exceed the present value of the reduction in the death benefit otherwise payable under the life insurance contract. The present value would be determined by reference to a maximum permissible discount rate,[9] and by assuming that the death benefit would be paid on the date that is 12 months from the date of the physician's certification. Second, the payment of the amount must reduce the cash surrender value and the death benefit payable under the contract proportionately.

The proposal would not apply in the case of a distribution to any taxpayer other than the insured, if such taxpayer has an insurable interest by reason of the insured being an officer or employee of the taxpayer, or

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the payment of the benefit must make a pro rata reduction in the cash surrender value and the death benefit under the policy. For purposes of the proposed regulations, an insured person would be treated as terminally ill if he or she has an illness that, despite appropriate medical care, is reasonably expected to result in death within 12 months from the date of payment of the accelerated death benefit. The proposed regulations would not explicitly require a doctor's certification as to the patient's condition. Under the proposed regulations, the maximum permissible discount rate would be the greater of (1) the applicable Federal rate (AFR) that applies under the discounting rules for property and casualty insurance loss reserves, or (2) the interest rate applicable to policy loans under the contract.

[8] The amount received for this purpose would include an amount received that gives rise to a lien of the issuing company against the contract.

[9] The maximum permissible discount rate would be the highest of the following three government and commercial rates: (1) the 90-day Treasury bill yield, (2) Moody's Corporate Bond Yield Average-Monthly Average Corporates (or any successor rate) for the month ending two months before the date the rate is determined, or (3) the rate used to determine cash surrender values under the contract during the applicable period plus 1 percent per annum.

by reason of the insured being financially interested in any trade or business carried on by the taxpayer.

For life insurance company tax purposes, the proposal would treat a qualified accelerated death benefit rider to a life insurance contract as life insurance.

Effective Date

The proposal generally would apply to amounts received after the date of enactment. A transition rule would provide that the rule determining the present value of the reduction in the death benefit (by reference to a maximum permissible discount rate and a 12-month period) would not apply to any amount received before January 1, 1995. The issuance of a qualified accelerated death benefit rider to a life insurance contract would not be treated as a modification or material change of the contract. The proposal treating a qualified accelerated death benefit rider as life insurance for life insurance company tax purposes would take effect on January 1, 1995.

J. TAX CREDIT FOR THE COST OF PERSONAL ASSISTANCE SERVICES REQUIRED BY INDIVIDUALS

Present Law

There is no tax credit for the costs of personal assistance required by individuals. Certain medical expenses, however, are deductible under section 213. Also, the costs of certain improvements to property may be included in the basis of a taxpayer's property unless it is otherwise deductible under section 213.

Description of Proposal

The proposal would provide a nonrefundable tax credit for up to 50 percent of an individual's personal assistance expenses up to $15,000.

Individuals would be eligible to claim the credit if, by reason of any medically determinable physical impairment, they are unable to engage in any substantial gainful activity without personal assistance in carrying out activities of daily living. Such physical impairment must be expected to result in death or must be expected to last for a continuous period of not less than 12 months. Nonresident aliens would not be eligible to claim the credit.

Personal assistance expenses would include expenses for: (1) personal assistance services appropriate to carry out the activities of daily living in or outside the home, (2) homemaker/chore services incidental to the provision of such personal assistance services, (3) assistance with life skills (in the case of an individual with a cognitive impairment), (4) communication services, (5) work-related support services, (6) coordination of services described in this paragraph, (7) assistive technology and devices (including assessment of need and training for such services), and

(8) modifications to the principal place of abode of the individual. Activities of daily living would be defined to include eating, toileting, transferring, bathing, and dressing.

The maximum annual amount of credit would be the lesser of $7,500 or one-half of the individual's earned income. The amount of the credit would be phased out by providing a lower credit rate for taxpayers with modified adjusted gross income (AGI) of $50,000 or more. The credit rate would be reduced by ten percentage points for each $5,000 of modified AGI, starting at $50,000 of modified AGI. Thus the credit would not be available for individuals with modified AGI of $70,000 or more.

The rate of the credit would be determined as follows —

For taxpayers with modified AGI:	The credit rate would be:
Less than $50,000	50 percent
At least $50,000, but less than $55,000	40 percent
At least $55,000, but less than $60,000	30 percent
At least $60,000, but less than $65,000	20 percent
At least $65,000, but less than $70,000	10 percent
At least $70,000	0 percent

The $15,000 (maximum amount of personal assistance expenditures eligible for the credit) and $50,000 (beginning of the credit's phaseout range) amounts would be indexed for inflation for taxable years beginning after 1996. The amount of modified AGI at which the credit is entirely phased out would not be indexed for inflation, but would always be $20,000 greater than the beginning of the phaseout range.

Modified AGI would mean adjusted gross income: (1) determined without regard to the exclusions provided for (a) interest on education savings bonds (sec. 135), (b) certain foreign earned income of United States citizens or residents living abroad (sec. 911), (c) certain income from sources within Guam, American Samoa, or the Northern Mariana Islands (sec. 931), and (d) income from sources within Puerto Rico (sec. 933); and (2) increased by the amount of tax-exempt interest received or accrued by the taxpayer during the taxable year.

Any amount taken into account in determining the credit could not be taken into account in determining deductible medical expenses (under sec. 213). Similarly, if a credit is allowed for expenses that would otherwise increase the basis of property, the basis increase would be reduced by the amount of the credit. The proposal also would deny the credit for payments to any person related to the taxpayer within the meaning of sections 267 or 707(b).

Effective Date

The proposal would be effective for taxable years beginning after

December 31, 1995.

K. TAX TREATMENT OF ORGANIZATIONS PROVIDING HEALTH CARE SERVICES AND RELATED ORGANIZATIONS

Present Law

1. Exempt status of charities

Code section 501(c)(3) lists certain types of organizations that are exempt from taxation, including those organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes no part of the net earnings of which inures to the benefit of any private shareholder or individual. Contributions to such organizations generally are deductible for Federal income tax purposes. In addition, such organizations are eligible for tax-exempt financing that is not subject to the State volume cap otherwise applicable to private users of tax-exempt financing and, in the case of hospitals, are exempt from the $150 million limit otherwise applicable to the amount of tax-exempt financing from which a section 501(c)(3) organization can benefit.

Although section 501(c)(3) does not specifically mention the furnishing of medical care and the operation of a not-for-profit hospital, such activities have long been considered to further charitable purposes described in section 501(c)(3) if they provide a community benefit (the so-called "community benefit standard"). The community benefit standard is a facts-and-circumstances test that the IRS has applied since 1969, under which a number of factors are examined (e.g., whether a hospital has an open emergency room, a board of directors drawn from the community, an open medical staff, treats Medicare and Medicaid patients, and applies surplus receipts to improving facilities, patient care, and medical education and research) to determine whether the organization provides benefits to the community as a whole rather than serving private interests. The same community benefit standard applies in determining whether a health maintenance organization ("HMO") qualifies for tax-exempt status under section 501(c)(3), although slightly different characteristics are examined.

2. Exempt status of social welfare organizations

Code section 501(c)(4) provides an exemption from income tax for organizations operated primarily to promote the common good and general welfare of the people in the community. Although social welfare organizations are exempt from income tax, contributions to such organizations are not deductible, and such organizations are not eligible to benefit from tax-exempt financing beyond financing available to other private users.

An HMO seeking exemption as a social welfare organization under section 501(c)(4) is not required to possess all of the same characteristics as an HMO that qualifies for exemption under section

501(c)(3); however, its activities must generally satisfy a community benefit standard similar to, but less exacting than, that imposed on charitable HMOs.

3. Private inurement

a. Charities.--Section 501(c)(3) specifically conditions tax-exempt status for all organizations described in that section on the requirement that no part of the net earnings of the organization inures to the benefit of any private shareholder or individual (the so-called "private inurement test").

Organizations described in section 501(c)(3) are classified as either public charities or private foundations. Private foundations (but not public charities) are subject to special penalty excise taxes that may be imposed on "self-dealing" transactions or on expenditures that do not accomplish a charitable purpose. Nonprofit hospitals, and other nonprofit entities the principal purpose or functions of which are providing medical care, automatically are eligible for public-charity status and, thus, are not subject to the special penalty excise taxes.

b. Social welfare organizations.--There is no specific statutory rule prohibiting the net earnings of a social welfare organization described in section 501(c)(4) from inuring to the benefit of a private shareholder or individual.

c. IRS remedy in cases of private inurement.--Because the Code generally does not provide for the imposition of penalty excise taxes in cases where a section 501(c)(3) public charity or a section 501(c)(4) social welfare organization engages in a transaction not furthering a tax-exempt purpose, the only sanction that may be imposed under the Code is revocation of the organization's tax-exempt status.

4. Filing and public disclosure rules applicable to tax-exempt organizations

Tax-exempt organizations generally are required to file an annual information return (Form 990) with the IRS. Code section 6104 requires that a tax-exempt organization (other than a private foundation) make available for public inspection at the organization's principal office a copy of the organization's Form 990 (except for the names of contributors to the organization) for the three most recent taxable years, as well as the organization's application to the IRS for recognition of tax-exempt status.

5. Insurance activities of tax-exempt organizations

Section 501(m) provides that an organization is not eligible for tax-exempt status under section 501(c)(3) or 501(c)(4) if a substantial part of its activities consists of providing "commercial-type insurance." Commercial-type insurance generally includes any insurance of a type provided by commercial insurance companies, but does not include incidental

health insurance provided by an HMO of a kind customarily provided by an HMO.

6. HMOs as taxable entities

The tax treatment of a taxable HMO (e.g., an HMO organized on a for-profit basis) depends largely on the extent to which it qualifies as an insurance company. In determining taxable income, property and casualty insurance companies include underwriting income. In calculating underwriting income, the company generally may take a reserve deduction for a portion of its unearned premiums and for the discounted amount of losses incurred (including incurred but not reported losses). These deductions may not reflect the "all events" test or the economic performance requirements that generally apply to accrual-method taxpayers.

7. Special rules applicable to certain taxable insurance companies

Section 833 provides special relief for Blue Cross and Blue Shield organizations existing on August 16, 1986, which were exempt from tax for their last taxable year beginning before January 1, 1987, and which have experienced no material change in their structure or operations since August 16, 1986. In addition, section 833 provides special relief for certain other organizations, substantially all of the activities of which involve the provision of health insurance, that meet certain community-service-related requirements.

Section 833 exempts eligible organizations from the rule (referred to above) that is generally applicable to property and casualty insurance companies, requiring a 20-percent reduction in the amount a company can deduct for any increase in unearned premium reserves. In addition, section 833 permits eligible organizations to claim a special deduction with respect to their health business in an amount equal to 25 percent of claims and expenses incurred during the taxable year, less adjusted surplus at the beginning of the year.

Description of Proposal

1. Requirements for tax-exempt health care service organizations

The proposal would impose new requirements on section 501(c)(3) or 501(c)(4) organizations that have as their predominant activity the provision of "health care services."[10] The requirements, therefore,

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[10] The term "health care services" would mean --

(i) any activity for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purposes of affecting any structure or function of the body;

(ii) any activity (such as nursing or old age

generally would apply to tax-exempt hospitals, clinics, nursing homes, old age homes, and HMOs. The proposal would not apply to organizations whose predominant activities are non-health care service activities (e.g., an educational organization, if the predominant activities of the organization do not involve the delivery of health care services to patients). In addition, the proposal specifically would provide that the new requirements do not apply to an organization that demonstrates, consistent with Treasury guidance, that a principal purpose of the organization is academic training or medical research, or to an organization that provides only uncompensated care regardless of the patient's income. The proposal would not apply to State and local governmental entities.

Under the proposal, in addition to satisfying a community benefit standard, tax-exempt organizations described in present-law section 501(c)(3) or 501(c)(4) that have as their predominant activity the provision of health care services would be required to:

(1) provide (directly or indirectly) significant "qualified outreach services." The term "qualified outreach services" would be defined as health care services, or related education or social services programs, provided (a) in an area that is medically underserved with respect to such health care services (such as a health professional shortage area "HPSA" designated by the Secretary of HHS or an area or population group reasonably determined by the organization, consistent with Treasury guidance, to have a shortage of health professionals relative to the number of individuals and their health needs in the area or population group); (b) below cost to individuals otherwise unable to afford such services; or (c) at specialty emergency care facilities that normally operate at a loss (i.e., emergency trauma, emergency psychiatry, or burn centers). An organization would demonstrate that it provides significant qualified outreach services on a facts-and-circumstances basis. An organization would have the option of directly furnishing such services or indirectly providing such services by making a grant or contribution to a donee organization that furnishes qualified outreach services. The provision of insurance would constitute a "qualified outreach service" only if provided on a subsidized basis.

(2) with the participation of community representatives, annually assess the health care and qualified outreach service needs of the community and develop a written plan that sets forth how the organization plans to meet those needs;

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home care) which is part of the exempt purpose of a 501(c)(3) organization solely because it is carried on as part of an activity described in (i) above; and

(iii) insurance (that is not commercial-type insurance under section 501(m)) with respect to an activity described in (i) or (ii) above.

(3) not discriminate in the provision of health care services on the basis of whether an individual is insured by a government-sponsored health plan (e.g., Medicare); and

(4) if the organization provides emergency health care services, not discriminate in the provision of such emergency services on the basis of the patient's ability to pay.

Disclosure requirements.--Organizations would be required to make available to the general public and the IRS the written community health care and outreach service needs plan required in (2) above, in the same manner that the Form 990 is required to be available under present law. In addition, organizations would be required to comply with requests from individuals who seek a copy of such plan (and, if so requested, a copy of the Form 990) by supplying copies without charge other than a reasonable fee for reproduction and mailing costs. (The requirement to provide copies could be waived by the IRS in cases involving abusive, excessive requests for documents). Organizations would be required to disclose information regarding the organization's implementation of the prior year's plan (including unrecovered costs and revenues foregone in furtherance of such plan). An organization also would be required to disclose if it has participated in an improper private inurement transaction that has resulted in the imposition of penalty taxes on a disqualified person or organization manager (see intermediate sanctions described below).

Effective date.--The new statutory requirements for certain tax-exempt health care service organizations would be effective on January 1, 1995.

2. HMO qualification under section 501(c)(3)

Under the proposal, an HMO seeking tax-exempt status under section 501(c)(3) would be required to furnish substantially all of its primary care health services at its own facilities through health care professionals who do not provide substantial health care services other than on behalf of such organization. Thus, tax-exempt status under section 501(c)(3) would be available to an HMO only if it is organized according to a so-called "staff model" or "dedicated-group model." In contrast, an HMO seeking tax-exempt status under section 501(c)(4) would not be required directly to furnish health care services at its own facility (but would, however, be required to meet the requirements of section 501(m), discussed below).

Effective date.--The proposal would be effective on the date of enactment.

3. Tax-exempt status for health insurance purchasing cooperatives and certain parent organizations

Qualified health insurance purchasing cooperatives would be eligible for Federal tax-exempt status, provided that private inurement, lobbying, and political activity restrictions are satisfied (similar to present-law section 501(c)(3)). Health insurance purchasing cooperatives generally

would not be eligible to use financing provided from the proceeds of tax-exempt bonds.

The proposal further would clarify that, under present-law section 509(a), organizations that serve as parent holding companies for hospitals or medical research organizations qualify as public charities rather than private foundations.

Effective date.--These proposals would be effective on the date of enactment.

4. Extend private inurement prohibition to social welfare organizations

The proposal would amend section 501(c)(4) to provide that if a social welfare organization or other organization described in that section has as its predominant activity the provision of health care services, such organization is eligible for tax-exempt status only if no part of its net earnings inures to the benefit of any private shareholder or individual.

Effective date.--The proposal generally would be effective on the date of committee action. However, under a special transition rule, the proposal would not apply to inurement occurring within two years of the date of committee action if such inurement results from a contractual arrangement that was in effect on the date of committee action and is not materially changed before such inurement occurs.

5. Intermediate sanctions for violations of private inurement prohibition

The proposal would impose two-tiered penalty excise taxes as an intermediate sanction in cases where "applicable tax-exempt health care organizations," meaning organizations described in section 501(c)(3) or section 501(c)(4) that have as their predominant activity the providing of health care services (other than private foundations), engage in a transaction resulting in "taxable inurement." These intermediate sanctions could be imposed by the IRS in lieu of revocation of an organization's tax-exempt status. The IRS would have authority to abate the excise tax penalty if the organization establishes that the violation was due to reasonable cause and not due to willful neglect.

"Taxable inurement" would mean any direct or indirect inurement of any part of the net earnings of an organization to the benefit of a disqualified person. Prohibited inurement would result from transactions in which a disqualified person receives unreasonable compensation or engages in a non-fair-market-value transaction with the organization, or from revenue sharing arrangements with a disqualified person that violate the present-law private inurement prohibition. The proposal would clarify that existing tax law standards would apply in determining reasonableness of compensation and fair market value and would identify certain procedural measures that an organization could take to create a presumption of the reasonableness of a compensation arrangement (e.g., approval of the compensation arrangement by an independent board). The proposal also would clarify that payment of personal expenses of, or other benefits granted to,

disqualified persons generally would be treated as compensation only if the organization intended and made the payments as compensation for services (e.g., the payments were included on the W-2 of the disqualified person). The Secretary of Treasury would be instructed to conduct a study of and issue guidance regarding transactions and arrangements that give rise to taxable inurement.

"Disqualified persons" would mean any person who was an organization manager at any time during the five-year period prior to the transaction at issue, as well as certain family members and 35-percent owned entities. The term "organization manager" would mean any officer, director, or trustee of a public charity or social welfare organization (or an individual having powers or responsibilities similar to those of officers, directors, or trustees of the organization), as well as any other individual who is in a position to exercise substantial influence over the affairs of the organization. Any person performing substantial medical services as a physician pursuant to an employment or other contractual relationship with the organization would be treated as an "organization manager."

Beneficiaries of taxable inurement would be subject to a first-tier penalty tax equal to 25 percent of the amount of the taxable inurement (e.g., the amount paid to a disqualified person exceeding reasonable compensation). Organization managers who knowingly participate in taxable inurement would be subject to a first-tier penalty tax of 2.5 percent of the amount of taxable inurement (subject to a maximum amount of tax of $10,000).

Additional, second-tier taxes would apply if "taxable inurement" is not corrected within a specified time period. In such cases, the beneficiary would be subject to a penalty tax equal to 200 percent of the amount of taxable inurement. Organization managers who refused to agree to correction would be subject to a penalty tax equal to 50 percent of the amount of taxable inurement (subject to a maximum amount of tax of $10,000). The term "correction" would mean undoing the inurement to the extent possible, establishing safeguards to prevent future inurement, and where fully undoing the inurement is not possible, such additional corrective action as prescribed by Treasury regulations.

Effective date.--The proposal would apply to inurement occurring on or after the date of committee action.

6. Insurance activities of tax-exempt organizations

Present-law section 501(m) would be clarified to provide that a health maintenance organization shall be treated as not providing commercial-type insurance if and only if: (1) care is provided by the organization to its members at its own facilities through health professionals who do not provide substantial health care services other than on behalf of the organization; (2) care is provided by a health care professional to a member of the organization on a basis under which substantially all of the risk with respect to rates of utilization by the member is assumed by the

health care professional; or (3) if ancillary to care described in (1) or (2), either (a) care other than primary care is provided to a member pursuant to a referral by the HMO, or (b) emergency care is provided to a member at a location outside the member's area of residence.

Effective date.--The proposal would be effective on the date of enactment.

7. Definition of taxable property and casualty insurance companies

The proposal would expand the scope of organizations treated as taxable property and casualty insurance companies. Under the proposal, any organization that is not tax-exempt, is not a life insurance company, and whose primary and predominant business activity during the taxable year falls into one of three categories, would be treated as a property and casualty insurance company. The three categories of activities are: (1) issuing accident and health insurance contracts or reinsuring accident and health risks; (2) operating as an HMO; or (3) entering into arrangements under which fixed payments or premiums are received by the organization as consideration for providing or arranging for the provision of health care services. The proposal would modify the "primary and predominant" requirement in the case of organizations that have, as a material business activity, the issuing or reinsurance of accident and health insurance contracts. For such organizations, the administering of accident and health insurance contracts would be treated as part of such business activity for purposes of determining whether the organization's activities fall within the scope of category (1) above.

Effective date

The proposal would be effective for taxable years beginning after December 31, 1994. A transition rule would provide that, for an organization other than one which (1) treated itself as subject to tax as a property and casualty insurance company on its original Federal tax return for taxable years beginning in 1992 through 1994, or (2) was tax-exempt for its last taxable year beginning before 1995, the change made by the proposal would be treated as a change in method of accounting, and required adjustments would be taken into account for its first taxable year beginning after December 31, 1994. A transition rule for any organization that was tax-exempt for its last taxable year beginning before 1995 and that becomes taxable under the proposal for its first taxable year beginning after December 31, 1994 would provide that, in general, (1) no adjustment would be made under section 481 due to a change in method of accounting required by the proposal for the organization's first taxable year beginning after December 31, 1994, and (2) adjusted basis for determining gain or loss of assets would be equal to fair market value on the first day of its first taxable year beginning after December 31, 1994.

8. Special rules applicable to certain taxable insurance companies

The proposal would repeal the special rules provided under section 833 to Blue Cross and Blue Shield organizations and other eligible

organizations (i.e., the special exception to the 20-percent reduction with respect to unearned premium reserves and the special deduction for 25 percent of claims and expenses).

The proposal would also apply the special rules under section 833 to the same extent they have been provided to certain existing Blue Cross or Blue Shield organizations, in the case of any organization that (1) is not a Blue Cross or Blue Shield organization existing on August 16, 1986, and (2) otherwise meets the requirements of section 833(c)(2) (including the requirement of no material change in operations or structure since August 16, 1986). Under the proposal, an organization qualifies for this treatment only if (1) it is not a health maintenance organization and (2) it is organized under and governed by State laws which are specifically and exclusively applicable to not-for-profit health insurance or health service type organizations.

Effective date.--The proposal generally would be effective for taxable years beginning after December 31, 1996. However, for eligible organizations, the proposal generally would be effective for taxable years beginning after December 31, 1998. Eligible organizations would be those that, for each of the three taxable years beginning before the date of enactment and each taxable year beginning on or after the date of enactment and before December 31, 1998, meet standards for open enrollment, community rating, coverage of pre-existing conditions and related standards.[11]

Transition rules would be provided. For the repeal of the exception to the 20-percent reduction, the proposal would require ratable income inclusion over a 6-year period following the effective date of 20 percent of the unearned premium reserve outstanding at the end of the most recent taxable year beginning before January 1, 1997 (or 1999, for organizations eligible for the December 31, 1998 effective date). For the repeal of the 25 percent of claims deduction, a phase-out would be provided for organizations meeting the community service requirements of present law.

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[11] These standards would be met by an organization if (1) substantially all its activities involve the providing of health insurance or health-related activities, (2) at least 10 percent of the health insurance it provides is provided on a community rated, open enrollment basis to individuals and small groups (taking into account any medicare supplemental coverage), (3) it provides continuous full-year open enrollment (including conversions) for individuals and small groups, (4) its policies covering individuals provide full coverage of pre-existing conditions of high-risk individuals without a price differential (with a reasonable waiting period), and coverage is provided without regard to age, income, or employment status of individuals under age 65, and (5) no part of its net earnings inures to the benefit of any private shareholder or individual. For this purpose, a small group would be the number of individuals required for a small group under applicable State law.

L. MODIFICATION OF RULES FOR CERTAIN QUALIFIED 501(c)(3) BONDS

Present Law

Interest on State and local government bonds generally is excluded from income if the bonds are issued to finance direct activities of these governments (Code sec. 103). Interest on bonds issued by these governments to finance activities of other persons, i.e., private activity bonds, is taxable unless a specific exception is included in the Internal Revenue Code (the "Code"). One such exception is for private activity bonds issued to finance activities of private, charitable organizations described in Code section 501(c)(3) ("section 501(c)(3) organizations") when the activities do not constitute an unrelated trade or business (sec. 141(e)(1)(G)).

Before enactment of the Tax Reform Act of 1986, State and local governments and section 501(c)(3) organizations both were defined as "exempt persons," under the Code bond provisions, and their bonds generally were subject to the same requirements. As exempt persons, section 501(c)(3) organizations (with respect to their exempt activities) were not treated as "private" persons, and their bonds were not "industrial development bonds" or "private loan bonds" (the predecessor designations for most current private activity bonds).

Present law treats section 501(c)(3) organizations as private persons, thus, bonds for their use may only be issued as private activity "qualified 501(c)(3) bonds," subject to the restrictions of Code section 145. The most significant of these restrictions limits the amount of outstanding bonds from which a section 501(c)(3) organization may benefit to $150 million. In applying this $150 million limitation, all section 501(c)(3) organizations under common management or control are treated as a single organization. The limit applies to bonds for all section 501(c)(3) health care facilities except hospital facilities, defined to include only acute care, primarily inpatient, organizations.

Description of Proposal

The proposal would repeal the $150 million per organization limit on outstanding bonds that applies to nonprofit health care facilities that are not acute care, inpatient facilities, and to other section 501(c)(3) organizations. In addition, the proposal would change the tax-exempt bond provisions of the Code to conform generally the treatment of bonds for nonprofit health care and other section 501(c)(3) organizations to that provided for bonds issued to finance direct State or local government activities.

Certain other restrictions, described below, that have been imposed on qualified 501(c)(3) bonds (but not on governmental bonds), and that address specialized policy concerns, would be retained--

(1) The requirement that existing residential rental

property acquired by a section 501(c)(3) organization in a tax-exempt-bond-financed transaction satisfy the same low-income tenant requirements as similar housing financing for for-profit developers;

(2) The present-law maturity limitations applicable to bonds for section 501(c)(3) organizations, and the public approval requirements applicable generally to private activity bonds; and

(3) The penalties on changes in use of tax-exempt-bond-financed section 501(c)(3) organization property to a use not qualified for such financing.

Effective Date

The proposal would apply to bonds issued after December 31, 1994.

M. ELIMINATE EXCLUSION FOR EMPLOYER-PROVIDED ACCIDENT OR HEALTH BENEFITS PROVIDED THROUGH A FLEXIBLE SPENDING ARRANGEMENT

Present Law

1. Cafeteria plans

Under present law, compensation generally is includible in gross income when actually or constructively received, i.e., when it is made available to the individual or the individual has an election to receive such amount. Under one exception to the general principle of constructive receipt, no amount is included in the gross income of a participant in a cafeteria plan maintained by an employer solely because the participant may elect among cash and certain employer-provided qualified benefits. In general, a qualified benefit is a benefit that is excludable from an employee's gross income by reason of a specific provision of the Internal Revenue Code. Employer-provided accident or health coverage is a qualified benefit.

The cafeteria plan exception from the principle of constructive receipt also applies for employment tax purposes.

2. Flexible spending arrangements

A flexible spending arrangement ("FSA") is a reimbursement account or similar arrangement under which an employee is reimbursed for medical expenses or other employer-provided qualified benefits, such as dependent care. FSAs that are part of a cafeteria plan generally are funded through salary reduction. FSAs may also be provided by an employer outside a cafeteria plan. FSAs are commonly used, for example, to reimburse employees for medical expenses not covered by insurance. If certain conditions are satisfied, amounts reimbursed under an FSA are excludable from gross income and wages for employment tax purposes.

Proposed Treasury regulations define a health FSA as a benefit program that provides employees with coverage under which specified, incurred expenses may be reimbursed (subject to reimbursement maximums and any other reasonable conditions) and under which the maximum amount of reimbursement that is reasonably available to a participant for a period of coverage is not substantially in excess of the total premium (including both employee-paid and employer-paid portions of the premium) for such participant's coverage. A maximum amount of reimbursement is not substantially in excess of the total premium if the maximum amount is less than 500 percent of the premium.

Description of Proposal

Under the proposal, accident or health benefits provided under an FSA would be includible in income and wages for income and employment tax purposes. A health FSA would be defined generally as under the proposed Treasury regulations.

Effective Date

The proposal would be effective on and after January 1, 1996.

N. PREMIUM ASSESSMENT

Present Law

There is no excise tax or other special Federal assessment on domestic health insurance policy premiums. A one-percent excise tax is imposed on premiums for certain foreign-issued sickness and accident insurance and reinsurance policies (sec. 4371).

Description of Proposal

1. In general

The proposal would impose an assessment on certain health expenses. Expenses subject to the assessment generally would include the costs of providing health coverage, as well as related administrative expenses and any costs of reinsurance. Health coverage would include, but not be limited to, coverage for sickness, accident, dental, preventive care, or payment of a fixed amount for hospitalization or other specified types of care. To the extent all of these costs are reflected in the premium or other charge to the purchaser of such benefits, the assessment would be imposed on the premium amount. If the costs are reflected in separate charges to the purchaser (i.e., a purchaser buys a health insurance policy and enters into an administrative services contract), the assessment would be imposed on each separate component.

In general, with respect to indemnity health insurance, the assessment would be imposed on premiums. With respect to prepaid health care arrangements, the assessment would be imposed on the fixed payments or

premiums paid by members. With respect to self-insured plans, the assessment would be imposed on the plan's health care expenditures and administrative expenses.

A portion of amounts derived from the imposition of this premium assessment would be used to fund the Academic Health Centers Trust Fund and the Health Research Trust Fund.

2. Assessment on health insurance policy premiums

The proposal would impose a 1.75 percent assessment on certain health insurance policy premiums, effective in 1996. The assessment would be paid by the issuer of the policy and would be imposed regardless of who pays the premium.

The assessment would be imposed on policies providing health care coverage. It would not be imposed on policies if the health care coverage is part of the coverage of liabilities incurred under employees' compensation laws, tort liabilities, or other similar liabilities. If a policy provides both health and other coverage, the assessment would be imposed only on the health portion if the charge for the nonhealth coverage is both separately stated and reasonable in relation to the total policy charges.

Certain prepaid health care arrangements also would be subject to the assessment. Such arrangements would include those pursuant to which an entity receives fixed payments or premiums (that do not vary in amount depending on the amount of health care provided) in exchange for an agreement to provide or arrange for the provision of health care. The entity receiving the payments or premiums would be treated as the issuer of the policy and would pay the assessment.

3. Assessment on health-related administrative services

The proposal would also impose the applicable assessment on amounts paid for certain health-related administrative services not included in the premium for a policy. The assessment would be paid by the provider of the services.

Services subject to the assessment would include claims processing or other administrative services performed in connection with health care coverage (if the charge for such services is not included in the premiums for such policy), and claims processing, arranging for the provision of health care, or other administrative services performed in connection with a self-insured plan established or maintained by another person.

4. Treatment of self-insured plans

Certain self-insured plans would be subject to a monthly assessment equal to the applicable assessment rate times the sum of the plan's health care expenditures and direct administrative expenses. This assessment would be paid by the plan sponsor.

Plans subject to the assessment would be plans that provide health care (other than through an insurance policy) that are established or maintained by one or more (1) employers for the benefit of their current and former employees; (2) employee organizations for the benefit of their current and former members; (3) employers and employee organizations jointly for the benefit of current or former employees; and (4) multiple employer welfare arrangements or plans maintained by rural cooperatives, not described in (1)-(3) above.

5. Exemption applicable to certain governmental programs

Certain direct governmental insurance programs would be exempt from this premium assessment. These would include Medicare, Medicaid, Indian Health Services, and any program that provides health care to members of the Armed Forces or veterans or to their spouses or dependents. Other government programs would be subject to the premium assessment as set forth above.

6. Academic Health Centers Trust Fund, Graduate Medical and Nursing Education Trust Fund, and Health Research Trust Fund

The revenues derived from the premium assessment would fund the Academic Health Centers Trust Fund, the Graduate Medical and Nursing Education Trust Fund, and the Health Research Trust Fund established under the proposal.

Effective Date

The proposal would be effective after December 31, 1995.

O. TAX TREATMENT OF FUNDING OF RETIREE HEALTH BENEFITS

Present Law

Under present law, employer-provided post-retirement medical benefits are generally excludable from the gross income of a plan participant or beneficiary. In addition, an employer may deduct contributions, within limits, made to a welfare benefit fund for retiree health and life insurance benefits of its employees. A welfare benefit fund is, in general, any fund that is part of a plan of an employer, and through which the employer provides welfare benefits to employees or their beneficiaries.

Contributions by an employer to a welfare benefit fund are not deductible under the usual income tax rules, but, if they otherwise would be deductible under the usual rules (e.g., if they are ordinary and necessary business expenses), the contributions are deductible within limits for the taxable year in which such contributions are made to the fund.

The amount of the deduction otherwise allowable to an employer for a contribution to a welfare benefit fund for any taxable year may not exceed

the qualified cost of the fund for the year. The qualified cost of a welfare benefit fund for a year is the sum of (1) the qualified direct cost of the fund for the year and (2) the addition (within limits) to the qualified asset account under the fund for the year, reduced by (3) the after-tax income of the fund.

A qualified asset account under a welfare benefit fund is an account consisting of assets set aside to provide for the payment of disability payments, medical benefits, supplemental unemployment compensation benefits or severance pay benefits, or life insurance benefits. Under present law, an account limit is provided for the amount in a qualified asset account for any year.

The account limit for any taxable year may include a reserve to provide certain post-retirement medical and life insurance benefits. This limit allows amounts reasonably necessary to accumulate reserves under a welfare benefit plan so that the liabilities for post-retirement medical and life insurance benefits with respect to a group of employees can be prefunded over the working lives of such employees.

Under present law, if an employer maintains a welfare benefit fund that provides a disqualified benefit during any taxable year, the employer is subject to an excise tax equal to 100 percent of the disqualified benefit. A disqualified benefit includes (1) a benefit provided to a key employee other than from a separate account required to be established for such an employee, (2) any post-retirement medical or life insurance benefit that is provided in a discriminatory manner, and (3) any portion of a welfare benefit fund reverting to the employer.

Description of Proposal

Under the proposal, the minimum period during which the cost of post-retirement medical and life insurance coverage could be funded under a welfare benefit fund would be at least 10 years. Thus, an employer would be permitted to deduct the costs of funding such coverage on a level basis over the working lives of covered employees, but not over a period of less than 10 years.

The proposal would clarify that a reserve to provide post-retirement medical and life insurance benefits under a welfare benefit plan would be maintained as a separate account. In addition, the proposal would include any payment from the separate account required to be maintained for post-retirement medical and life insurance benefits that is not used to provide a post-retirement medical or life insurance benefit in the list of disqualified benefits for which the employer is subject to a 100-percent excise tax.

Effective Dates

The proposal relating to reserves for post-retirement medical and life insurance benefits under welfare benefit plans would be effective for contributions paid or accrued after December 31, 1994, in taxable years

ending after that date. The proposal that would require that the reserve for post-retirement medical and life insurance benefits be maintained as a separate account would be effective for contributions paid or accrued after the date of enactment, in taxable years ending after that date.

P. NONREFUNDABLE CREDIT FOR CERTAIN PRIMARY HEALTH SERVICES PROVIDERS

Present Law

1. Geographically targeted tax provisions

In general, the operation of Internal Revenue Code rules does not vary based on the location within the United States of income-producing activity. Nonetheless, present law provides favorable Federal income tax treatment for certain U.S. corporations that operate in Puerto Rico, the U.S. Virgin Islands, or possessions of the United States to encourage the conduct of trades or business within these areas. In addition, certain Code sections provide additional benefits in targeted geographic areas (e.g., low-income housing credit and qualified mortgage bond provisions target certain economically distressed areas).

The Omnibus Budget Reconciliation Act of 1993 ("1993 Act") provides for the designation of nine empowerment zones and 95 enterprise communities in economically distressed areas satisfying certain criteria. The designations are to be made during 1994 and 1995, and generally will remain in effect for 10 years. During the period the designation is in effect, special tax incentives (i.e., an employer wage credit, additional section 179 expensing, and expanded tax-exempt financing) are available for certain business activities conducted in empowerment zones. Expanded tax-exempt financing benefits are available for certain facilities located in enterprise communities. In addition, the 1993 Act provides accelerated depreciation benefits and an incremental employer wage credit for certain business activities conducted on Indian reservations.

2. Tax benefits available for medical care providers

Code section 108(f) provides an exclusion from Federal income tax for what otherwise would be discharge-of-indebtedness income if a student loan is discharged pursuant to a provision in the loan agreement that requires the student to work for a period of time in certain professions for any of a broad class of employers. Section 108(f) applies only to student loans made from funds provided by the Federal Government, a State or local government, or certain public benefit corporations described in section 501(c)(3). For example, the favorable treatment provided by section 108(f) applies when a government agency discharges a student loan upon the student's provision of medical services to an underserved area.

Present law does not provide for a special credit against Federal income taxes for individuals who provide medical services in medically underserved geographic areas.

3. Nontax benefits for medical care providers

Other, non-tax provisions of Federal law provide that certain health care professionals who agree to work full time for at least two years at an approved government or nonprofit employment site within a "health professional shortage area" (HPSA) are eligible for scholarships or repayments of student loans.[12] The scholarship and loan repayment programs are administered by the National Health Service Corp (NHSC), which is part of the Department of Health and Human Services.[13]

Description of Proposal

A physician who provides primary health services in certain medically underserved areas would be eligible for a nonrefundable credit against Federal income taxes of $1,000 per month for up to 36 months ($500 per month if the physician already was providing medical services in an underserved area at the time the credit becomes effective). The credit rate would be $500 per month in the case of a physician assistant, nurse-practitioner, or certified nurse-midwife (regardless of when the individual began providing medical services in an underserved area). The credit would be available to a taxpayer only if he or she provides primary

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[12] HPSAs are designated geographic areas, as well as certain designated population groups and government facilities. Currently, more than 2,400 primary care HPSAs have been designated, covering all or parts of 1,800 counties in the United States. There are also over 1000 dental HPSAs and over 700 mental health HPSAs. HPSAs are designated by the Bureau of Primary Health Care, which is part of the United States Public Health Service. HPSAs are identified on the basis of State and local government requests for designation. Primary care HPSAs are designated on the basis of rate of poverty, access to primary health care, low birthweight births, infant mortality, and the physician/population ratio. See vol. 59 Federal Register no. 14 (January 21, 1994) at 3411-5307. The NHSC Revitalization Amendments of 1990 (sec. 333A of Pub. Law 101-697) require that the Secretary of HHS annually prepare a list of HPSAs in order of greatest shortage of medical practitioners (by using certain exclusive factors) and that priority in the assignment of National Health Service Corp (NHSC) personnel be given to government or nonprofit entities serving HPSAs with the greatest shortages. See 42 U.S.C. 254f-1.

[13] As of September 30, 1993, a total of 1,163 practitioners (i.e., primary-care physicians and physician assistants, general practice dentists, primary-care nurse practitioners, and certified nurse midwives) were providing medical care in HPSAs throughout the United States pursuant to the NHSC scholarship and loan repayment programs.

health services[14] on a full-time basis in a "health professional shortage area" (HPSA) (as defined under present-law section 332(a)(1)(A) of the Public Health Service Act).[15] To be eligible for the credit, the taxpayer would be required to obtain certification from the Bureau of Primary Health Care, United States Public Health Service of the Department of Health and Human Services, that he or she is a full-time provider of primary health services in a HPSA, and, in the case of a taxpayer working in an urban HPSA, that he or she performs services (as an employee or independent contractor) for a governmental or nonprofit entity.[16] The credit would not be available, however, if the taxpayer participated in the National Health Service Corps (NHSC) scholarship or loan repayment program.

Under the proposal, a taxpayer would be required to work full time providing primary health services in the HPSA for two consecutive years (following certification) in order to receive the tax credit. If a taxpayer did not provide primary health services on a full-time basis in the HPSA for at least two consecutive years (following certification), any credit previously claimed would be completely recaptured. The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, would be granted authority to waive recapture of credits when a taxpayer ceases to provide services in the HPSA due to extraordinary circumstances.

Effective Date

The proposal would be effective for taxable years beginning after 1994.

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[14] For purposes of the provision, the term "primary health services" would have the meaning given such term by section 330(b)(1) of the Public Health Service Act.

[15] See Title 42, U.S. Code, sections 254e and 254f-1. For purposes of the proposal, medically underserved areas would include population groups and public facilities that have HPSA designation.

[16] For purposes of the credit, a health care practitioner would be treated as providing services in a HPSA, even if the area no longer has designation as such, so long as the area was designated as a HPSA when the practitioner was certified by the Department of HHS as being eligible for the credit (i.e., the practitioner was already working in an area designated as a HPSA at the time the credit became effective or subsequently began practicing in an area when it was designated as a HPSA).

Q. EXPENSING OF MEDICAL EQUIPMENT USED IN HEALTH CARE SHORTAGE AREAS

Present Law

1. Depreciation rules

In general, the cost of property that has a useful life longer than one year must be capitalized and recovered over time pursuant to depreciation or amortization rules. Tangible depreciable property placed in service after 1986 is depreciated under the modified Accelerated Cost Recovery System (MACRS) enacted as part of the Tax Reform Act of 1986. Under MACRS, high technology medical equipment is depreciated for regular tax purposes over a 5-year recovery period using the 200-percent declining balance method. "High technology medical equipment" means any electronic, electromechanical, or computer-based high technology equipment used in the screening, monitoring, observation, diagnosis, or treatment of patients in a laboratory, medical, or hospital environment.

In general, MACRS deductions are reduced for property under an alternative depreciation system by calculating depreciation using the straight-line method over the property's class life. A property's class life generally corresponds to its Asset Depreciation Range (ADR) midpoint life and often is longer than the recovery period applicable for regular tax purposes. The alternative depreciation system applies to foreign use property, tax-exempt use property, tax-exempt bond financed property, certain imported property, and property which the taxpayer so elects and is used to compute corporate earnings and profits. The class lives of the alternative depreciation system also are used for purposes of the corporate and individual alternative minimum tax. The class lives of some assets are set by statute, regardless of the asset's ADR midpoint life. The class life of high technology medical equipment is set by statute at five years.

2. Section 179 expensing allowances

In lieu of depreciation, a taxpayer with a sufficiently small amount of annual investment may elect to deduct up to $17,500 of the cost of qualifying property placed in service for the taxable year under section 179.[17] In general, qualifying property is defined as depreciable tangible personal property that is purchased for use in the active conduct of a trade or business. The $17,500 amount is reduced (but not below zero) by

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[17] Section 13116 of the Omnibus Budget Reconciliation Act of 1993 increased the amount allowed to be expensed under section 179 from $10,000 to $17,500 for qualified property placed in service in taxable years beginning after 1992. In addition, under section 13301 of the 1993 Act, the amount allowed to be expensed under section 179 by an enterprise zone business is increased by the lesser of: (1) $20,000 or (2) the cost of section 179 property that is qualified zone property placed in service during the taxable year.

the amount by which the cost of qualifying property placed in service during the taxable year exceeds $200,000. In addition, the amount eligible to be expensed for a taxable year may not exceed the taxable income of the taxpayer for the year that is derived from the active conduct of a trade or business (determined without regard to this provision). Any amount that is not allowed as a deduction because of the taxable income limitation may be carried forward to succeeding taxable years (subject to similar limitations).

Description of Proposal

The proposal would increase the amount allowed to be expensed under section 179 in a taxable year by the lesser of: (1) the cost of section 179 property which is health care property placed in service during the year or (2) $15,000. For this purpose, "health care property" would mean section 179 property: (1) which is medical equipment used in the screening, monitoring, observation, diagnosis, or treatment of patients in a laboratory, medical, or hospital environment; (2) which is owned (directly or indirectly) and used by a physician (as defined by section 1861(r) of the Social Security Act) in the active conduct of such physician's full-time trade or business of providing primary health services (as defined in section 330(b)(1) of the Public Health Service Act) in a health professional shortage area ("HPSA") (as defined in section 332(a)(1)(A) of the Public Health Service Act); and (3) substantially all the use of which is in such area. Similar to the proposed nonrefundable credit for certain primary care providers, physicians working in urban HPSAs would be eligible for the additional section 179 expensing only if they perform services for a government or nonprofit entity.

Effective Date

The proposal would apply to property placed in service in taxable years beginning after December 31, 1994.

R. COORDINATION WITH HEALTH CARE CONTINUATION PROVISIONS

Present Law

In general, an employer with 20 or more employees must provide health plan participants with the opportunity to continue their coverage in the employer's health plan for a specified period of time after the occurrence of certain qualifying events that otherwise would have terminated such coverage.

The qualifying events that may trigger rights to continuation coverage are (1) the death of the employee, (2) the voluntary or involuntary termination of the employee's employment (other than by reason of gross misconduct), (3) a reduction of the employee's hours, (4) the divorce or legal separation of the employee, (5) the employee becoming entitled to benefits under Medicare, (6) a dependent child of the employee ceasing to be a dependent under the employer's plan, and (7) in certain cases the

commencement of bankruptcy proceedings with respect to an employer. The maximum period of health care continuation coverage that may be elected is 36 months, except in the case of termination of employment or reduction of hours for which the maximum period is 18 months. The 18-month period is extended to 29 months in certain cases involving the disability of the plan participant. Certain events, such as the failure by the plan participant to pay the required premium, may trigger an earlier cessation of the health care continuation coverage.

Within limits, employers may require health plan participants that elect health care continuation coverage to pay for such coverage.

Description of Proposal

The proposal would retain the present-law health care continuation rules, except that the maximum period of continuation coverage that could be elected by a qualified beneficiary for any qualifying event would be reduced. Under the proposal, a qualified beneficiary could elect health care continuation coverage for the longer of 6 months or until the end of the calendar year in which the qualifying event occurs.

Effective Date

The proposal would be effective with respect to qualifying events that occur on or after January 1, 1997.

8. DISCLOSURE OF TAXPAYER RETURN INFORMATION FOR ADMINISTRATION OF HEALTH SUBSIDY PROGRAMS

Present Law

The Internal Revenue Code prohibits disclosure of tax returns and return information, except to the extent specifically authorized by the Code (sec. 6103). Unauthorized disclosure is a felony punishable by a fine not exceeding $5,000 or imprisonment of not more than five years, or both (sec. 7213). An action for civil damages also may be brought for unauthorized disclosure (sec. 7431). No tax information may be furnished by the Internal Revenue Service (IRS) to another agency unless the other agency has established procedures satisfactory to the IRS for safeguarding the tax information it receives (sec. 6103(p)).

Description of Proposal

The proposal would permit disclosure of certain taxpayer return information to any Federal, State, or local agency administering health subsidy programs for use in verifying eligibility for such subsidies. Disclosable information would include taxpayer return information relating to adjusted gross income, the untaxed portion of social security benefits,

and tax-exempt interest income.[18] In addition, information regarding marital status and dependents could be disclosed.

Taxpayer return information would only be disclosed in response to a taxpayer's application for a health subsidy, only to the agency responsible for determining eligibility for the subsidy,[19] and only to the extent necessary to make that determination.

Under the proposal, any Federal, State, or local agency receiving taxpayer return information would be required to comply with the safeguards presently contained in the Code governing the use of disclosed tax information. Also, the present-law penalties for unauthorized disclosure of information would apply to recipient agencies and their employees.

Effective Date

The proposal would be effective on the date of enactment.

T. TAX TREATMENT OF VOLUNTARY EMPLOYER HEALTH CARE CONTRIBUTIONS

Present Law

There is currently no requirement that employers contribute to health plans on behalf of their employees. If an employer elects to contribute towards the cost of a health plan on behalf of its employees, the employer generally may determine the level of contributions it will make to the plan. Employers can generally deduct the full cost of employer-provided health care as an ordinary and necessary business expense.

Employer-provided health coverage is generally fully excludable from gross income. However, if an employer provides its employees with health benefits under a self-insured medical reimbursement plan (sec. 105(h)), reimbursements under such plan are excludable with respect to a highly compensated individual only to the extent that the plan does not discriminate in favor of highly compensated individuals either as to eligibility to participate or as to benefits. Under the requirements for nondiscrimination in benefits, a self-insured plan may establish a limit for the amount of reimbursement which may be paid for any single benefit or

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[18] In addition, welfare benefits would be considered to be income for purposes of computing eligibility for a health subsidy. Welfare benefits are not income for tax purposes and are not presently reported to the IRS. They are therefore not return information for purposes of the tax disclosure rules. A separate reporting system for welfare benefits would be established under the proposal.

[19] Disclosure would also be permitted for reviewing and auditing health subsidy determinations.

combination of benefits under the plan. However, any maximum limit on the amount of reimbursement for health expenses attributable to employer contributions under a self-insured medical expense plan must be uniform for all participants and for all dependents of employees who are participants and may not be modified by reason of a participant's age or years of service (Treas. Reg. § 1.105-11(c)(3)(i)).

Description of Proposal

1. In general

The proposal would not require employers to contribute toward the cost of health coverage for any employee. However, employers that voluntarily contribute toward the cost of health coverage for their employees would be required to satisfy certain voluntary contribution rules. Employers that violate the voluntary contribution rules would be subject to an excise tax designed to approximate the effect of denying the employer deduction for health expenses.

2. Limitation on deductibility of employer contributions for health coverage other than permitted coverage

Under the proposal, employer contributions to an accident or health plan other than employer contributions for permitted coverage would be subject to an excise tax designed to approximate the effect of denying the employer deduction for such health expenses. Permitted coverage would include (1) coverage under a certified standard health plan, (2) cost-sharing amounts under a certified standard health plan (including cost-sharing policies), (3) coverage providing wages or payments in lieu of wages for any period during which the employee is absent from work on account of sickness or injury, (4) coverage providing payment for permanent injuries of an employee, his or her spouse or a dependent that are computed with reference to the nature of the injury without regard to the period the employee is absent from work (but not coverage under a long-term care insurance policy), (5) coverage provided to an employee or former employee after such employee has attained age 65 unless such coverage is provided by reason of the current employment of the individual with the employer providing the coverage, (6) coverage provided under Federal law to veterans or any member of the Armed Forces of the United States and their spouses and dependents and (7) coverage under a certified supplemental health plan, and (8) coverage under a certified long-term care insurance policy.

The provision does not affect the present-law rules regarding taxation of employer contributions for coverage or the taxation of any payments received by the individual. Whether or not something is permitted coverage for purposes of the excise tax is independent of income or employment tax treatment.

The excise tax would not be imposed with respect to any period for which it is established to the satisfaction of the Secretary that the employer did not know nor, through exercising reasonable diligence, should have known, that coverage did not meet the applicable standards.

3. Voluntary employer contributions cannot vary based on health status

Any employer that voluntarily contributes towards the cost of coverage for employees under a health plan cannot impose a waiting period, deny coverage, or vary the amount of the contribution based on any employee's health status, claims experience, medical history, receipt of health care, or lack of evidence of insurability.

4. Same voluntary employer contribution

Any employer that voluntarily contributes towards the cost of coverage for any employee under a certified standard health plan would be required to contribute either the same dollar amount or the same percentage (with or without a dollar cap) towards the cost of the standard coverage selected by any other employee. This rule would be applied separately with respect to full-time employees and part-time employees. Employers that voluntarily contribute to the purchase of any part-time employee's coverage would be required to make a contribution to all part-time employees proportionate to the number of hours worked by the part-time employee. The voluntary contribution requirement would apply only to coverage under a certified standard health plan made available by the employer (consistent with other parts of the proposal).

For example, assume that an employer offers to pay 80 percent of a $4,000 premium for single coverage under a certified health maintenance organization for all of its full-time salaried employees, but not for any of its part-time employees. Under the proposal, the employer would be required to offer to contribute one of the following amounts towards the cost of single or family coverage for all full-time employees: (1) the same dollar amount ($3,200), (2) the same percentage (80 percent) of the single or family premium, or (3) the same percentage (80 percent) of the single or family premium, but no more than $3,200. No contribution would be required with respect to part-time employees.

A full-time employee would be an employee who is normally employed at least 24 hours in a week. A part-time employee would be an employee who is normally employed at least 10 hours per week and less than 24 hours per week. The following employees (whether full-time or part-time) would be excluded for purposes of this rule: (1) employees who have not completed 6 months of service; (2) employees who normally work not more than 6 months during any year; (3) employees who are included in a unit of employees covered by a collective bargaining agreement if health coverage was the subject of good faith bargaining; (4) employees who have not attained age 18; and (5) employees who are non-resident aliens and who receive no U.S. source earned income.

For purposes of the proposal, certain aggregation rules would apply. All employees of corporations that are members of a controlled group of corporations, or all employees of trades and businesses (whether or not incorporated) that are under common control, would be aggregated and treated as if employed by a single employer (sec. 414(b) and (c)). Similarly, all employees of employers that are members of an affiliated

service group would be treated as employed by a single employer (sec. 414(m)). Finally, the Secretary of the Treasury would have general regulatory authority to prevent avoidance of the voluntary contribution requirements through the use of certain arrangements (sec. 414(o)). Under the proposal, if an employer is treated as operating separate lines of business for a year for pension plan purposes, the employer may apply the voluntary contribution rules separately to each separate line of business for that year.

5. Penalties for employer violations of the voluntary contribution rules

Employers that violate either of the voluntary contribution rules would be subject to an excise tax designed to approximate the effect of denying the employer deduction for health expenses. If an employer impermissibly varies health care contributions based on health status or violates the rules relating to contributions for health coverage other than permitted coverage, the excise tax would be equal to the product of the highest corporate income tax rate in effect (currently 35 percent) and the total health care expenses for coverage other than permitted coverage incurred by the employer during the period in which the violation occurs. If an employer violates the rules relating to employer contribution levels, the excise tax would be equal to the product of the highest corporate income tax rate in effect (currently 35 percent) and the total health care expenses for standard coverage incurred by the employer during the period in which the violation occurs.

Both excise taxes would be imposed on all employers that violate the voluntary contribution requirements, including tax-exempt and governmental employers. The excise taxes would not be deductible. The Secretary of the Treasury would be permitted to waive all or part of both excise taxes under certain circumstances, to the extent that the payment of such taxes would be excessive relative to the failure involved.

Effective Date

The voluntary contribution rules would apply to employer contributions made on or after January 1, 1996.

U. ASSESSMENT ON LARGE EMPLOYERS

Present Law

No provision.

Description of Proposal

Under the proposal, an annual assessment of 1 percent of payroll would be imposed on employers with 500 or more employees. Payroll would mean the sum of (1) wages (as defined for hospital insurance tax purposes under the proposal); (2) in the case of a sole proprietorship, the net earnings from

self employment of the proprietor attributable to the trade or business; (3) in the case of a partnership, the aggregate of the net earnings from self employment of each partner which is attributable to the partnership; and (4) in the case of an S corporation the aggregate of the net earnings from self employment of each shareholder which is attributable to such corporation. Net earnings from self employment would be defined as under the proposal.

Effective Date

The proposal would be effective on and after January 1, 1996.

V. INCREASE EXCISE TAX ON HANDGUN AMMUNITION

Present Law

1. Ad valorem excise taxes

A 10-percent excise tax is imposed on the sale of pistols and revolvers by a manufacturer, producer or importer thereof. Other firearms and shells and cartridges are subject to an 11-percent excise tax (Code sec. 4181).

An exemption is provided for sales of firearms and ammunition for use by the United States Department of Defense. In addition, no excise tax is imposed on sales by manufacturers, producers or importers: (1) for use by the purchaser in further manufacture, or for resale by the purchaser for use by the second purchaser in further manufacture; (2) for export, or for resale by the purchaser to a second purchaser for export; (3) for use by the purchaser as supplies for military vessels or aircraft; (4) to a State or local government for their exclusive use; or (5) to a nonprofit educational organization for its exclusive use. In general, the effect of the State and local government exemption is to exempt sales to State and local police departments.

Amounts equivalent to revenues from these excise taxes fund the Federal Aid to Wildlife Program for use in making grants to support State wildlife programs.

2. Transfer and making taxes; special occupational taxes

a. Transfer and making taxes.--Present law also imposes making and transfer taxes on certain firearms and other destructive devices. A transfer tax of $200 is imposed on each "firearm" transferred, and a making tax at the rate of $200 is imposed on each firearm made (Code secs. 5811 and 5821). The ad valorem excise taxes described above do not apply to firearms subject to these making and transfer taxes.

Firearms subject to the making and transfer taxes are machine guns, short-length or short-barrelled rifles or shotguns, pen guns, handguns with smooth bore barrels, firearms silencers, mufflers or suppressors, silencer

parts, machine gun receivers and parts designed to convert a weapon into a machine gun (generally, firearms subject to regulation under the National Firearms Act ("NFA firearms")).

In general, Federal, State and local governments are exempt from the making and transfer taxes. In addition, transfers between persons subject to the special occupational tax (described below) are exempt from the transfer tax, as are transfers of unserviceable firearms and exported firearms.

b. Special occupational tax.--All importers, manufacturers and dealers in NFA firearms are required to register with the Secretary of the Treasury. Importers and manufacturers are subject to a special occupational tax of $1,000 per year (small importers and manufacturers are eligible for a reduced rate of tax); dealers are subject to a special occupational tax of $500 per year (Code sec. 5801).

An exemption from the special occupational tax is available for persons who conduct business exclusively with or on behalf of the United States.

Description of Proposal

The proposal would increase the ad valorem excise tax rate on certain handgun ammunition. Centerfire cartridges with a cartridge case of less than 1.3 inches in length and cartridge cases of less than 1.3 inches in length would be taxed at 50 percent. A 10,000-percent rate would apply to (1) jacketed, hollow point projectiles which may be used in a handgun and are designed to produce, upon impact, evenly-spaced sharp or barb-like projections that extend beyond the diameter of the unfired projectile; and (2) cartridges with a projectile measuring 0.500 inch or greater in diameter which may be used in a handgun. The taxation of rifle ammunition and .22 caliber rimfire cartridges generally would not be affected by the proposal.

Amounts equivalent to revenues from these increased excise taxes would be added to the General Fund and would not be used to fund the Federal Aid to Wildlife Program.

The proposal also would impose a special occupational tax on each importer and manufacturer of handgun ammunition (i.e., centerfire cartridges with a cartridge case of less than 1.3 inches in length and cartridge cases of less than 1.3 inches in length) of $10,000 per year. These importers and manufacturers also would be required to register with the Secretary of Treasury.

Effective Date

The proposal generally would be effective after December 31, 1994. A floor stocks tax would be imposed on taxed ammunition products held for sale on January 1, 1995.

W. PREFUNDING OF POSTAL SERVICE RETIREE HEALTH BENEFITS

Effective February 1, 1995, the U. S. Postal Service would be required to prefund health benefits for retirees.

VIII. MEDICAID

Present Law

Title XIX of the Social Security Act (Medicaid) provides for mandatory coverage by all States of acute care services for individuals and families receiving either Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) income support payments. These groups are referred to as the "cash population" within Medicaid. In addition, States must extend coverage to pregnant women and children up to age six with family incomes up to 133 percent of the Federal poverty level and children born after September 1983 up to 100 percent of the Federal poverty level. The Medicaid program provides States the option to extend coverage of pregnant women and children up to age one up to 185 percent of poverty. There are many other optional and mandatory coverage groups for acute care Medicaid services, one of which is Medically Needy eligibility under which families with significant medical care expenses can 'spend down' into Medicaid eligibility.

Federal law establishes a basic set of mandatory services that States must provide including: inpatient and outpatient hospital services; laboratory and x-ray services; rural health clinic and federally qualified health center services; nursing facility services; family planning services; early and periodic screening, diagnostic and treatment (EPSDT) services for children under 21 years old; home health services; and physician, nurse midwife and certain certified nurse practitioner services. There are many other services a State may choose to offer including: prescription drugs, case management, personal attendant care, physical therapy, rehabilitation, and mental health services.

Description of Proposal

A. ACUTE CARE SERVICES

1. AFDC and Acute Care Non-Cash Population

Both groups would be integrated into the general health care reform program and these groups would be treated like other low-income people eligible for Federal subsidies and enrollment in certified health plans. States would be required to make general maintenance of effort (MOE) payments for services covered under the standard benefit package. The State MOE would be indexed to new Federal premium targets. The Federal government would subsidize the health coverage purchase of this group in the same manner as other low-income individuals.

2. Disabled Medicaid Population

SSI/Medicaid beneficiaries would not be included in the community rated market. States would have the option to pay a per capita amount for each SSI/Medicaid recipient (who is not enrolled in Medicare) to certified health plans. States would negotiate with certified health plans for rates

for the Medicaid disabled population that are separate from the community rate. No certified health plan could have more than 50 percent of its enrollment composed of SSI/Medicaid recipients.

3. Individuals Dually Eligible for Medicaid and Medicare

This group would remain under Medicaid and would not be enrolled in health plans.

Effective Date

January 1, 1997.

B. SUPPLEMENTAL SERVICES

Current Medicaid rules governing covered services and recipient eligibility would be retained to cover services not otherwise provided through certified health plans. Because Medicaid is a secondary payer when a recipient has private coverage, the program would provide supplemental services for low-income groups currently entitled to Medicaid. The current flexibility provided to States to determine the optional services and groups it will cover would be retained.

Effective Date

January 1, 1997.

C. DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

The Federal share of these matching payments would be gradually phased down over a period of years, beginning Fiscal Year 1997. The DSH program would be changed into a more targeted program to compensate hospitals for uncompensated care.

D. MEDICAID LONG TERM CARE

The Medicaid program would be amended to:

1. Increase the Federal Medical Assistance Percentage by 10 percentage points for: personal care attendant services, Sec. 1915 home and community based long term care waiver services, and the frail elderly home care option under Medicaid.

2. Allow States to expand eligibility for home-based Medicaid long term care services for single individuals by increasing the asset limit from $2,000 to $4,000 for services including personal care attendant services, the Sec. 1915 waiver programs, and the frail elderly home care option.

3. Expand the Program of All-inclusive Care for the Elderly. Increase authorized demonstration sites from 15 to 40. Require the

Secretary of HHS to develop provider and service protocols.

4. Eliminate the requirement that individuals need to have been institutionalized as a condition of eligibility for habilitation services under a home and community based care waiver.

5. Eliminate the 'cold bed rule' for waiver programs that currently requires States to demonstrate the availability of an institutional bed in order to have an equivalent slot in a home and community based waiver program.

E. MISCELLANEOUS MEDICAID PROVISION

State Medicaid programs would be required to reimburse directly for services provided by all certified nurse practitioners or clinical nurse specialists that they are legally authorized under State law or regulation to perform, whether or not they operate under the supervision of a physician or other health care provider.