

104<sup>TH</sup> CONGRESS  
1<sup>ST</sup> SESSION

# H. R. 2425

To amend title XVIII of the Social Security Act to preserve and reform  
the medicare program.

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## IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 29, 1995

Mr. ARCHER (for himself, Mr. BLILEY, Mr. BILIRAKIS, Mr. THOMAS, Mr. HYDE, Mr. GREENWOOD, Mr. HASTERT, Mrs. JOHNSON of Connecticut, and Mr. MCCREERY) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committees on Commerce, the Judiciary, and Rules, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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## A BILL

To amend title XVIII of the Social Security Act to preserve  
and reform the medicare program.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. PURPOSE.**

4 The purpose of this Act is to reform the medicare  
5 program, in order to preserve and protect the financial  
6 stability of the program.

# **TITLE XV—MEDICARE**

**SEC. 15000. SHORT TITLE OF TITLE; AMENDMENTS AND  
REFERENCES TO OBRA; TABLE OF CONTENTS  
OF TITLE.**

(a) **SHORT TITLE.**—This title may be cited as the “Medicare Preservation Act of 1995”.

(b) **AMENDMENTS TO SOCIAL SECURITY ACT.**—Except as otherwise specifically provided, whenever in this title an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) **REFERENCES TO OBRA.**—In this title, the terms “OBRA–1986”, “OBRA–1987”, “OBRA–1989”, “OBRA–1990”, and “OBRA–1993” refer to the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509), the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203), the Omnibus Budget Reconciliation Act of 1989 (Public Law 101–239), the Omnibus Budget Reconciliation Act of 1990 (Public Law 101–508), and the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66), respectively.

(d) **TABLE OF CONTENTS OF TITLE.**—The table of contents of this title is as follows:

Sec. 15000. Short title of title; amendments and references to OBRA; table of contents of title.

### **Subtitle A—MedicarePlus Program**

#### PART 1—INCREASING CHOICE UNDER THE MEDICARE PROGRAM

- Sec. 15001. Increasing choice under medicare.
- Sec. 15002. MedicarePlus program.

#### “PART C—PROVISIONS RELATING TO MEDICAREPLUS

- “Sec. 1851. Requirements for MedicarePlus organizations; high deductible/medisave products.
- “Sec. 1852. Requirements relating to benefits, provision of services, enrollment, and premiums.
- “Sec. 1853. Patient protection standards.
- “Sec. 1854. Provider-sponsored organizations.
- “Sec. 1855. Payments to MedicarePlus organizations.
- “Sec. 1856. Establishment of standards for MedicarePlus organizations and products.
- “Sec. 1857. MedicarePlus certification.
- “Sec. 1858. Contracts with MedicarePlus organizations.
- Sec. 15003. Duplication and coordination of medicare-related products.
- Sec. 15004. Transitional rules for current medicare HMO program.

#### PART 2—SPECIAL RULES FOR MEDICAREPLUS MEDICAL SAVINGS ACCOUNTS

- Sec. 15011. MedicarePlus MSA's.
- Sec. 15012. Certain rebates excluded from gross income.

#### PART 3—SPECIAL ANTITRUST RULE FOR PROVIDER SERVICE NETWORKS

- Sec. 15021. Application of antitrust rule of reason to provider service networks.

#### PART 4—COMMISSIONS

- Sec. 15031. Medicare Payment Review Commission.
- Sec. 15032. Commission on the Effect of the Baby Boom Generation on the Medicare Program.
- Sec. 15033. Change in appointment of Administrator of HCFA.

### **Subtitle B—Preventing Fraud and Abuse**

- Sec. 15101. Increasing awareness of fraud and abuse.
- Sec. 15102. Beneficiary incentive programs.
- Sec. 15103. Intermediate sanctions for medicare health maintenance organizations.
- Sec. 15104. Voluntary disclosure program.
- Sec. 15105. Revisions to current sanctions.
- Sec. 15106. Consolidated funding for anti-fraud and abuse activities under Medicare Integrity Program.
- Sec. 15107. Permitting carriers to carry out prior authorization for certain items of durable medical equipment.
- Sec. 15108. Establishment of Health Care Anti-Fraud Task Force.
- Sec. 15109. Study of adequacy of private quality assurance programs.

### **Subtitle C—Regulatory Relief**

#### PART 1—PHYSICIAN OWNERSHIP REFERRAL REFORM

- Sec. 15201. Repeal of prohibitions based on compensation arrangements.

- Sec. 15202. Revision of designated health services subject to prohibition.
- Sec. 15203. Delay in implementation until promulgation of regulations.
- Sec. 15204. Exceptions to prohibition.
- Sec. 15205. Repeal of reporting requirements.
- Sec. 15206. Preemption of State law.
- Sec. 15207. Effective date.

#### PART 2—OTHER MEDICARE REGULATORY RELIEF

- Sec. 15211. Repeal of Medicare and Medicaid Coverage Data Bank.
- Sec. 15212. Clarification of level of intent required for imposition of sanctions.
- Sec. 15213. Clarification of and additions to exceptions to anti-kickback penalties.
- Sec. 15214. Solicitation and publication of modifications to existing safe harbors and new safe harbors.
- Sec. 15215. Issuance of advisory opinions under title XI.
- Sec. 15216. Prior notice of changes in billing and claims processing requirements for physicians' services.

#### PART 3—PROMOTING PHYSICIAN SELF-POLICING

- Sec. 15221. Exemption from antitrust laws for certain activities of medical self-regulatory entities.

### **Subtitle D—Medical Liability Reform**

#### PART 1—GENERAL PROVISIONS

- Sec. 15301. Federal reform of health care liability actions.
- Sec. 15302. Definitions.
- Sec. 15303. Effective date.

#### PART 2—UNIFORM STANDARDS FOR HEALTH CARE LIABILITY ACTIONS

- Sec. 15311. Statute of limitations.
- Sec. 15312. Calculation and payment of damages.
- Sec. 15313. Alternative dispute resolution.

### **Subtitle E—Teaching Hospitals and Graduate Medical Education**

#### PART 1—TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND

- Sec. 15401. Establishment of Fund; payments to teaching hospitals.

#### “TITLE XXII—TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND

##### “PART A—ESTABLISHMENT OF FUND

- “Sec. 2201. Establishment of Fund.

##### “PART B—PAYMENTS TO TEACHING HOSPITALS

##### “Subpart 1—Requirement of Payments

- “Sec. 2211. Formula payments to teaching hospitals.

“Subpart 2—Amount Relating to Indirect Costs of Graduate Medical Education

- “Sec. 2221. Determination of amount relating to indirect costs.
- “Sec. 2222. Indirect costs; special rules regarding determination of hospital-specific percentage.
- “Sec. 2223. Indirect costs; alternative payments regarding teaching hospitals in certain States.

“Subpart 3—Amount Relating to Direct Costs of Graduate Medical Education

- “Sec. 2231. Determination of amount relating to direct costs.
- “Sec. 2232. Direct costs; special rules regarding determination of hospital-specific percentage.
- “Sec. 2233. Direct costs; authority for payments to consortia of providers.
- “Sec. 2234. Direct costs; alternative payments regarding teaching hospitals in certain States.

“Subpart 4—General Provisions

- “Sec. 2241. Adjustments in payment amounts.

PART 2—AMENDMENTS TO MEDICARE PROGRAM

- Sec. 15411. Transfers to Teaching Hospital and Graduate Medical Education Trust Fund.
- Sec. 15412. Modification in payment policies regarding graduate medical education.

PART 3—REFORM OF FEDERAL POLICIES REGARDING TEACHING HOSPITALS AND GRADUATE MEDICAL EDUCATION

- Sec. 15421. Establishment of advisory panel for recommending policies.

“PART C—OTHER MATTERS

- “Sec. 2251. Advisory Panel on Reform in Financing of Teaching Hospitals and Graduate Medical Education.

**Subtitle F—Provisions Relating to Medicare Part A**

PART 1—HOSPITALS

SUBPART A—GENERAL PROVISIONS RELATING TO HOSPITALS

- Sec. 15501. Reductions in inflation updates for PPS hospitals.
- Sec. 15502. Reductions in disproportionate share payment adjustments.
- Sec. 15503. Payments for capital-related costs for inpatient hospital services.
- Sec. 15504. Reduction in adjustment for indirect medical education.
- Sec. 15505. Treatment of PPS-exempt hospitals.
- Sec. 15506. Reduction in payments to hospitals for enrollees’ bad debts.
- Sec. 15507. Permanent extension of hemophilia pass-through.
- Sec. 15508. Conforming amendment to certification of Christian Science providers.

SUBPART B—PROVISIONS RELATING TO RURAL HOSPITALS

- Sec. 15511. Sole community hospitals.

- Sec. 15512. Clarification of treatment of EAC and RPC hospitals.
- Sec. 15513. Rural emergency access care hospitals.
- Sec. 15514. Classification of rural referral centers.
- Sec. 15515. Floor on area wage index.

#### PART 2—PAYMENTS TO SKILLED NURSING FACILITIES

- Sec. 15521. Payments for routine service costs.
- Sec. 15522. Incentives for cost effective management of covered non-routine services.
- Sec. 15523. Payments for routine service costs.
- Sec. 15524. Reductions in payment for capital-related costs.
- Sec. 15525. Treatment of items and services paid for under part B.
- Sec. 15526. Certification of facilities meeting revised nursing home reform standards.
- Sec. 15527. Medical review process.
- Sec. 15528. Report by Medicare Payment Review Commission.
- Sec. 15529. Effective date.

### **Subtitle G—Provisions Relating to Medicare Part B**

#### PART 1—PAYMENT REFORMS

- Sec. 15601. Payments for physicians' services.
- Sec. 15602. Elimination of formula-driven overpayments for certain outpatient hospital services.
- Sec. 15603. Reduction in updates to payment amounts for durable medical equipment.
- Sec. 15604. Reduction in updates to payment amounts for clinical diagnostic laboratory tests.
- Sec. 15605. Extension of reductions in payments for costs of hospital outpatient services.
- Sec. 15606. Freeze in payments for ambulatory surgical center services.
- Sec. 15607. Rural emergency access care hospitals.

#### PART 2—PART B PREMIUM

- Sec. 15611. Extension of part B premium.
- Sec. 15612. Income-related reduction in medicare subsidy.

### **Subtitle H—Provisions Relating to Medicare Parts A and B**

#### PART 1—HOME HEALTH SERVICES

- Sec. 15701. Payment for home health services.
- Sec. 15702. Maintaining savings resulting from temporary freeze on payment increases for home health services.
- Sec. 15703. Extension of waiver of presumption of lack of knowledge of exclusion from coverage for home health agencies.

#### PART 2—MEDICARE SECONDARY PAYER IMPROVEMENTS

- Sec. 15711. Extension and expansion of existing requirements.
- Sec. 15712. Improvements in recovery of payments.
- Sec. 15713. Prohibiting retroactive application of policy regarding ESRD beneficiaries enrolled in primary plans.

#### PART 3—FAILSAFE

Sec. 15721. Failsafe budget mechanism.

PART 4—ADMINISTRATIVE SIMPLIFICATION

Sec. 15731. Standards for medicare information transactions and data elements.

PART 5—OTHER PROVISIONS RELATING TO PARTS A AND B

Sec. 15741. Clarification of medicare coverage of items and services associated with certain medical devices approved for investigational use.

Sec. 15742. Additional exclusion from coverage.

**Subtitle I—Clinical Laboratories**

Sec. 15801. Exemption of physician office laboratories.

**1 Subtitle A—MedicarePlus Program**

**2 PART 1—INCREASING CHOICE UNDER THE**  
**3 MEDICARE PROGRAM**

**4 SEC. 15001. INCREASING CHOICE UNDER MEDICARE.**

**5 (a) IN GENERAL.—**Title XVIII is amended by insert-  
**6 ing after section 1804 the following new section:**

**7 “PROVIDING FOR CHOICE OF COVERAGE**

**8 “SEC. 1805. (a) CHOICE OF COVERAGE.—**

**9 “(1) IN GENERAL.—**Subject to the provisions of  
**10 this section, every individual who is entitled to bene-**  
**11 fits under part A and enrolled under part B shall**  
**12 elect to receive benefits under this title through one**  
**13 of the following:**

**14 “(A) THROUGH FEE-FOR-SERVICE SYS-**  
**15 TEM.—**Through the provisions of parts A and  
**16 B.**

1           “(B) THROUGH A MEDICAREPLUS PROD-  
2           UCT.—Through a MedicarePlus product (as de-  
3           fined in paragraph (2)), which may be—

4                   “(i) a high deductible/medisave prod-  
5                   uct (and a contribution into a  
6                   MedicarePlus medical savings account  
7                   (MSA)),

8                   “(ii) a product offered by a provider-  
9                   sponsored organization,

10                   “(iii) a product offered by an organi-  
11                   zation that is a union, Taft-Hartley plan,  
12                   or association, or

13                   “(iv) a product providing for benefits  
14                   on a fee-for-service or other basis.

15           “(2) MEDICAREPLUS PRODUCT DEFINED.—For  
16           purposes this section and part C, the term  
17           ‘MedicarePlus product’ means health benefits cov-  
18           erage offered under a policy, contract, or plan by a  
19           MedicarePlus organization (as defined in section  
20           1851(a)) pursuant to and in accordance with a con-  
21           tract under section 1857.

22           “(3) TERMINOLOGY RELATING TO OPTIONS.—  
23           For purposes of this section and part C—

24                   “(A) NON-MEDICAREPLUS OPTION.—An  
25                   individual who has made the election described

1 in paragraph (1)(A) is considered to have elect-  
2 ed the ‘Non-MedicarePlus option’.

3 “(B) **MEDICAREPLUS OPTION.**—An indi-  
4 vidual who has made the election described in  
5 paragraph (1)(B) to obtain coverage through a  
6 MedicarePlus product is considered to have  
7 elected the ‘MedicarePlus option’ for that prod-  
8 uct.

9 “(b) **SPECIAL RULES.**—

10 “(1) **RESIDENCE REQUIREMENT.**—Except as  
11 the Secretary may otherwise provide, an individual is  
12 eligible to elect a MedicarePlus product offered by a  
13 MedicarePlus organization only if the organization  
14 in relation to the product serves the geographic area  
15 in which the individual resides.

16 “(2) **AFFILIATION REQUIREMENTS FOR CER-**  
17 **TAIN PRODUCTS.**—

18 “(A) **IN GENERAL.**—Subject to subpara-  
19 graph (B), an individual is eligible to elect a  
20 MedicarePlus product offered by a limited en-  
21 rollment MedicarePlus organization (as defined  
22 in section 1852(c)(4)(E)) only if—

23 “(i) the individual is eligible under  
24 section 1852(c)(4) to make such election,  
25 and

1           “(ii) in the case of a MedicarePlus or-  
2           ganization that is a union sponsor or a  
3           Taft-Hartley sponsor (as defined in section  
4           1852(c)(4)), the individual elected under  
5           this section a MedicarePlus product offered  
6           by the sponsor during the first enrollment  
7           period in which the individual was eligible  
8           to make such election with respect to such  
9           sponsor.

10           “(B)       NO       REELECTION       AFTER  
11           DISENROLLMENT FOR CERTAIN PRODUCTS.—  
12           An individual is not eligible to elect a  
13           MedicarePlus product offered by a  
14           MedicarePlus organization that is union spon-  
15           sor or a Taft-Hartley sponsor if the individual  
16           previously had elected a MedicarePlus product  
17           offered by the organization and had subse-  
18           quently discontinued to elect such a product of-  
19           fered by the organization.

20           “(3) SPECIAL RULE FOR CERTAIN ANNU-  
21           ITANTS.—An individual is not eligible to elect a high  
22           deductible/medisave product if the individual is enti-  
23           tled to benefits under chapter 89 of title 5, United  
24           States Code, as an annuitant or spouse of an annu-  
25           itant.

1 “(c) PROCESS FOR EXERCISING CHOICE.—

2 “(1) IN GENERAL.—The Secretary shall estab-  
3 lish a process through which elections described in  
4 subsection (a) are made and changed, including the  
5 form and manner in which such elections are made  
6 and changed. Such elections shall be made or  
7 changed only during coverage election periods speci-  
8 fied under subsection (e) and shall become effective  
9 as provided in subsection (f).

10 “(2) EXPEDITED IMPLEMENTATION.—The Sec-  
11 retary shall establish the process of electing coverage  
12 under this section during the transition period (as  
13 defined in subsection (e)(1)(B)) in such an expedited  
14 manner as will permit such an election for  
15 MedicarePlus products in an area as soon as such  
16 products become available in that area.

17 “(3) COORDINATION THROUGH MEDICAREPLUS  
18 ORGANIZATIONS.—

19 “(A) ENROLLMENT.—Such process shall  
20 permit an individual who wishes to elect a  
21 MedicarePlus product offered by a  
22 MedicarePlus organization to make such elec-  
23 tion through the filing of an appropriate elec-  
24 tion form with the organization.

1           “(B) DISENROLLMENT.—Such process  
2 shall permit an individual, who has elected a  
3 MedicarePlus product offered by a  
4 MedicarePlus organization and who wishes to  
5 terminate such election, to terminate such elec-  
6 tion through the filing of an appropriate elec-  
7 tion form with the organization.

8           “(4) DEFAULT.—

9           “(A) INITIAL ELECTION.—

10           “(i) IN GENERAL.—Subject to clause  
11 (ii), an individual who fails to make an  
12 election during an initial election period  
13 under subsection (e)(1) is deemed to have  
14 chosen the Non-MedicarePlus option.

15           “(ii) SEAMLESS CONTINUATION OF  
16 COVERAGE.—The Secretary shall establish  
17 procedures under which individuals who  
18 are enrolled with a MedicarePlus organiza-  
19 tion at the time of the initial election pe-  
20 riod and who fail to elect to receive cov-  
21 erage other than through the organization  
22 are deemed to have elected an appropriate  
23 MedicarePlus product offered by the orga-  
24 nization.

1           “(B) CONTINUING PERIODS.—An individ-  
2           ual who has made (or deemed to have made) an  
3           election under this section is considered to have  
4           continued to make such election until such time  
5           as—

6                       “(i) the individual changes the elec-  
7                       tion under this section, or

8                       “(ii) a MedicarePlus product is dis-  
9                       continued, if the individual had elected  
10                      such product at the time of the discontinu-  
11                      ation.

12           “(5) AGREEMENTS WITH COMMISSIONER OF SO-  
13           CIAL SECURITY TO PROMOTE EFFICIENT ADMINIS-  
14           TRATION.—In order to promote the efficient admin-  
15           istration of this section and the MedicarePlus pro-  
16           gram under part C, the Secretary may enter into an  
17           agreement with the Commissioner of Social Security  
18           under which the Commissioner performs administra-  
19           tive responsibilities relating to enrollment and  
20           disenrollment in MedicarePlus products under this  
21           section.

22           “(d) PROVISION OF BENEFICIARY INFORMATION TO  
23           PROMOTE INFORMED CHOICE.—

24                       “(1) IN GENERAL.—The Secretary shall provide  
25                       for activities under this subsection to disseminate

1 broadly information to medicare beneficiaries (and  
2 prospective medicare beneficiaries) on the coverage  
3 options provided under this section in order to pro-  
4 mote an active, informed selection among such op-  
5 tions. Such information shall be made available on  
6 such a timely basis (such as 6 months before the  
7 date an individual would first attain eligibility for  
8 medicare on the basis of age) as to permit individ-  
9 uals to elect the MedicarePlus option during the ini-  
10 tial election period described in subsection (e)(1).

11 “(2) USE OF NONFEDERAL ENTITIES.—The  
12 Secretary shall, to the maximum extent feasible,  
13 enter into contracts with appropriate non-Federal  
14 entities to carry out activities under this subsection.

15 “(3) SPECIFIC ACTIVITIES.—In carrying out  
16 this subsection, the Secretary shall provide for at  
17 least the following activities in all areas in which  
18 MedicarePlus products are offered:

19 “(A) INFORMATION BOOKLET.—

20 “(i) IN GENERAL.—The Secretary  
21 shall publish an information booklet and  
22 disseminate the booklet to all individuals  
23 eligible to elect the MedicarePlus option  
24 under this section during coverage election  
25 periods.

1           “(ii) INFORMATION INCLUDED.—The  
2 booklet shall include information presented  
3 in plain English and in a standardized for-  
4 mat regarding—

5                   “(I) the benefits and premiums  
6 for the various MedicarePlus products  
7 in the areas involved;

8                   “(II) the quality of such prod-  
9 ucts, including consumer satisfaction  
10 information; and

11                   “(III) rights and responsibilities  
12 of medicare beneficiaries under such  
13 products.

14           “(iii) PERIODIC UPDATING.—The  
15 booklet shall be updated on a regular basis  
16 (not less often than once every 12 months)  
17 to reflect changes in the availability of  
18 MedicarePlus products and the benefits  
19 and premiums for such products.

20           “(B) TOLL-FREE NUMBER.—The Secretary  
21 shall maintain a toll-free number for inquiries  
22 regarding MedicarePlus options and the oper-  
23 ation of part C.

24           “(C) GENERAL INFORMATION IN MEDI-  
25 CARE HANDBOOK.—The Secretary shall include

1 information about the MedicarePlus option pro-  
2 vided under this section in the annual notice of  
3 medicare benefits under section 1804.

4 “(e) COVERAGE ELECTION PERIODS.—

5 “(1) INITIAL CHOICE UPON ELIGIBILITY TO  
6 MAKE ELECTION.—

7 “(A) IN GENERAL.—In the case of an indi-  
8 vidual who first becomes entitled to benefits  
9 under part A and enrolled under part B after  
10 the beginning of the transition period (as de-  
11 fined in subparagraph (B)), the individual shall  
12 make the election under this section during a  
13 period (of a duration and beginning at a time  
14 specified by the Secretary) at the first time the  
15 individual both is entitled to benefits under part  
16 A and enrolled under part B. Such period shall  
17 be specified in a manner so that, in the case of  
18 an individual who elects a MedicarePlus prod-  
19 uct during the period, coverage under the prod-  
20 uct becomes effective as of the first date on  
21 which the individual may receive such coverage.

22 “(B) TRANSITION PERIOD DEFINED.—In  
23 this subsection, the term ‘transition period’  
24 means, with respect to an individual in an area,  
25 the period beginning on the first day of the first

1 month in which a MedicarePlus product is first  
2 made available to individuals in the area and  
3 ending with the month preceding the beginning  
4 of the first annual, coordinated election period  
5 under paragraph (3).

6 “(2) DURING TRANSITION PERIOD.—Subject to  
7 paragraph (6)—

8 “(A) CONTINUOUS OPEN ENROLLMENT  
9 INTO A MEDICAREPLUS OPTION.—During the  
10 transition period, an individual who is eligible  
11 to make an election under this section and who  
12 has elected the non-MedicarePlus option may  
13 change such election to a MedicarePlus option  
14 at any time.

15 “(B) OPEN DISENROLLMENT BEFORE END  
16 OF TRANSITION PERIOD.—

17 “(i) IN GENERAL.—During the transi-  
18 tion period, an individual who has elected  
19 a MedicarePlus option for a MedicarePlus  
20 product may change such election to an-  
21 other MedicarePlus product or to the non-  
22 MedicarePlus option.

23 “(ii) SPECIAL RULE.—During the  
24 transition period, an individual who has  
25 elected a high deductible/medisave product

1           may not change such election to a  
2           MedicarePlus product that is not a high  
3           deductible/medisave product unless the in-  
4           dividual has had such election in effect for  
5           12 months.

6           “(3) ANNUAL, COORDINATED ELECTION PE-  
7           RIOD.—

8           “(A) IN GENERAL.—Subject to paragraph  
9           (5), each individual who is eligible to make an  
10          election under this section may change such  
11          election during annual, coordinated election pe-  
12          riods.

13          “(B) ANNUAL, COORDINATED ELECTION  
14          PERIOD.—For purposes of this section, the  
15          term ‘annual, coordinated election period’  
16          means, with respect to a calendar year (begin-  
17          ning with 1998), the month of October before  
18          such year.

19          “(C) MEDICAREPLUS HEALTH FAIR DUR-  
20          ING OCTOBER, 1996.—In the month of October,  
21          1996, the Secretary shall provide for a nation-  
22          ally coordinated educational and publicity cam-  
23          paign to inform individuals, who are eligible to  
24          elect MedicarePlus products, about such prod-  
25          ucts and the election process provided under

1           this section (including the annual, coordinated  
2           election periods that occur in subsequent years).

3           “(4) SPECIAL 90-DAY DISENROLLMENT OP-  
4           TION.—

5                   “(A) IN GENERAL.—In the case of an indi-  
6           vidual who first elects a MedicarePlus option  
7           (other than a high deductible/medisave product)  
8           under this section, the individual may dis-  
9           continue such election through the filing of an  
10          appropriate notice during the 90-day period be-  
11          ginning on the first day on which the individ-  
12          ual’s coverage under the MedicarePlus product  
13          under such option becomes effective.

14                   “(B) EFFECT OF DISCONTINUATION OF  
15          ELECTION.—An individual who discontinues an  
16          election under this paragraph shall be deemed  
17          at the time of such discontinuation to have  
18          elected the non-MedicarePlus option.

19                   “(5) SPECIAL ELECTION PERIODS.—An individ-  
20          ual may discontinue an election of a MedicarePlus  
21          product offered by a MedicarePlus organization  
22          other than during an annual, coordinated election  
23          period and make a new election under this section  
24          if—

1           “(A) the organization’s or product’s certifi-  
2 cation under part C has been terminated or the  
3 organization has terminated or otherwise dis-  
4 continued providing the product;

5           “(B) in the case of an individual who has  
6 elected a MedicarePlus product offered by a  
7 MedicarePlus organization, the individual is no  
8 longer eligible to elect the product because of a  
9 change in the individual’s place of residence or  
10 other change in circumstances (specified by the  
11 Secretary, but not including termination of  
12 membership in a qualified association in the  
13 case of a product offered by a qualified associa-  
14 tion or termination of the individual’s enroll-  
15 ment on the basis described in clause (i) or (ii),  
16 section 1852(c)(3)(B));

17           “(C) the individual demonstrates (in ac-  
18 cordance with guidelines established by the Sec-  
19 retary) that—

20           “(i) the organization offering the  
21 product substantially violated a material  
22 provision of the organization’s contract  
23 under part C in relation to the individual  
24 and the product; or

1           “(ii) the organization (or an agent or  
2           other entity acting on the organization’s  
3           behalf) materially misrepresented the prod-  
4           uct’s provisions in marketing the product  
5           to the individual; or

6           “(D) the individual meets such other con-  
7           ditions as the Secretary may provide.

8           “(6) SPECIAL RULE FOR HIGH DEDUCTIBLE/  
9           MEDISAVE PRODUCTS.—Notwithstanding the pre-  
10          vious provisions of this subsection, an individual may  
11          elect a high deductible/medisave product only during  
12          an annual, coordinated election period described in  
13          paragraph (3)(B) or during the month of October,  
14          1996.

15          “(f) EFFECTIVENESS OF ELECTIONS.—

16                 “(1) DURING INITIAL COVERAGE ELECTION PE-  
17                 RIOD.—An election of coverage made during the ini-  
18                 tial coverage election period under subsection  
19                 (e)(1)(A) shall take effect upon the date the individ-  
20                 ual becomes entitled to benefits under part A and  
21                 enrolled under part B, except as the Secretary may  
22                 provide (consistent with section 1838) in order to  
23                 prevent retroactive coverage.

24                 “(2) DURING TRANSITION; 90-DAY  
25                 DISENROLLMENT OPTION.—An election of coverage

1 made under subsection (e)(2) and an election to dis-  
2 continue a MedicarePlus option under subsection  
3 (e)(4) at any time shall take effect with the first cal-  
4 endar month following the date on which the election  
5 is made.

6 “(3) ANNUAL, COORDINATED ELECTION PERIOD  
7 AND MEDISAVE ELECTION.—An election of coverage  
8 made during an annual, coordinated election period  
9 (as defined in subsection (e)(3)(B)) in a year or for  
10 a high deductible/medisave product shall take effect  
11 as of the first day of the following year.

12 “(4) OTHER PERIODS.—An election of coverage  
13 made during any other period under subsection  
14 (e)(5) shall take effect in such manner as the Sec-  
15 retary provides in a manner consistent (to the extent  
16 practicable) with protecting continuity of health ben-  
17 efit coverage.

18 “(g) EFFECT OF ELECTION OF MEDICAREPLUS OP-  
19 TION.—Subject to the provisions of section 1855(f), pay-  
20 ments under a contract with a MedicarePlus organization  
21 under section 1857(a) with respect to an individual elect-  
22 ing a MedicarePlus product offered by the organization  
23 shall be instead of the amounts which (in the absence of  
24 the contract) would otherwise be payable under parts A  
25 and B for items and services furnished to the individual.

1 “(h) ADMINISTRATION.—

2 “(1) IN GENERAL.—This part and sections  
3 1805 and 1876 shall be administered through an op-  
4 erating division (A) that is established or identified  
5 by the Secretary in the Department of Health and  
6 Human Services, (B) that is separate from the  
7 Health Care Financing Administration, and (C) the  
8 primary function of which is the administration of  
9 this part and such sections. The director of such di-  
10 vision shall be of equal pay and rank to that of the  
11 individual responsible for overall administration of  
12 parts A and B.

13 “(2) TRANSFER AUTHORITY.—The Secretary  
14 shall transfer such personnel, administrative support  
15 systems, assets, records, funds, and other resources  
16 in the Health Care Financing Administration to the  
17 operating division referred to in paragraph (1) as  
18 are used in the administration of section 1876 and  
19 as may be required to implement the provisions re-  
20 ferred to in such paragraph promptly and effi-  
21 ciently.”.

22 **SEC. 15002. MEDICAREPLUS PROGRAM.**

23 (a) IN GENERAL.—Title XVIII is amended by redес-  
24 ignating part C as part D and by inserting after part B  
25 the following new part:

1 “PART C—PROVISIONS RELATING TO MEDICAREPLUS  
2 “REQUIREMENTS FOR MEDICAREPLUS ORGANIZATIONS;  
3 HIGH DEDUCTIBLE/MEDISAVE PRODUCTS

4 “SEC. 1851. (a) MEDICAREPLUS ORGANIZATION DE-  
5 FINED.—In this part, subject to the succeeding provisions  
6 of this section, the term ‘MedicarePlus organization’  
7 means a public or private entity that is certified under  
8 section 1857 as meeting the requirements of this part for  
9 such an organization.

10 “(b) ORGANIZED AND LICENSED UNDER STATE  
11 LAW.—

12 “(1) IN GENERAL.—A MedicarePlus organiza-  
13 tion shall be organized and licensed under State law  
14 to offer health insurance or health benefits coverage  
15 in each State in which it offers a MedicarePlus prod-  
16 uct.

17 “(2) EXCEPTION FOR UNION AND TAFT-HART-  
18 LEY SPONSORS.—Paragraph (1) shall not apply to a  
19 MedicarePlus organization that is a union sponsor  
20 or a Taft-Hartley sponsor (as defined in section  
21 1852(c)(4)).

22 “(3) EXCEPTION FOR PROVIDER-SPONSORED  
23 ORGANIZATIONS.—Paragraph (1) shall not apply to  
24 a MedicarePlus organization that is a provider-spon-

1       sored organization (as defined in section 1854(a))  
2       except to the extent provided under section 1857(c).

3       “(c) PREPAID PAYMENT.—A MedicarePlus organiza-  
4       tion shall be compensated (except for deductibles, coinsur-  
5       ance, and copayments) for the provision of health care  
6       services to enrolled members by a payment which is paid  
7       on a periodic basis without regard to the date the health  
8       care services are provided and which is fixed without re-  
9       gard to the frequency, extent, or kind of health care serv-  
10      ice actually provided to a member.

11      “(d) ASSUMPTION OF FULL FINANCIAL RISK.—The  
12      MedicarePlus organization shall assume full financial risk  
13      on a prospective basis for the provision of the health care  
14      services (other than hospice care) for which benefits are  
15      required to be provided under section 1852(a)(1), except  
16      that the organization—

17              “(1) may obtain insurance or make other ar-  
18              rangements for the cost of providing to any enrolled  
19              member such services the aggregate value of which  
20              exceeds \$5,000 in any year,

21              “(2) may obtain insurance or make other ar-  
22              rangements for the cost of such services provided to  
23              its enrolled members other than through the organi-  
24              zation because medical necessity required their pro-

1 vision before they could be secured through the orga-  
2 nization,

3 “(3) may obtain insurance or make other ar-  
4 rangements for not more than 90 percent of the  
5 amount by which its costs for any of its fiscal years  
6 exceed 115 percent of its income for such fiscal year,  
7 and

8 “(4) may make arrangements with physicians  
9 or other health professionals, health care institu-  
10 tions, or any combination of such individuals or in-  
11 stitutions to assume all or part of the financial risk  
12 on a prospective basis for the provision of basic  
13 health services by the physicians or other health pro-  
14 fessionals or through the institutions.

15 “(e) PROVISION AGAINST RISK OF INSOLVENCY.—

16 “(1) IN GENERAL.—Each MedicarePlus organi-  
17 zation shall meet standards under section 1856 re-  
18 lating to the financial solvency and capital adequacy  
19 of the organization. Such standards shall take into  
20 account the nature and type of MedicarePlus prod-  
21 ucts offered by the organization.

22 “(2) TREATMENT OF UNION AND TAFT-HART-  
23 LEY SPONSORS.—An entity that is a union sponsor  
24 or a Taft-Hartley sponsor is deemed to meet the re-  
25 quirement of paragraph (1).

1       “(f) HIGH DEDUCTIBLE/MEDISAVE PRODUCT DE-  
2 FINED.—

3               “(1) IN GENERAL.—In this part, the term ‘high  
4 deductible/medisave product’ means a MedicarePlus  
5 product that—

6                       “(A) provides reimbursement for at least  
7 the items and services described in section  
8 1852(a)(1) in a year but only after the enrollee  
9 incurs countable expenses (as specified under  
10 the product) equal to the amount of a deduct-  
11 ible (described in paragraph (2));

12                      “(B) counts as such expenses (for purposes  
13 of such deductible) at least all amounts that  
14 would have been payable under parts A and B  
15 or by the enrollee if the enrollee had elected to  
16 receive benefits through the provisions of such  
17 parts; and

18                      “(C) provides, after such deductible is met  
19 for a year and for all subsequent expenses for  
20 benefits referred to in subparagraph (A) in the  
21 year, for a level of reimbursement that is not  
22 less than—

23                               “(i) 100 percent of such expenses, or

24                               “(ii) 100 percent of the amounts that  
25 would have been paid (without regard to

1           any deductibles or coinsurance) under  
2           parts A and B with respect to such ex-  
3           penses,

4           whichever is less. Such term does not include  
5           the MedicarePlus MSA itself or any contribu-  
6           tion into such account.

7           “(2) DEDUCTIBLE.—The amount of deductible  
8           under a high deductible/medisave product—

9                   “(A) for contract year 1997 shall be not  
10                   more than \$10,000; and

11                   “(B) for a subsequent contract year shall  
12                   be not more than the maximum amount of such  
13                   deductible for the previous contract year under  
14                   this paragraph increased by the national aver-  
15                   age per capita growth rate under section  
16                   1855(c)(3) for the year.

17           If the amount of the deductible under subparagraph  
18           (B) is not a multiple of \$50, the amount shall be  
19           rounded to the nearest multiple of \$50.

20           “(g) ORGANIZATIONS TREATED AS MEDICAREPLUS  
21           ORGANIZATIONS DURING TRANSITION.—Any of the fol-  
22           lowing organizations shall be considered to qualify as a  
23           MedicarePlus organization for contract years beginning  
24           before January 1, 1998:

1           “(1) HEALTH MAINTENANCE ORGANIZA-  
2           TIONS.—An organization that is organized under the  
3           laws of any State and that is a qualified health  
4           maintenance organization (as defined in section  
5           1310(d) of the Public Health Service Act), an orga-  
6           nization recognized under State law as a health  
7           maintenance organization, or a similar organization  
8           regulated under State law for solvency in the same  
9           manner and to the same extent as such a health  
10          maintenance organization.

11          “(2) LICENSED INSURERS.—An organization  
12          that is organized under the laws of any State and—

13               “(A) is licensed by a State agency as an  
14               insurer for the offering of health benefit cov-  
15               erage, or

16               “(B) is licensed by a State agency as a  
17               service benefit plan,

18          but only for individuals residing in an area in which  
19          the organization is licensed to offer health insurance  
20          coverage.

21          “(3) CURRENT RISK-CONTRACTORS.—An orga-  
22          nization that is an eligible organization (as defined  
23          in section 1876(b)) and that has a risk-sharing con-  
24          tract in effect under section 1876 as of the date of  
25          the enactment of this section.

1 “REQUIREMENTS RELATING TO BENEFITS, PROVISION OF  
2 SERVICES, ENROLLMENT, AND PREMIUMS

3 “SEC. 1852. (a) BENEFITS COVERED.—

4 “(1) IN GENERAL.—Except as provided in sub-  
5 section (b), in section 1851(f)(1) with respect to  
6 high deductible/medisave products, and in section  
7 1853(a), each MedicarePlus product offered under  
8 this part shall provide benefits for at least the items  
9 and services for which benefits are available under  
10 parts A and B consistent with the standards for cov-  
11 erage of such items and services applicable under  
12 this title.

13 “(2) ORGANIZATION AS SECONDARY PAYER.—  
14 Notwithstanding any other provision of law, a  
15 MedicarePlus organization may (in the case of the  
16 provision of items and services to an individual  
17 under this part under circumstances in which pay-  
18 ment under this title is made secondary pursuant to  
19 section 1862(b)(2)) charge or authorize the provider  
20 of such services to charge, in accordance with the  
21 charges allowed under such law or policy—

22 “(A) the insurance carrier, employer, or  
23 other entity which under such law, plan, or pol-  
24 icy is to pay for the provision of such services,  
25 or

1           “(B) such individual to the extent that the  
2           individual has been paid under such law, plan,  
3           or policy for such services.

4           “(b) ANTIDISCRIMINATION.—A MedicarePlus organi-  
5           zation may not deny, limit, or condition the coverage or  
6           provision of benefits under this part based on the health  
7           status, claims experience, receipt of health care, medical  
8           history, or lack of evidence of insurability, of an individual.

9           “(c) GUARANTEED ISSUE AND RENEWAL.—

10           “(1) IN GENERAL.—Except as provided in this  
11           subsection, a MedicarePlus organization shall pro-  
12           vide that at any time during which elections are ac-  
13           cepted under section 1805 with respect to a  
14           MedicarePlus product offered by the organization,  
15           the organization will accept without restrictions indi-  
16           viduals who are eligible to make such election.

17           “(2) PRIORITY.—If the Secretary determines  
18           that a MedicarePlus organization, in relation to a  
19           MedicarePlus product it offers, has a capacity limit  
20           and the number of eligible individuals who elect the  
21           product under section 1805 exceeds the capacity  
22           limit, the organization may limit the election of indi-  
23           viduals of the product under such section but only  
24           if priority in election is provided—

1           “(A) first to such individuals as have elect-  
2           ed the product at that time, and

3           “(B) then to other such individuals in such  
4           a manner that does not discriminate among the  
5           individuals (who seek to elect the product) on a  
6           basis described in paragraph (1).

7           “(3) LIMITATION ON TERMINATION OF ELEC-  
8           TION.—

9           “(A) IN GENERAL.—Subject to subpara-  
10           graph (B), a MedicarePlus organization may  
11           not for any reason terminate the election of any  
12           individual under section 1805 for a  
13           MedicarePlus product it offers.

14           “(B) BASIS FOR TERMINATION OF ELEC-  
15           TION.—A MedicarePlus organization may ter-  
16           minate an individual’s election under section  
17           1805 with respect to a MedicarePlus product it  
18           offers if—

19                   “(i) any premiums required with re-  
20                   spect to such product are not paid on a  
21                   timely basis (consistent with standards  
22                   under section 1856 that provide for a  
23                   grace period for late payment of pre-  
24                   miums),

1           “(ii) the individual has engaged in  
2           disruptive behavior (as specified in such  
3           standards), or

4           “(iii) the product is terminated with  
5           respect to all individuals under this part.

6           Any individual whose election is so terminated  
7           is deemed to have elected the Non-MedicarePlus  
8           option (as defined in section 1805(a)(3)(A)).

9           “(D) ORGANIZATION OBLIGATION WITH RE-  
10          SPECT TO ELECTION FORMS.—Pursuant to a con-  
11          tract under section 1858, each MedicarePlus organi-  
12          zation receiving an election form under section  
13          1805(c)(2) shall transmit to the Secretary (at such  
14          time and in such manner as the Secretary may  
15          specify) a copy of such form or such other informa-  
16          tion respecting the election as the Secretary may  
17          specify.

18          “(4) SPECIAL RULES FOR LIMITED ENROLL-  
19          MENT MEDICAREPLUS ORGANIZATIONS.—

20                 “(A) UNIONS.—

21                         “(i) IN GENERAL.—Subject to sub-  
22                         paragraph (D), a union sponsor (as de-  
23                         fined in subsection (b)(2)) shall limit eligi-  
24                         bility of enrollees under this part for  
25                         MedicarePlus products it offers to individ-

1 uals who are members of the sponsor and  
2 affiliated with the sponsor through an em-  
3 ployment relationship with any employer or  
4 are the spouses of such members.

5 “(ii) UNION SPONSOR.—In this part  
6 and section 1805, the term ‘union sponsor’  
7 means an employee organization in relation  
8 to a group health plan that is established  
9 or maintained by the organization other  
10 than pursuant to a collective bargaining  
11 agreement.

12 “(B) TAFT-HARTLEY SPONSORS.—

13 “(i) IN GENERAL.—Subject to sub-  
14 paragraph (D), a MedicarePlus organiza-  
15 tion that is a Taft-Hartley sponsor (as de-  
16 fined in clause (ii)) shall limit eligibility of  
17 enrollees under this part for MedicarePlus  
18 products it offers to individuals who are  
19 entitled to obtain benefits through such  
20 products under the terms of an applicable  
21 collective bargaining agreement.

22 “(ii) TAFT-HARTLEY SPONSOR.—In  
23 this part and section 1805, the term ‘Taft-  
24 Hartley sponsor’ means, in relation to a  
25 group health plan that is established or

1 maintained by two or more employers or  
2 jointly by one or more employers and one  
3 or more employee organizations, the asso-  
4 ciation, committee, joint board of trustees,  
5 or other similar group of representatives of  
6 parties who establish or maintain the plan.

7 “(C) QUALIFIED ASSOCIATIONS.—

8 “(i) IN GENERAL.—Subject to sub-  
9 paragraph (D), a MedicarePlus organiza-  
10 tion that is a qualified association (as de-  
11 fined in clause (iii)) shall limit eligibility of  
12 individuals under this part for products it  
13 offers to individuals who are members of  
14 the association (or who are spouses of such  
15 individuals).

16 “(ii) LIMITATION ON TERMINATION  
17 OF COVERAGE.—Such a qualifying associa-  
18 tion offering a MedicarePlus product to an  
19 individual may not terminate coverage of  
20 the individual on the basis that the individ-  
21 ual is no longer a member of the associa-  
22 tion except pursuant to a change of elec-  
23 tion during an open election period occur-  
24 ring on or after the date of the termination  
25 of membership.

1           “(iii) QUALIFIED ASSOCIATION.—In  
2 this part and section 1805, the term ‘quali-  
3 fied association’ means an association, reli-  
4 gious fraternal organization, or other orga-  
5 nization (which may be a trade, industry,  
6 or professional association, a chamber of  
7 commerce, or a public entity association)  
8 that the Secretary finds—

9           “(I) has been formed for pur-  
10 poses other than the sale of any  
11 health insurance and does not restrict  
12 membership based on the health sta-  
13 tus, claims experience, receipt of  
14 health care, medical history, or lack of  
15 evidence of insurability, of an individ-  
16 ual,

17           “(II) does not exist solely or  
18 principally for the purpose of selling  
19 insurance, and

20           “(III) has at least 1,000 individ-  
21 ual members or 200 employer mem-  
22 bers.

23 Such term includes a subsidiary or cor-  
24 poration that is wholly owned by one or  
25 more qualified organizations.

1           “(D) LIMITATION.—Rules of eligibility to  
2 carry out the previous subparagraphs of this  
3 paragraph shall not have the effect of denying  
4 eligibility to individuals on the basis of health  
5 status, claims experience, receipt of health care,  
6 medical history, or lack of evidence of insurabil-  
7 ity.

8           “(E) LIMITED ENROLLMENT  
9 MEDICAREPLUS ORGANIZATION.—In this part  
10 and section 1805, the term ‘limited enrollment  
11 MedicarePlus organization’ means a  
12 MedicarePlus organization that is a union spon-  
13 sor, Taft-Hartley sponsor, or a qualified asso-  
14 ciation.

15           “(F) EMPLOYER, ETC.—In this paragraph,  
16 the terms ‘employer’, ‘employee organization’,  
17 and ‘group health plan’ have the meanings  
18 given such terms for purposes of part 6 of sub-  
19 title B of title I of the Employee Retirement In-  
20 come Security Act of 1974.

21           “(d) SUBMISSION AND CHARGING OF PREMIUMS.—

22           “(1) IN GENERAL.—Each MedicarePlus organi-  
23 zation shall file with the Secretary each year, in a  
24 form and manner and at a time specified by the Sec-  
25 retary—

1           “(A) the amount of the monthly premiums  
2           for coverage under each MedicarePlus product  
3           it offers under this part in each payment area  
4           (as determined for purposes of section 1855) in  
5           which the product is being offered; and

6           “(B) the enrollment capacity in relation to  
7           the product in each such area.

8           “(2) AMOUNTS OF PREMIUMS CHARGED.—The  
9           amount of the premium charged by a MedicarePlus  
10          organization for a MedicarePlus product offered in  
11          a payment area to an individual under this part  
12          shall be equal to the amount (if any) by which—

13           “(A) the amount of the premium for the  
14           product for the area and period involved, as  
15           submitted under paragraph (1), exceeds

16           “(B)  $\frac{1}{12}$  of the annual MedicarePlus capi-  
17           tation rate specified in section 1855(b)(2) for  
18           the area and period involved.

19           “(3) UNIFORM PREMIUM.—

20           “(A) IN GENERAL.—Except as provided in  
21           subparagraph (B), the premiums charged by a  
22           MedicarePlus organization under this part may  
23           not vary among individuals who reside in the  
24           same payment area.

1           “(B) EXCEPTION FOR HIGH DEDUCTIBLE/  
2           MEDISAVE PRODUCTS.—A MedicarePlus organi-  
3           zation shall establish premiums for any high de-  
4           ductible/medisave product it offers in a payment  
5           area in a manner consistent with and based on  
6           each of the risk adjustment categories estab-  
7           lished for purposes of determining the amount  
8           of the payment to MedicarePlus organizations  
9           under section 1855(b)(1).

10           “(4) TERMS AND CONDITIONS OF IMPOSING  
11           PREMIUMS.—Each MedicarePlus organization shall  
12           permit the payment of monthly premiums on a  
13           monthly basis and may terminate election of individ-  
14           uals for a MedicarePlus product for failure to make  
15           premium payments only in accordance with sub-  
16           section (c)(3)(B).

17           “(e) REQUIREMENT FOR ADDITIONAL BENEFITS,  
18           PART B PREMIUM DISCOUNT REBATES, OR BOTH.—

19           “(1) REQUIREMENT.—

20           “(A) IN GENERAL.—Each MedicarePlus  
21           organization (in relation to a MedicarePlus  
22           product it offers) shall provide that if there is  
23           an excess amount (as defined in subparagraph  
24           (B)) for the product for a contract year, subject  
25           to the succeeding provisions of this subsection,

1 the organization shall provide to individuals  
2 such additional benefits (as the organization  
3 may specify), a monetary rebate (paid on a  
4 monthly basis) of the part B monthly premium,  
5 or a combination thereof, in a total value which  
6 is at least equal to the adjusted excess amount  
7 (as defined in subparagraph (C)).

8 “(B) EXCESS AMOUNT.—For purposes of  
9 this paragraph, the ‘excess amount’, for an or-  
10 ganization for a product, is the amount (if any)  
11 by which—

12 “(i) the average of the capitation pay-  
13 ments made to the organization under this  
14 part for the product at the beginning of  
15 contract year, exceeds

16 “(ii) the actuarial value of the mini-  
17 mum benefits described in subsection  
18 (a)(1) under the product for individuals  
19 under this part, as determined based upon  
20 an adjusted community rate described in  
21 paragraph (5).

22 “(C) ADJUSTED EXCESS AMOUNT.—For  
23 purposes of this paragraph, the ‘adjusted excess  
24 amount’, for an organization for a product, is  
25 the excess amount reduced to reflect any

1 amount withheld and reserved for the organiza-  
2 tion for the year under paragraph (3).

3 “(D) NO APPLICATION TO HIGH DEDUCT-  
4 IBLE/MEDISAVE PRODUCT.—Subparagraph (A)  
5 shall not apply to a high deductible/medisave  
6 product.

7 “(E) UNIFORM APPLICATION.—This para-  
8 graph shall be applied uniformly for all enroll-  
9 ees for a product in a service area.

10 “(F) CONSTRUCTION.—Nothing in this  
11 subsection shall be construed as preventing a  
12 MedicarePlus organization from providing  
13 health care benefits that are in addition to the  
14 benefits otherwise required to be provided under  
15 this paragraph and from imposing a premium  
16 for such additional benefits.

17 “(2) LIMITATION ON AMOUNT OF PART B PRE-  
18 MIUM DISCOUNT REBATE.—In no case shall the  
19 amount of a part B premium discount rebate under  
20 paragraph (1)(A) exceed, with respect to a month,  
21 the amount of premiums imposed under part B (not  
22 taking into account section 1839(b) (relating to pen-  
23 alty for late enrollment) or 1839(h) (relating to af-  
24 fluence testing)), for the individual for the month.  
25 Except as provided in the previous sentence, a

1 MedicarePlus organization is not authorized to pro-  
2 vide for cash or other monetary rebates as an in-  
3 ducement for enrollment or otherwise.

4 “(3) STABILIZATION FUND.—A MedicarePlus  
5 organization may provide that a part of the value of  
6 an excess actuarial amount described in paragraph  
7 (1) be withheld and reserved in the Federal Hospital  
8 Insurance Trust Fund and in the Federal Supple-  
9 mentary Medical Insurance Trust Fund (in such  
10 proportions as the Secretary determines to be appro-  
11 priate) by the Secretary for subsequent annual con-  
12 tract periods, to the extent required to stabilize and  
13 prevent undue fluctuations in the additional benefits  
14 and rebates offered in those subsequent periods by  
15 the organization in accordance with such paragraph.  
16 Any of such value of amount reserved which is not  
17 provided as additional benefits described in para-  
18 graph (1)(A) to individuals electing the  
19 MedicarePlus product in accordance with such para-  
20 graph prior to the end of such periods, shall revert  
21 for the use of such trust funds.

22 “(4) DETERMINATION BASED ON INSUFFICIENT  
23 DATA.—For purposes of this subsection, if the Sec-  
24 retary finds that there is insufficient enrollment ex-  
25 perience (including no enrollment experience in the

1 case of a provider-sponsored organization) to deter-  
2 mine an average of the capitation payments to be  
3 made under this part at the beginning of a contract  
4 period, the Secretary may determine such an aver-  
5 age based on the enrollment experience of other con-  
6 tracts entered into under this part.

7 “(5) ADJUSTED COMMUNITY RATE.—

8 “(A) IN GENERAL.—For purposes of this  
9 subsection, subject to subparagraph (B), the  
10 term ‘adjusted community rate’ for a service or  
11 services means, at the election of a  
12 MedicarePlus organization, either—

13 “(i) the rate of payment for that serv-  
14 ice or services which the Secretary annu-  
15 ally determines would apply to an individ-  
16 ual electing a MedicarePlus product under  
17 this part if the rate of payment were deter-  
18 mined under a ‘community rating system’  
19 (as defined in section 1302(8) of the Pub-  
20 lic Health Service Act, other than subpara-  
21 graph (C)), or

22 “(ii) such portion of the weighted ag-  
23 gregate premium, which the Secretary an-  
24 nually estimates would apply to such an in-  
25 dividual, as the Secretary annually esti-

1           mates is attributable to that service or  
2           services,  
3           but adjusted for differences between the utiliza-  
4           tion characteristics of the individuals electing  
5           coverage under this part and the utilization  
6           characteristics of the other enrollees with the  
7           organization (or, if the Secretary finds that  
8           adequate data are not available to adjust for  
9           those differences, the differences between the  
10          utilization characteristics of individuals select-  
11          ing other MedicarePlus coverage, or individuals  
12          in the area, in the State, or in the United  
13          States, eligible to elect MedicarePlus coverage  
14          under this part and the utilization characteris-  
15          tics of the rest of the population in the area, in  
16          the State, or in the United States, respectively).

17           “(B) SPECIAL RULE FOR PROVIDER-SPON-  
18          SORED ORGANIZATIONS.—In the case of a  
19          MedicarePlus organization that is a provider-  
20          sponsored organization, the adjusted community  
21          rate under subparagraph (A) for a  
22          MedicarePlus product may be computed (in a  
23          manner specified by the Secretary) using data  
24          in the general commercial marketplace or (dur-  
25          ing a transition period) based on the costs in-

1 curred by the organization in providing such a  
2 product.

3 “(f) RULES REGARDING PHYSICIAN PARTICIPA-  
4 TION.—

5 “(1) PROCEDURES.—Each MedicarePlus orga-  
6 nization shall establish reasonable procedures relat-  
7 ing to the participation (under an agreement be-  
8 tween a physician and the organization) of physi-  
9 cians under MedicarePlus products offered by the  
10 organization under this part. Such procedures shall  
11 include—

12 “(A) providing notice of the rules regard-  
13 ing participation,

14 “(B) providing written notice of participa-  
15 tion decisions that are adverse to physicians,  
16 and

17 “(C) providing a process within the organi-  
18 zation for appealing adverse decisions, including  
19 the presentation of information and views of the  
20 physician regarding such decision.

21 “(2) CONSULTATION IN MEDICAL POLICIES.—A  
22 MedicarePlus organization shall consult with physi-  
23 cians who have entered into participation agree-  
24 ments with the organization regarding the organiza-

1       tion’s medical policy, quality, and medical manage-  
2       ment procedures.

3               “(3) LIMITATIONS ON PHYSICIAN INCENTIVE  
4       PLANS.—

5               “(A) IN GENERAL.—Each MedicarePlus  
6       organization may not operate any physician in-  
7       centive plan (as defined in subparagraph (B))  
8       unless the following requirements are met:

9                       “(i) No specific payment is made di-  
10                      rectly or indirectly under the plan to a  
11                      physician or physician group as an induce-  
12                      ment to reduce or limit medically necessary  
13                      services provided with respect to a specific  
14                      individual enrolled with the organization.

15                     “(ii) If the plan places a physician or  
16                     physician group at substantial financial  
17                     risk (as determined by the Secretary) for  
18                     services not provided by the physician or  
19                     physician group, the organization—

20                               “(I) provides stop-loss protection  
21                              for the physician or group that is ade-  
22                              quate and appropriate, based on  
23                              standards developed by the Secretary  
24                              that take into account the number of  
25                              physicians placed at such substantial

1 financial risk in the group or under  
2 the plan and the number of individ-  
3 uals enrolled with the organization  
4 who receive services from the physi-  
5 cian or the physician group, and

6 “(II) conducts periodic surveys of  
7 both individuals enrolled and individ-  
8 uals previously enrolled with the orga-  
9 nization to determine the degree of  
10 access of such individuals to services  
11 provided by the organization and sat-  
12 isfaction with the quality of such serv-  
13 ices.

14 “(iii) The organization provides the  
15 Secretary with descriptive information re-  
16 garding the plan, sufficient to permit the  
17 Secretary to determine whether the plan is  
18 in compliance with the requirements of this  
19 subparagraph.

20 “(B) PHYSICIAN INCENTIVE PLAN DE-  
21 FINED.—In this paragraph, the term ‘physician  
22 incentive plan’ means any compensation ar-  
23 rangement between a MedicarePlus organiza-  
24 tion and a physician or physician group that  
25 may directly or indirectly have the effect of re-

1           ducing or limiting services provided with respect  
2           to individuals enrolled with the organization  
3           under this part.

4           “(g) PROVISION OF INFORMATION.—A MedicarePlus  
5 organization shall provide the Secretary with such infor-  
6 mation on the organization and each MedicarePlus prod-  
7 uct it offers as may be required for the preparation of  
8 the information booklet described in section  
9 1805(d)(2)(A).

10          “(h) COORDINATED ACUTE AND LONG-TERM CARE  
11 BENEFITS UNDER A MEDICAREPLUS PRODUCT.—Noth-  
12 ing in this part shall be construed as preventing a State  
13 from coordinating benefits under its MediGrant program  
14 under title XXI with those provided under a MedicarePlus  
15 product in a manner that assures continuity of a full-  
16 range of acute care and long-term care services to poor  
17 elderly or disabled individuals eligible for benefits under  
18 this title and under such program.

19                   “PATIENT PROTECTION STANDARDS

20          “SEC. 1853. (a) DISCLOSURE TO ENROLLEES.—A  
21 MedicarePlus organization shall disclose in clear, accurate,  
22 and standardized form, information regarding all of the  
23 following for each MedicarePlus product it offers:

24                   “(1) Benefits under the MedicarePlus product  
25                   offered, including exclusions from coverage and, if it  
26                   is a high deductible/medisave product, a comparison

1 of benefits under such a product with benefits under  
2 other MedicarePlus products.

3 “(2) Rules regarding prior authorization or  
4 other review requirements that could result in  
5 nonpayment.

6 “(3) Potential liability for cost-sharing for out-  
7 of-network services.

8 “(4) The number, mix, and distribution of par-  
9 ticipating providers.

10 “(5) The financial obligations of the enrollee,  
11 including premiums, deductibles, co-payments, and  
12 maximum limits on out-of-pocket losses for items  
13 and services (both in and out of network).

14 “(6) Statistics on enrollee satisfaction with the  
15 product and organization, including rates of  
16 reenrollment.

17 “(7) Enrollee rights and responsibilities, includ-  
18 ing the grievance process provided under subsection  
19 (f).

20 “(8) A statement that the use of the 911 emer-  
21 gency telephone number is appropriate in emergency  
22 situations and an explanation of what constitutes an  
23 emergency situation.

1 Such information shall be disclosed to each enrollee under  
2 this part at the time of enrollment and at least annually  
3 thereafter.

4 “(b) ACCESS TO SERVICES.—

5 “(1) IN GENERAL.—A MedicarePlus organiza-  
6 tion offering a MedicarePlus product may restrict  
7 the providers from whom the benefits under the  
8 product are provided so long as—

9 “(A) the organization makes such benefits  
10 available and accessible to each individual elect-  
11 ing the product within the product service area  
12 with reasonable promptness and in a manner  
13 which assures continuity in the provision of  
14 benefits;

15 “(B) when medically necessary the organi-  
16 zation makes such benefits available and acces-  
17 sible 24 hours a day and 7 days a week;

18 “(C) the product provides for reimburse-  
19 ment with respect to services which are covered  
20 under subparagraphs (A) and (B) and which  
21 are provided to such an individual other than  
22 through the organization, if—

23 “(i) the services were medically nec-  
24 essary and immediately required because of

1 an unforeseen illness, injury, or condition,  
2 and

3 “(ii) it was not reasonable given the  
4 circumstances to obtain the services  
5 through the organization; and

6 “(D) coverage is provided for emergency  
7 services (as defined in paragraph (4)) without  
8 regard to prior authorization or the emergency  
9 care provider’s contractual relationship with the  
10 organization.

11 “(2) MINIMUM PAYMENT LEVELS WHERE PRO-  
12 VIDING POINT-OF-SERVICE COVERAGE.—If a  
13 MedicarePlus product provides benefits for items  
14 and services (not described in paragraph (1)(C))  
15 through a network of providers and also permits  
16 payment to be made under the product for such  
17 items and services not provided through such a net-  
18 work, the payment level under the product with re-  
19 spect to such items and services furnished outside  
20 the network shall be at least 70 percent (or, if the  
21 effective cost-sharing rate is 50 percent, at least 35  
22 percent) of the lesser of—

23 “(A) the payment basis (determined with-  
24 out regard to deductibles and cost-sharing) that

1 would have applied for such items and services  
2 under parts A and B, or

3 “(B) the amount charged by the entity fur-  
4 nishing such items and services.

5 “(3) PROTECTION OF ENROLLEES FOR CERTAIN  
6 OUT-OF-NETWORK SERVICES.—

7 “(A) PARTICIPATING PROVIDERS.—In the  
8 case of physicians’ services or renal dialysis  
9 services described in subparagraph (C) which  
10 are furnished by a participating physician or  
11 provider of services or renal dialysis facility to  
12 an individual enrolled with a MedicarePlus or-  
13 ganization under this section, the applicable  
14 participation agreement is deemed to provide  
15 that the physician or provider of services or  
16 renal dialysis facility will accept as payment in  
17 full from the organization the amount that  
18 would be payable to the physician or provider of  
19 services or renal dialysis facility under part B  
20 and from the individual under such part, if the  
21 individual were not enrolled with such an orga-  
22 nization under this part.

23 “(B) NONPARTICIPATING PROVIDERS.—In  
24 the case of physicians’ services described in sub-  
25 paragraph (C) which are furnished by a

1 nonparticipating physician, the limitations on  
2 actual charges for such services otherwise appli-  
3 cable under part B (to services furnished by in-  
4 dividuals not enrolled with a MedicarePlus or-  
5 ganization under this section) shall apply in the  
6 same manner as such limitations apply to serv-  
7 ices furnished to individuals not enrolled with  
8 such an organization.

9 “(C) SERVICES DESCRIBED.—The physi-  
10 cians’ services or renal dialysis services de-  
11 scribed in this subparagraph are physicians’  
12 services or renal dialysis services which are fur-  
13 nished to an enrollee of a MedicarePlus organi-  
14 zation under this part by a physician, provider  
15 of services, or renal dialysis facility who is not  
16 under a contract with the organization.

17 “(4) DEFINITION OF EMERGENCY SERVICES.—  
18 In this subsection, the term ‘emergency services’  
19 means, with respect to an individual enrolled with an  
20 organization, covered inpatient and outpatient serv-  
21 ices that—

22 “(A) are furnished by an appropriate  
23 source other than the organization,

24 “(B) are needed immediately because of an  
25 injury or sudden illness, and

1           “(C) are needed because the time required  
2           to reach the organization’s providers or suppli-  
3           ers would have meant risk of permanent dam-  
4           age to the patient’s health.

5           “(c) CONFIDENTIALITY AND ACCURACY OF EN-  
6           ROLLEE RECORDS.—Each MedicarePlus organization  
7           shall establish procedures—

8           “(1) to safeguard the privacy of individually  
9           identifiable enrollee information, and

10           “(2) to maintain accurate and timely medical  
11           records for enrollees.

12           “(d) QUALITY ASSURANCE PROGRAM.—

13           “(1) IN GENERAL.—Each MedicarePlus organi-  
14           zation must have arrangements, established in ac-  
15           cordance with regulations of the Secretary, for an  
16           ongoing quality assurance program for health care  
17           services it provides to such individuals.

18           “(2) ELEMENTS OF PROGRAM.—The quality as-  
19           surance program shall—

20           “(A) stress health outcomes;

21           “(B) provide for the establishment of writ-  
22           ten protocols for utilization review, based on  
23           current standards of medical practice;

24           “(C) provide review by physicians and  
25           other health care professionals of the process

1 followed in the provision of such health care  
2 services;

3 “(D) monitors and evaluates high volume  
4 and high risk services and the care of acute and  
5 chronic conditions;

6 “(E) evaluates the continuity and coordi-  
7 nation of care that enrollees receive,

8 “(F) has mechanisms to detect both under-  
9 utilization and overutilization of services,

10 “(G) after identifying areas for improve-  
11 ment, establishes or alters practice parameters,

12 “(H) takes action to improve quality and  
13 assesses the effectiveness of such action  
14 through systematic follow-up,

15 “(I) makes available information on quality  
16 and outcomes measures to facilitate beneficiary  
17 comparison and choice of health coverage op-  
18 tions (in such form and on such quality and  
19 outcomes measures as the Secretary determines  
20 to be appropriate), and

21 “(J) is evaluated on an ongoing basis as to  
22 its effectiveness.

23 “(e) COVERAGE DETERMINATIONS.—

24 “(1) DECISIONS ON NONEMERGENCY CARE.—A  
25 MedicarePlus organization shall make determina-

1 tions regarding authorization requests for non-  
2 emergency care on a timely basis, depending on the  
3 urgency of the situation.

4 “(2) APPEALS.—

5 “(A) IN GENERAL.—Appeals from a deter-  
6 mination of an organization denying coverage  
7 shall be decided within 30 days of the date of  
8 receipt of medical information, but not later  
9 than 60 days after the date of the decision.

10 “(B) PHYSICIAN DECISION ON CERTAIN  
11 APPEALS.—Appeal decisions relating to a deter-  
12 mination to deny coverage based on a lack of  
13 medical necessity shall be made only by a physi-  
14 cian.

15 “(C) EMERGENCY CASES.—Appeals from  
16 such a determination involving a life-threaten-  
17 ing or emergency situation shall be decided on  
18 an expedited basis.

19 “(f) GRIEVANCES AND APPEALS.—

20 “(1) GRIEVANCE MECHANISM.—Each  
21 MedicarePlus organization must provide meaningful  
22 procedures for hearing and resolving grievances be-  
23 tween the organization (including any entity or indi-  
24 vidual through which the organization provides  
25 health care services) and enrollees under this part.

1           “(2) APPEALS.—An enrollee with an organiza-  
2           tion under this part who is dissatisfied by reason of  
3           the enrollee’s failure to receive any health service to  
4           which the enrollee believes is entitled and at no  
5           greater charge than the enrollee believes is required  
6           to pay is entitled, if the amount in controversy is  
7           \$100 or more, to a hearing before the Secretary to  
8           the same extent as is provided in section 205(b), and  
9           in any such hearing the Secretary shall make the or-  
10          ganization a party. If the amount in controversy is  
11          \$1,000 or more, the individual or organization shall,  
12          upon notifying the other party, be entitled to judicial  
13          review of the Secretary’s final decision as provided  
14          in section 205(g), and both the individual and the  
15          organization shall be entitled to be parties to that  
16          judicial review. In applying sections 205(b) and  
17          205(g) as provided in this subparagraph, and in ap-  
18          plying section 205(l) thereto, any reference therein  
19          to the Commissioner of Social Security or the Social  
20          Security Administration shall be considered a ref-  
21          erence to the Secretary or the Department of Health  
22          and Human Services, respectively.

23          “(g) INFORMATION ON ADVANCE DIRECTIVES.—  
24          Each MedicarePlus organization shall meet the require-

1 ment of section 1866(f) (relating to maintaining written  
2 policies and procedures respecting advance directives).

3 “(h) APPROVAL OF MARKETING MATERIALS.—

4 “(1) SUBMISSION.—Each MedicarePlus organi-  
5 zation may not distribute marketing materials un-  
6 less—

7 “(A) at least 45 days before the date of  
8 distribution the organization has submitted the  
9 material to the Secretary for review, and

10 “(B) the Secretary has not disapproved the  
11 distribution of such material.

12 “(2) REVIEW.—The standards established  
13 under section 1856 shall include guidelines for the  
14 review of all such material submitted and under  
15 such guidelines the Secretary shall disapprove such  
16 material if the material is materially inaccurate or  
17 misleading or otherwise makes a material misrepre-  
18 sentation.

19 “(3) DEEMED APPROVAL (1-STOP SHOPPING).—

20 In the case of material that is submitted under sub-  
21 paragraph (A)(i) to the Secretary or a regional office  
22 of the Department of Health and Human Services  
23 and the Secretary or the office has not disapproved  
24 the distribution of marketing materials under sub-  
25 paragraph (A)(ii) with respect to a MedicarePlus

1 product in an area, the Secretary is deemed not to  
2 have disapproved such distribution in all other areas  
3 covered by the product and organization.

4 “(4) PROHIBITION OF CERTAIN MARKETING  
5 PRACTICES.—Each MedicarePlus organization shall  
6 conform to fair marketing standards in relation to  
7 MedicarePlus products offered under this part, in-  
8 cluded in the standards established under section  
9 1856. Such standards shall include a prohibition  
10 against an organization (or agent of such an organi-  
11 zation) completing any portion of any election form  
12 under section 1805 on behalf of any individual.

13 “PROVIDER-SPONSORED ORGANIZATIONS

14 “SEC. 1854. (a) PROVIDER-SPONSORED ORGANIZA-  
15 TION DEFINED.—

16 “(1) IN GENERAL.—In this part, the term ‘pro-  
17 vider-sponsored organization’ means a public or pri-  
18 vate entity that (in accordance with standards estab-  
19 lished under subsection (b)) is a provider, or group  
20 of affiliated providers, that provides a substantial  
21 proportion (as defined by the Secretary under such  
22 standards) of the health care items and services  
23 under the contract under this part directly through  
24 the provider or affiliated group of providers.

1           “(2) SUBSTANTIAL PROPORTION.—In defining  
2           what is a ‘substantial proportion’ for purposes of  
3           paragraph (1), the Secretary—

4                   “(A) shall take into account the need for  
5                   such an organization to assume responsibility  
6                   for a substantial proportion of services in order  
7                   to assure financial stability and the practical  
8                   difficulties in such an organization integrating  
9                   a very wide range of service providers; and

10                   “(B) may vary such proportion based upon  
11                   relevant differences among organizations, such  
12                   as their location in an urban or rural area.

13           “(3) AFFILIATION.—For purposes of this sub-  
14           section, a provider is ‘affiliated’ with another pro-  
15           vider if, through contract, ownership, or otherwise—

16                   “(A) one provider, directly or indirectly,  
17                   controls, is controlled by, or is under common  
18                   control with the other,

19                   “(B) each provider is a participant in a  
20                   lawful combination under which each provider  
21                   shares, directly or indirectly, substantial finan-  
22                   cial risk in connection with their operations,

23                   “(C) both providers are part of a con-  
24                   trolled group of corporations under section  
25                   1563 of the Internal Revenue Code of 1986, or

1           “(D) both providers are part of an affili-  
2           ated service group under section 414 of such  
3           Code.

4           “(4) CONTROL.—For purposes of paragraph  
5           (3), control is presumed to exist if one party, di-  
6           rectly or indirectly, owns, controls, or holds the  
7           power to vote, or proxies for, not less than 51 per-  
8           cent of the voting rights or governance rights of an-  
9           other.

10          “(b) PROCESS FOR ESTABLISHING STANDARDS FOR  
11 PROVIDER-SPONSORED ORGANIZATIONS.—For process of  
12 establishing of standards for provider-sponsored organiza-  
13 tions, see section 1856(c).

14          “(c) PROCESS FOR STATE CERTIFICATION OF PRO-  
15 VIDER-SPONSORED ORGANIZATIONS.—For process of  
16 State certification of provider-sponsored organizations, see  
17 section 1857(c).

18          “(d) CONDITIONS FOR PREEMPTION FROM STATE  
19 INSURANCE LICENSING REQUIREMENTS.—

20               “(1) IN GENERAL.—Except as provided in para-  
21               graph (3), notwithstanding any other provision of  
22               law, in the case of a provider-sponsored organization  
23               with respect to a State that—

24                       “(A) only enrolls in the State individuals  
25                       who are entitled to benefits under this title, and

1           “(B) cannot do business as a MedicarePlus  
2 organization in the State because that State by  
3 law, regulation, or otherwise—

4                   “(i) requires that the organization  
5 meet requirements for insurers of health  
6 services or health maintenance organiza-  
7 tions doing business in the State with re-  
8 spect to initial capitalization and establish-  
9 ment of financial reserves against insol-  
10 vency, or

11                   “(ii) imposes requirements that would  
12 prohibit the entity from complying with the  
13 applicable requirements of this part,

14 such requirements shall not apply to the organiza-  
15 tion so as to prevent it from operating as a  
16 MedicarePlus organization under this part.

17           “(2) NOT TREATING CERTAIN INDIVIDUALS AS  
18 ENROLLEES.—For purposes of paragraph (1)(A), an  
19 individual who—

20                   “(A) is a participant or beneficiary of an  
21 employee welfare benefit plan to which section  
22 514(a) of the Employee Retirement Income Se-  
23 curity Act of 1974 applies, and

1           “(B) receives health services from a pro-  
2           vider-sponsored organization under an arrange-  
3           ment with the plan,  
4           shall be considered to be enrolled with the employee  
5           welfare benefit plan and shall not be considered to  
6           be enrolled with the organization.

7           “(3) TREATMENT OF STATES WITH APPROVED  
8           CERTIFICATION PROGRAMS.—

9           “(A) IN GENERAL.—In the case of an or-  
10          ganization that is operating in an approved  
11          State (as defined in subparagraph (C)), the  
12          provisions of paragraph (1) and section 1851(b)  
13          shall not apply.

14          “(B) EFFECTIVE DATE.—Subparagraph  
15          (A) shall apply—

16               “(i) in the case of an entity that has  
17               a contract under this part in effect as of  
18               the date the State becomes an approved  
19               State, at the end of the first contract year  
20               that begins after such date, or

21               “(ii) in the case of any other entity,  
22               for contract years that begin after such  
23               date.

24          “(C) APPROVED STATE DEFINED.—In this  
25          paragraph, the term ‘approved State’ means a

1 State with a certification program approved  
2 under section 1857(c) with respect to provider-  
3 sponsored organizations in the State.

4 “PAYMENTS TO MEDICAREPLUS ORGANIZATIONS

5 “SEC. 1855. (a) PAYMENTS.—

6 “(1) IN GENERAL.—Under a contract under  
7 section 1858 the Secretary shall pay to each  
8 MedicarePlus organization, with respect to coverage  
9 of an individual under this part in a payment area  
10 for a month, an amount equal to the monthly ad-  
11 justed MedicarePlus capitation rate (as provided  
12 under subsection (b)) with respect to that individual  
13 for that area.

14 “(2) ANNUAL ANNOUNCEMENT.—The Secretary  
15 shall annually determine, and shall announce (in a  
16 manner intended to provide notice to interested par-  
17 ties) not later than September 7 before the calendar  
18 year concerned—

19 “(A) the annual MedicarePlus capitation  
20 rate for each payment area for the year, and

21 “(B) the factors to be used in adjusting  
22 such rates under subsection (b) for payments  
23 for months in that year.

24 “(3) ADVANCE NOTICE OF METHODOLOGICAL  
25 CHANGES.—At least 45 days before making the an-  
26 nouncement under paragraph (2) for a year, the

1 Secretary shall provide for notice to MedicarePlus  
2 organizations of proposed changes to be made in the  
3 methodology or benefit coverage assumptions from  
4 the methodology and assumptions used in the pre-  
5 vious announcement and shall provide such organi-  
6 zations an opportunity to comment on such proposed  
7 changes.

8 “(4) EXPLANATION OF ASSUMPTIONS.—In each  
9 announcement made under paragraph (2) for a year,  
10 the Secretary shall include an explanation of the as-  
11 sumptions (including any benefit coverage assump-  
12 tions) and changes in methodology used in the an-  
13 nouncement in sufficient detail so that MedicarePlus  
14 organizations can compute monthly adjusted  
15 MedicarePlus capitation rates for classes of individ-  
16 uals located in each payment area which is in whole  
17 or in part within the service area of such an organi-  
18 zation.

19 “(b) MONTHLY ADJUSTED MEDICAREPLUS CAPITA-  
20 TION RATE.—

21 “(1) IN GENERAL.—For purposes of this sec-  
22 tion, the ‘monthly adjusted MedicarePlus capitation  
23 rate’ under this subsection, for a month in a year  
24 for an individual in a payment area (specified under  
25 paragraph (3)) and in a class (established under

1 paragraph (4)), is  $\frac{1}{12}$  of the annual MedicarePlus  
2 capitation rate specified in paragraph (2) for that  
3 area for the year, adjusted to reflect the actuarial  
4 value of benefits under this title with respect to indi-  
5 viduals in such class compared to the national aver-  
6 age for individuals in all classes.

7 “(2) ANNUAL MEDICAREPLUS CAPITATION  
8 RATES.—For purposes of this section, the annual  
9 MedicarePlus capitation rate for a payment area for  
10 a year is equal to the annual MedicarePlus capita-  
11 tion rate for the area for the previous year (or, in  
12 the case of 1996, the average annual per capita rate  
13 of payment described in section 1876(a)(1)(C) for  
14 the area for 1995) increased by the per capita  
15 growth rate for that area and year (as determined  
16 under subsection (c)).

17 “(3) PAYMENT AREA DEFINED.—In this sec-  
18 tion, the term ‘payment area’ means a county (or  
19 equivalent area specified by the Secretary), except  
20 that in the case of the population group described in  
21 paragraph (5)(C), the payment area shall be each  
22 State.

23 “(4) CLASSES.—

24 “(A) IN GENERAL.—For purposes of this  
25 section, the Secretary shall define appropriate

1 classes of enrollees, consistent with paragraph  
2 (5), based on age, gender, welfare status, insti-  
3 tutionalization, and such other factors as the  
4 Secretary determines to be appropriate, so as to  
5 ensure actuarial equivalence. The Secretary  
6 may add to, modify, or substitute for such  
7 classes, if such changes will improve the deter-  
8 mination of actuarial equivalence.

9 “(B) RESEARCH.—The Secretary shall  
10 conduct such research as may be necessary to  
11 provide for greater accuracy in the adjustment  
12 of capitation rates under this subsection. Such  
13 research may include research into the addition  
14 or modification of classes under subparagraph  
15 (A). The Secretary shall submit to Congress a  
16 report on such research by not later than Janu-  
17 ary 1, 1997.

18 “(5) DIVISION OF MEDICARE POPULATION.—In  
19 carrying out paragraph (4) and this section, the Sec-  
20 retary shall recognize the following separate popu-  
21 lation groups:

22 “(A) AGED.—Individuals 65 years of age  
23 or older who are not described in subparagraph  
24 (C).

1           “(B) DISABLED.—Disabled individuals  
2           who are under 65 years of age and not de-  
3           scribed in subparagraph (C).

4           “(C) INDIVIDUALS WITH END STAGE  
5           RENAL DISEASE.—Individuals who are deter-  
6           mined to have end stage renal disease.

7           “(c) PER CAPITA GROWTH RATES.—

8           “(1) FOR 1996.—

9           “(A) IN GENERAL.—For purposes of this  
10           section and subject to subparagraph (B), the  
11           per capita growth rates for 1996, for a payment  
12           area assigned to a service utilization cohort  
13           under subsection (d), shall be the following:

14                   “(i) LOWEST SERVICE UTILIZATION  
15                   COHORT.—For areas assigned to the low-  
16                   est service utilization cohort, 9.7 percent.

17                   “(ii) LOWER SERVICE UTILIZATION  
18                   COHORT.—For areas assigned to the lower  
19                   service utilization cohort, 8.0 percent.

20                   “(iii) MEDIAN SERVICE UTILIZATION  
21                   COHORT.—For areas assigned to the me-  
22                   dian service utilization cohort, 5.3 percent.

23                   “(iv) HIGHER SERVICE UTILIZATION  
24                   COHORT.—For areas assigned to the high-  
25                   er service utilization cohort, 4.7 percent.

1           “(v) HIGHEST SERVICE UTILIZATION  
2           COHORT.—For areas assigned to the high-  
3           est service utilization cohort, 4.0 percent.

4           “(B) BUDGET NEUTRAL ADJUSTMENT.—  
5           The Secretary shall adjust the per capita  
6           growth rates specified in subparagraph (A) for  
7           all the areas by such uniform factor as may be  
8           necessary to assure that the total capitation  
9           payments under this section during 1996 are  
10          the same as the amount such payments would  
11          have been if the per capita growth rate for all  
12          such areas for 1996 were equal to the national  
13          average per capita growth rate, specified in  
14          paragraph (3) for 1996.

15          “(2) FOR SUBSEQUENT YEARS.—

16                 “(A) IN GENERAL.—For purposes of this  
17                 section and subject to subparagraph (B), the  
18                 Secretary shall compute a per capita growth  
19                 rate for each year after 1996, for each payment  
20                 area as assigned to a service utilization cohort  
21                 under subsection (d), consistent with the follow-  
22                 ing rules:

23                         “(i) MEDIAN SERVICE UTILIZATION  
24                         COHORT SET AT NATIONAL AVERAGE PER  
25                         CAPITA GROWTH RATE.—The per capita

1 growth rate for areas assigned to the me-  
2 dian service utilization cohort for the year  
3 shall be the national average per capita  
4 growth rate for the year (as specified  
5 under paragraph (3)).

6 “(ii) HIGHEST SERVICE UTILIZATION  
7 COHORT SET AT 75 PERCENT OF NATIONAL  
8 AVERAGE PER CAPITA GROWTH RATE.—  
9 The per capita growth rate for areas as-  
10 signed to the highest service utilization co-  
11 hort for the year shall be 75 percent of the  
12 national average per capita growth rate for  
13 the year.

14 “(iii) LOWEST SERVICE UTILIZATION  
15 COHORT SET AT 187.5 PERCENT OF NA-  
16 TIONAL AVERAGE PER CAPITA GROWTH  
17 RATE.—The per capita growth rate for  
18 areas assigned to the lowest service utiliza-  
19 tion cohort for the year shall be 187.5 per-  
20 cent of the national average per capita  
21 growth rate for the year.

22 “(iv) LOWER SERVICE UTILIZATION  
23 COHORT SET AT 150 PERCENT OF NA-  
24 TIONAL AVERAGE PER CAPITA GROWTH  
25 RATE.—

1           “(I) IN GENERAL.—Subject to  
2           subclause (II), the per capita growth  
3           rate for areas assigned to the lower  
4           service utilization cohort for the year  
5           shall be 150 percent of the national  
6           average per capita growth rate for the  
7           year.

8           “(II) ADJUSTMENT.—If the Sec-  
9           retary has established under clause  
10          (v) the per capita growth rate for  
11          areas assigned to the higher service  
12          utilization cohort for the year at 75  
13          percent of the national average per  
14          capita growth rate, the Secretary may  
15          provide for a reduced per capita  
16          growth rate under subclause (I) to the  
17          extent necessary to comply with sub-  
18          paragraph (B).

19          “(v) HIGHER SERVICE UTILIZATION  
20          COHORT.—The per capita growth rate for  
21          areas assigned to the higher service utiliza-  
22          tion cohort for set year shall be such per-  
23          cent (not less than 75 percent) of the na-  
24          tional average per capita growth rate, as

1           the Secretary may determine consistent  
2           with subparagraph (B).

3           “(B) AVERAGE PER CAPITA GROWTH RATE  
4           AT NATIONAL AVERAGE TO ASSURE BUDGET  
5           NEUTRALITY.—The Secretary shall compute per  
6           capita growth rates for a year under subpara-  
7           graph (A) in a manner so that the weighted av-  
8           erage per capita growth rate for all areas for  
9           the year (weighted to reflect the number of  
10          medicare beneficiaries in each area) is equal to  
11          the national average per capita growth rate  
12          under paragraph (3) for the year.

13          “(3) NATIONAL AVERAGE PER CAPITA GROWTH  
14          RATES.—In this subsection, the ‘national average  
15          per capita growth rate’ for—

16                  “(A) 1996 is 5.3 percent,

17                  “(B) 1997 is 3.8 percent,

18                  “(C) 1998 is 4.6 percent,

19                  “(D) 1999 is 4.3 percent,

20                  “(E) 2000 is 3.8 percent,

21                  “(F) 2001 is 5.5 percent,

22                  “(G) 2002 is 5.6 percent, and

23                  “(H) each subsequent year is 5.0 percent.

24          “(d) ASSIGNMENT OF PAYMENT AREAS TO SERVICE  
25          UTILIZATION COHORTS.—

1           “(1) IN GENERAL.—For purposes of determin-  
2           ing per capita growth rates under subsection (c) for  
3           areas for a year, the Secretary shall assign each pay-  
4           ment area to a service utilization cohort (based on  
5           the service utilization index value for that area de-  
6           termined under paragraph (2)) as follows:

7                   “(A) LOWEST SERVICE UTILIZATION CO-  
8                   HORT.—Areas with a service utilization index  
9                   value of less than .80 shall be assigned to the  
10                  lowest service utilization cohort.

11                  “(B) LOWER SERVICE UTILIZATION CO-  
12                  HORT.—Areas with a service utilization index  
13                  value of at least .80 but less than .90 shall be  
14                  assigned to the lower service utilization cohort.

15                  “(C) MEDIAN SERVICE UTILIZATION CO-  
16                  HORT.—Areas with a service utilization index  
17                  value of at least .90 but less than 1.10 shall be  
18                  assigned to the median service utilization co-  
19                  hort.

20                  “(D) HIGHER SERVICE UTILIZATION CO-  
21                  HORT.—Areas with a service utilization index  
22                  value of at least 1.10 but less than 1.20 shall  
23                  be assigned to the higher service utilization co-  
24                  hort.

1           “(E) HIGHEST SERVICE UTILIZATION CO-  
2           HORT.—Areas with a service utilization index  
3           value of at least 1.20 shall be assigned to the  
4           highest service utilization cohort.

5           “(2) DETERMINATION OF SERVICE UTILIZATION  
6           INDEX VALUES.—In order to determine the per cap-  
7           ita growth rate for a payment area for each year  
8           (beginning with 1996), the Secretary shall determine  
9           for such area and year a service utilization index  
10          value, which is equal to—

11           “(A) the annual MedicarePlus capitation  
12           rate under this section for the area for the year  
13           in which the determination is made (or, in the  
14           case of 1996, the average annual per capita  
15           rate of payment (described in section  
16           1876(a)(1)(C)) for the area for 1995); divided  
17           by

18           “(B) the input-price-adjusted annual na-  
19           tional MedicarePlus capitation rate (as deter-  
20           mined under paragraph (3)) for that area for  
21           the year in which the determination is made.

22           “(3) DETERMINATION OF INPUT-PRICE-AD-  
23           JUSTED RATES.—

24           “(A) IN GENERAL.—For purposes of para-  
25           graph (2), the ‘input-price-adjusted annual na-

1 tional MedicarePlus capitation rate’ for a pay-  
2 ment area for a year is equal to the sum, for  
3 all the types of medicare services (as classified  
4 by the Secretary), of the product (for each such  
5 type) of—

6 “(i) the national standardized  
7 MedicarePlus capitation rate (determined  
8 under subparagraph (B)) for the year,

9 “(ii) the proportion of such rate for  
10 the year which is attributable to such type  
11 of services, and

12 “(iii) an index that reflects (for that  
13 year and that type of services) the relative  
14 input price of such services in the area  
15 compared to the national average input  
16 price of such services.

17 In applying clause (iii), the Secretary shall, sub-  
18 ject to subparagraph (C), apply those indices  
19 under this title that are used in applying (or  
20 updating) national payment rates for specific  
21 areas and localities.

22 “(B) NATIONAL STANDARDIZED  
23 MEDICAREPLUS CAPITATION RATE.—In this  
24 paragraph, the ‘national standardized

1 MedicarePlus capitation rate' for a year is  
2 equal to—

3 “(i) the sum (for all payment areas)  
4 of the product of (I) the annual  
5 MedicarePlus capitation rate for that year  
6 for the area under subsection (b)(2), and  
7 (II) the average number of medicare bene-  
8 ficiaries residing in that area in the year;  
9 divided by

10 “(ii) the total average number of med-  
11 icare beneficiaries residing in all the pay-  
12 ment areas for that year.

13 “(C) SPECIAL RULES FOR 1996.—In apply-  
14 ing this paragraph for 1996—

15 “(i) medicare services shall be divided  
16 into 2 types of services: part A services  
17 and part B services;

18 “(ii) the proportions described in sub-  
19 paragraph (A)(ii) for such types of services  
20 shall be 66 percent and 34 percent respec-  
21 tively;

22 “(iii) for the part A services, 70 per-  
23 cent of payments attributable to such serv-  
24 ices shall be adjusted by the index used  
25 under section 1886(d)(3)(E) to adjust pay-

1           ment rates for relative hospital wage levels  
2           for hospitals located in the payment area  
3           involved;

4           “(iv) for part B services—

5           “(I) 66 percent of payments at-  
6           tributable to such services shall be ad-  
7           justed by the index of the geographic  
8           area factors under section 1848(e)  
9           used to adjust payment rates for phy-  
10          sicians’ services furnished in the pay-  
11          ment area, and

12          “(II) of the remaining 34 percent  
13          of the amount of such payments, 70  
14          percent shall be adjusted by the index  
15          described in clause (iii);

16          “(v) the index values shall be com-  
17          puted based only on the beneficiary popu-  
18          lation described in subsection (b)(5)(A).

19          The Secretary may continue to apply the rules  
20          described in this subparagraph (or similar  
21          rules) for 1997.

22          “(e) PAYMENT PROCESS.—

23          “(1) IN GENERAL.—Subject to subsection (f),  
24          the Secretary shall make monthly payments under  
25          this section in advance and in accordance with the

1 rate determined under subsection (a) to the plan for  
2 each individual enrolled with a MedicarePlus organi-  
3 zation under this part.

4 “(2) ADJUSTMENT TO REFLECT NUMBER OF  
5 ENROLLEES.—

6 “(A) IN GENERAL.—The amount of pay-  
7 ment under this subsection may be retroactively  
8 adjusted to take into account any difference be-  
9 tween the actual number of individuals enrolled  
10 with an organization under this part and the  
11 number of such individuals estimated to be so  
12 enrolled in determining the amount of the ad-  
13 vance payment.

14 “(B) SPECIAL RULE FOR CERTAIN EN-  
15 ROLLEES.—

16 “(i) IN GENERAL.—Subject to clause  
17 (ii), the Secretary may make retroactive  
18 adjustments under subparagraph (A) to  
19 take into account individuals enrolled dur-  
20 ing the period beginning on the date on  
21 which the individual enrolls with a  
22 MedicarePlus organization under a product  
23 operated, sponsored, or contributed to by  
24 the individual’s employer or former em-  
25 ployer (or the employer or former employer

1 of the individual's spouse) and ending on  
2 the date on which the individual is enrolled  
3 in the organization under this part, except  
4 that for purposes of making such retro-  
5 active adjustments under this subpara-  
6 graph, such period may not exceed 90  
7 days.

8 “(ii) EXCEPTION.—No adjustment  
9 may be made under clause (i) with respect  
10 to any individual who does not certify that  
11 the organization provided the individual  
12 with the disclosure statement described in  
13 section 1853(a) at the time the individual  
14 enrolled with the organization.

15 “(f) SPECIAL RULES FOR INDIVIDUALS ELECTING  
16 HIGH DEDUCTIBLE/MEDISAVE PRODUCT.—

17 “(1) IN GENERAL.—In the case of an individual  
18 who has elected a high deductible/medisave product,  
19 notwithstanding the preceding provisions of this sec-  
20 tion—

21 “(A) the amount of the payment to the  
22 MedicarePlus organization offering the high de-  
23 ductible/medisave product shall not exceed the  
24 premium for the product, and

1           “(B) subject to paragraph (2), the dif-  
2           ference between the amount of payment that  
3           would otherwise be made and the amount of  
4           payment to such organization shall be made di-  
5           rectly into a MedicarePlus MSA established  
6           (and, if applicable, designated) by the individual  
7           under paragraph (2).

8           “(2) ESTABLISHMENT AND DESIGNATION OF  
9           MEDICAREPLUS MEDICAL SAVINGS ACCOUNT AS RE-  
10          QUIREMENT FOR PAYMENT OF CONTRIBUTION.—In  
11          the case of an individual who has elected coverage  
12          under a high deductible/medisave product, no pay-  
13          ment shall be made under paragraph (1)(B) on be-  
14          half of an individual for a month unless the individ-  
15          ual—

16                 “(A) has established before the beginning  
17                 of the month (or by such other deadline as the  
18                 Secretary may specify) a MedicarePlus MSA  
19                 (as defined in section 137(b) of the Internal  
20                 Revenue Code of 1986), and

21                 “(B) if the individual has established more  
22                 than one MedicarePlus MSA, has designated  
23                 one of such accounts as the individual’s  
24                 MedicarePlus MSA for purposes of this part.

1 Under rules under this section, such an individual  
2 may change the designation of such account under  
3 subparagraph (B) for purposes of this part.

4 “(3) LUMP SUM DEPOSIT OF MEDICAL SAVINGS  
5 ACCOUNT CONTRIBUTION.—In the case of an indi-  
6 vidual electing a high deductible/medisave product  
7 effective beginning with a month in a year, the  
8 amount of the contribution to the MedicarePlus  
9 MSA on behalf of the individual for that month and  
10 all successive months in the year shall be deposited  
11 during that first month. In the case of a termination  
12 of such an election as of a month before the end of  
13 a year, the Secretary shall provide for a procedure  
14 for the recovery of deposits attributable to the re-  
15 maining months in the year.

16 “(g) PAYMENTS FROM TRUST FUND.—The payment  
17 to a MedicarePlus organization under this section for indi-  
18 viduals enrolled under this part with the organization, and  
19 payments to a MedicarePlus MSA under subsection  
20 (f)(1)(B), shall be made from the Federal Hospital Insur-  
21 ance Trust Fund and the Federal Supplementary Medical  
22 Insurance Trust Fund in such proportion as the Secretary  
23 determines reflects the relative weight that benefits under  
24 part A and under part B represents of the actuarial value  
25 of the total benefits under this title.

1       “(h) SPECIAL RULE FOR CERTAIN INPATIENT HOS-  
2 PITAL STAYS.—In the case of an individual who is receiv-  
3 ing inpatient hospital services from a subsection (d) hos-  
4 pital (as defined in section 1886(d)(1)(B)) as of the effec-  
5 tive date of the individual’s—

6               “(1) election under this part of a MedicarePlus  
7 product offered by a MedicarePlus organization—

8                       “(A) payment for such services until the  
9 date of the individual’s discharge shall be made  
10 under this title through the MedicarePlus prod-  
11 uct or Non-MedicarePlus option (as the case  
12 may be) elected before the election with such  
13 organization,

14                       “(B) the elected organization shall not be  
15 financially responsible for payment for such  
16 services until the date after the date of the indi-  
17 vidual’s discharge, and

18                       “(C) the organization shall nonetheless be  
19 paid the full amount otherwise payable to the  
20 organization under this part; or

21               “(2) termination of election with respect to a  
22 MedicarePlus organization under this part—

23                       “(A) the organization shall be financially  
24 responsible for payment for such services after

1 such date and until the date of the individual's  
2 discharge,

3 “(B) payment for such services during the  
4 stay shall not be made under section 1886(d) or  
5 by succeeding the MedicarePlus organization,  
6 and

7 “(C) the terminated organization shall not  
8 receive any payment with respect to the individ-  
9 ual under this part during the period the indi-  
10 vidual is not enrolled.

11 “ESTABLISHMENT OF STANDARDS FOR MEDICAREPLUS  
12 ORGANIZATIONS AND PRODUCTS

13 “SEC. 1856. (a) STANDARDS APPLICABLE TO STATE-  
14 REGULATED ORGANIZATIONS AND PRODUCTS.—

15 “(1) RECOMMENDATIONS OF NAIC.—The Sec-  
16 retary shall request the National Association of In-  
17 surance Commissioners to develop and submit to the  
18 Secretary, not later than 12 months after the date  
19 of the enactment of the Medicare Preservation Act  
20 of 1995, proposed standards consistent with the re-  
21 quirements of this part for MedicarePlus organiza-  
22 tions (other than a union sponsors, Taft-Hartley  
23 sponsors, and provider-sponsored organizations) and  
24 MedicarePlus products offered by such organiza-  
25 tions.

1           “(2) REVIEW.—If the Association submits such  
2 standards on a timely basis, the Secretary shall re-  
3 view such standards to determine if the standards  
4 meet the requirements of the part. The Secretary  
5 shall complete the review of the standards not later  
6 than 90 days after the date of their submission. The  
7 Secretary shall promulgate such proposed standards  
8 to apply to organizations and products described in  
9 paragraph (1) except to the extent that the Sec-  
10 retary modifies such proposed standards because  
11 they do not meet such requirements.

12           “(3) FAILURE TO SUBMIT.—If the Association  
13 does not submit such standards on a timely basis,  
14 the Secretary shall promulgate such standards by  
15 not later than the date the Secretary would other-  
16 wise have been required to promulgate standards  
17 under paragraph (2).

18           “(4) USE OF INTERIM RULES.—For the period  
19 in which this part is in effect and standards are  
20 being developed and established under the preceding  
21 provisions of this subsection, the Secretary shall pro-  
22 vide for the application of such interim standards  
23 (without regard to any requirements for notice and  
24 public comment) as may be appropriate to provide  
25 for the expedited implementation of this part. Such

1 interim standards shall not apply after the date  
2 standards are established under the preceding provi-  
3 sions of this subsection.

4 “(b) UNION AND TAFT-HARTLEY SPONSORS AND  
5 PRODUCTS.—

6 “(1) IN GENERAL.—The Secretary shall develop  
7 and promulgate by regulation standards consistent  
8 with the requirements of this part for union and  
9 Taft-Hartley sponsors and for MedicarePlus prod-  
10 ucts offered by such sponsors.

11 “(2) CONSULTATION WITH LABOR.—The Sec-  
12 retary shall consult with the Secretary of Labor with  
13 respect to such standards for such sponsors and  
14 products.

15 “(3) TIMING.—Standards under this subsection  
16 shall be promulgated at or about the time standards  
17 are promulgated under subsection (a).

18 “(c) ESTABLISHMENT OF STANDARDS FOR PRO-  
19 VIDER-SPONSORED ORGANIZATIONS.—

20 “(1) IN GENERAL.—The Secretary shall estab-  
21 lish, on an expedited basis and using a negotiated  
22 rulemaking process under subchapter 3 of chapter 5  
23 of title 5, United States Code, standards that enti-  
24 ties must meet to qualify as provider-sponsored or-  
25 ganizations under this part.

1           “(2) PUBLICATION OF NOTICE.—In carrying  
2           out the rulemaking process under this subsection,  
3           the Secretary, after consultation with the National  
4           Association of Insurance Commissioners, the Amer-  
5           ican Academy of Actuaries, organizations represent-  
6           ative of medicare beneficiaries, and other interested  
7           parties, shall publish the notice provided for under  
8           section 564(a) of title 5, United States Code, by not  
9           later than 45 days after the date of the enactment  
10          of Medicare Preservation Act of 1995.

11          “(3) TARGET DATE FOR PUBLICATION OF  
12          RULE.—As part of the notice under paragraph (2),  
13          and for purposes of this subsection, the ‘target date  
14          for publication’ (referred to in section 564(a)(5) of  
15          such title) shall be September 1, 1996.

16          “(4) ABBREVIATED PERIOD FOR SUBMISSION  
17          OF COMMENTS.—In applying section 564(c) of such  
18          title under this subsection, ‘15 days’ shall be sub-  
19          stituted for ‘30 days’.

20          “(5) APPOINTMENT OF NEGOTIATED RULE-  
21          MAKING COMMITTEE AND FACILITATOR.—The Sec-  
22          retary shall provide for—

23                  “(A) the appointment of a negotiated rule-  
24                  making committee under section 565(a) of such  
25                  title by not later than 30 days after the end of

1 the comment period provided for under section  
2 564(c) of such title (as shortened under para-  
3 graph (4)), and

4 “(B) the nomination of a facilitator under  
5 section 566(c) of such title by not later than 10  
6 days after the date of appointment of the com-  
7 mittee.

8 “(6) PRELIMINARY COMMITTEE REPORT.—The  
9 negotiated rulemaking committee appointed under  
10 paragraph (5) shall report to the Secretary, by not  
11 later than June 1, 1996, regarding the committee’s  
12 progress on achieving a consensus with regard to the  
13 rulemaking proceeding and whether such consensus  
14 is likely to occur before one month before the target  
15 date for publication of the rule. If the committee re-  
16 ports that the committee has failed to make signifi-  
17 cant progress towards such consensus or is unlikely  
18 to reach such consensus by the target date, the Sec-  
19 retary may terminate such process and provide for  
20 the publication of a rule under this subsection  
21 through such other methods as the Secretary may  
22 provide.

23 “(7) FINAL COMMITTEE REPORT.—If the com-  
24 mittee is not terminated under paragraph (6), the  
25 rulemaking committee shall submit a report contain-

1       ing a proposed rule by not later than one month be-  
2       fore the target publication date.

3           “(8) INTERIM, FINAL EFFECT.—The Secretary  
4       shall publish a rule under this subsection in the Fed-  
5       eral Register by not later than the target publication  
6       date. Such rule shall be effective and final imme-  
7       diately on an interim basis, but is subject to change  
8       and revision after public notice and opportunity for  
9       a period (of not less than 60 days) for public com-  
10      ment. In connection with such rule, the Secretary  
11      shall specify the process for the timely review and  
12      approval of applications of entities to be certified as  
13      provider-sponsored organizations pursuant to such  
14      rules and consistent with this subsection.

15           “(9) PUBLICATION OF RULE AFTER PUBLIC  
16      COMMENT.—The Secretary shall provide for consid-  
17      eration of such comments and republication of such  
18      rule by not later than 1 year after the target publi-  
19      cation date.

20           “(10) PROCESS FOR APPROVAL OF APPLICA-  
21      TIONS FOR CERTIFICATION.—

22           “(A) IN GENERAL.—The Secretary shall  
23      establish a process for the receipt and approval  
24      of applications of entities for certification as  
25      provider-sponsored organizations under this

1 part. Under such process, the Secretary shall  
2 act upon a complete application submitted with-  
3 in 60 days after the date it is received.

4 “(B) CIRCULATION OF PROPOSED APPLI-  
5 CATION FORM.—By March 1, 1996, the Sec-  
6 retary, after consultation with the negotiated  
7 rulemaking committee, shall circulate a pro-  
8 posed application form that could be used by  
9 entities considering becoming certified as a pro-  
10 vider-sponsored organization under this part.

11 “(d) COORDINATION AMONG FINAL STANDARDS.—In  
12 establishing standards (other than on an interim basis)  
13 under the previous provisions of this section, the Secretary  
14 shall seek to provide for consistency (as appropriate)  
15 across the different types of MedicarePlus organizations,  
16 in order to promote equitable treatment of different types  
17 of organizations and consistent protection for individuals  
18 who elect products offered by the different types of  
19 MedicarePlus organizations.

20 “(e) USE OF CURRENT STANDARDS FOR INTERIM  
21 STANDARDS.—To the extent practicable and consistent  
22 with the requirements of this part, standards established  
23 on an interim basis to carry out requirements of this part  
24 may be based on currently applicable standards, such as  
25 the rules established under section 1876 (as in effect as

1 of the date of the enactment of this section) to carry out  
 2 analogous provisions of such section or standards estab-  
 3 lished or developed for application in the private health  
 4 insurance market.

5 “(f) APPLICATION OF NEW STANDARDS TO ENTITIES  
 6 WITH A CONTRACT.—In the case of a MedicarePlus orga-  
 7 nization with a contract in effect under this part at the  
 8 time standards applicable to the organization under this  
 9 section are changed, the organization may elect not to  
 10 have such changes apply to the organization until the end  
 11 of the current contract year (or, if there is less than 6  
 12 months remaining in the contract year, until 1 year after  
 13 the end of the current contract year).

14 “(g) RELATION TO STATE LAWS.—The standards es-  
 15 tablished under this section shall supersede any State law  
 16 or regulation with respect to MedicarePlus products of-  
 17 fered under this part to the extent such law or regulation  
 18 is inconsistent with such standards.

19 “MEDICAREPLUS CERTIFICATION

20 “SEC. 1857. (a) STATE CERTIFICATION PROCESS  
 21 FOR STATE-REGULATED ORGANIZATIONS.—

22 “(1) APPROVAL OF STATE PROCESS.—The Sec-  
 23 retary shall approve a MedicarePlus certification and  
 24 enforcement program established by a State for ap-  
 25 plying the standards established under section 1856  
 26 to MedicarePlus organizations (other than union

1 sponsors, Taft-Hartley sponsors, and provider-spon-  
2 sored organizations) and MedicarePlus products of-  
3 fered by such organizations if the Secretary deter-  
4 mines that the program effectively provides for the  
5 application and enforcement of such standards in  
6 the State with respect to such organizations and  
7 products. Such program shall provide for certifi-  
8 cation of compliance of MedicarePlus organizations  
9 and products with the applicable requirements of  
10 this part not less often than once every 3 years.

11 “(2) EFFECT OF CERTIFICATION UNDER STATE  
12 PROCESS.—A MedicarePlus organization and  
13 MedicarePlus product offered by such an organiza-  
14 tion that is certified under such program is consid-  
15 ered to have been certified under this subsection  
16 with respect to the offering of the product to individ-  
17 uals residing in the State.

18 “(3) USER FEES.—The State may impose user  
19 fees on organizations seeking certification under this  
20 subsection in such amounts as the State deems suffi-  
21 cient to finance the costs of such certification. Noth-  
22 ing in this paragraph shall be construed as restrict-  
23 ing a State’s authority to impose premium taxes,  
24 other taxes, or other levies.

1           “(4) REVIEW.—The Secretary periodically shall  
2 review State programs approved under paragraph  
3 (1) to determine if they continue to provide for cer-  
4 tification and enforcement described in such para-  
5 graph. If the Secretary finds that a State program  
6 no longer so provides, before making a final deter-  
7 mination, the Secretary shall provide the State an  
8 opportunity to adopt such a plan of correction as  
9 would permit the State program to meet the require-  
10 ments of paragraph (1). If the Secretary makes a  
11 final determination that the State program, after  
12 such an opportunity, fails to meet such require-  
13 ments, the provisions of subsection (b) shall apply to  
14 MedicarePlus organizations and products in the  
15 State.

16           “(5) EFFECT OF NO STATE PROGRAM.—Begin-  
17 ning on the date standards are established under  
18 section 1856, in the case of organizations and prod-  
19 ucts in States in which a certification program has  
20 not been approved and in operation under paragraph  
21 (1), the Secretary shall establish a process for the  
22 certification of MedicarePlus organizations (other  
23 than union sponsors, Taft-Hartley sponsors, and  
24 provider-sponsored organizations) and products of  
25 such organizations as meeting such standards.

1           “(6) PUBLICATION OF LIST OF APPROVED  
2 STATE PROGRAMS.—The Secretary shall publish  
3 (and periodically update) a list of those State pro-  
4 grams which are approved for purposes of this sub-  
5 section.

6           “(b) FEDERAL CERTIFICATION PROCESS FOR UNION  
7 AND TAFT-HARTLEY SPONSORS AND PROVIDER-SPON-  
8 SORED ORGANIZATIONS.—

9           “(1) ESTABLISHMENT.—The Secretary shall es-  
10 tablish a process for the certification of union spon-  
11 sors, Taft-Hartley sponsors, and provider-sponsored  
12 organizations and MedicarePlus products offered by  
13 such sponsors and organizations as meeting the ap-  
14 plicable standards established under section 1856.

15           “(2) INVOLVEMENT OF SECRETARY OF  
16 LABOR.—Such process shall be established and oper-  
17 ated in cooperation with the Secretary of Labor with  
18 respect to union sponsors or Taft-Hartley sponsors.

19           “(3) USE OF STATE LICENSING AND PRIVATE  
20 ACCREDITATION PROCESSES.—

21           “(A) IN GENERAL.—The process under  
22 this subsection shall, to the maximum extent  
23 practicable, provide that MedicarePlus organi-  
24 zations and products that are licensed or cer-  
25 tified through a qualified private accreditation

1 process that the Secretary finds applies stand-  
2 ards that are no less stringent than the require-  
3 ments of this part are deemed to meet the cor-  
4 responding requirements of this part for such  
5 an organization or product.

6 “(B) PERIODIC ACCREDITATION.—The use  
7 of an accreditation under subparagraph (A)  
8 shall be valid only for such period as the Sec-  
9 retary specifies.

10 “(4) USER FEES.—The Secretary may impose  
11 user fees on entities seeking certification under this  
12 subsection in such amounts as the Secretary deems  
13 sufficient to finance the costs of such certification.

14 “(c) CERTIFICATION OF PROVIDER-SPONSORED OR-  
15 GANIZATIONS BY STATES.—

16 “(1) IN GENERAL.—The Secretary shall estab-  
17 lish a process under which a State may propose to  
18 provide for certification of entities as meeting the re-  
19 quirements of this part to be provider-sponsored or-  
20 ganizations.

21 “(2) CONDITIONS FOR APPROVAL.—The Sec-  
22 retary may not approve such a process unless the  
23 Secretary determines that the certification process  
24 applies standards that are consistent with the stand-  
25 ards and requirements provided under this part and

1 does not impose requirements more restrictive than  
2 those that would apply if this subsection were not in  
3 effect.

4 “(d) NOTICE TO ENROLLEES IN CASE OF DECERTI-  
5 FICATION.—If a MedicarePlus organization or product is  
6 decertified under this section, the organization shall notify  
7 each enrollee with the organization and product under this  
8 part of such decertification.

9 “(e) QUALIFIED ASSOCIATIONS.—In the case of  
10 products offered by a MedicarePlus organization that is  
11 a qualified association, nothing in this section shall be con-  
12 strued as limiting the authority of States to regulate such  
13 products.

14 “CONTRACTS WITH MEDICAREPLUS ORGANIZATIONS

15 “SEC. 1858. (a) IN GENERAL.—The Secretary shall  
16 not permit the election under section 1805 of a  
17 MedicarePlus product offered by a MedicarePlus organiza-  
18 tion under this part, and no payment shall be made under  
19 section 1856 to an organization, unless the Secretary has  
20 entered into a contract under this section with an organi-  
21 zation with respect to the offering of such product. Such  
22 a contract with an organization may cover more than one  
23 MedicarePlus product. Such contract shall provide that  
24 the organization agrees to comply with the requirements  
25 of this part and the terms and conditions of payment as  
26 provided for in this part.

1 “(b) ENROLLMENT REQUIREMENTS.—

2 “(1) MINIMUM ENROLLMENT.—

3 “(A) IN GENERAL.—Subject to subpara-  
4 graphs (B) and (C), the Secretary may not  
5 enter into a contract under this section with a  
6 MedicarePlus organization (other than a union  
7 sponsor or a Taft-Hartley sponsor) unless the  
8 organization has at least 5,000 individuals (or  
9 1,500 individuals in the case of an organization  
10 that is a provider-sponsored organization) who  
11 are receiving health benefits through the orga-  
12 nization, except that the standards under sec-  
13 tion 1856 may permit the organization to have  
14 a lesser number of beneficiaries (but not less  
15 than 500 in the case of an organization that is  
16 a provider-sponsored organization) if the orga-  
17 nization primarily serves individuals residing  
18 outside of urbanized areas.

19 “(B) EXCEPTION FOR HIGH DEDUCTIBLE/  
20 MEDISAVE PRODUCT.—Subparagraph (A) shall  
21 not apply with respect to a contract that relates  
22 only to a high deductible/medisave product.

23 “(C) ALLOWING TRANSITION.—The Sec-  
24 retary may waive the requirement of subpara-

1 graph (A) during the first 3 contract years with  
2 respect to an organization.

3 “(c) CONTRACT PERIOD AND EFFECTIVENESS.—

4 “(1) PERIOD.—Each contract under this sec-  
5 tion shall be for a term of at least one year, as de-  
6 termined by the Secretary, and may be made auto-  
7 matically renewable from term to term in the ab-  
8 sence of notice by either party of intention to termi-  
9 nate at the end of the current term.

10 “(2) TERMINATION AUTHORITY.—In accord-  
11 ance with procedures established under subsection  
12 (h), the Secretary may at any time terminate any  
13 such contract or may impose the intermediate sanc-  
14 tions described in an applicable paragraph of sub-  
15 section (g) on the MedicarePlus organization if the  
16 Secretary determines that the organization—

17 “(A) has failed substantially to carry out  
18 the contract;

19 “(B) is carrying out the contract in a man-  
20 ner inconsistent with the efficient and effective  
21 administration of this part;

22 “(C) is operating in a manner that is not  
23 in the best interests of the individuals covered  
24 under the contract; or

1           “(D) no longer substantially meets the ap-  
2           plicable conditions of this part.

3           “(3) EFFECTIVE DATE OF CONTRACTS.—The  
4           effective date of any contract executed pursuant to  
5           this section shall be specified in the contract, except  
6           that in no case shall a contract under this section  
7           which provides for coverage under a high deductible/  
8           medisave account be effective before January 1997  
9           with respect to such coverage.

10          “(4) PREVIOUS TERMINATIONS.—The Secretary  
11          may not enter into a contract with a MedicarePlus  
12          organization if a previous contract with that organi-  
13          zation under this section was terminated at the re-  
14          quest of the organization within the preceding five-  
15          year period, except in circumstances which warrant  
16          special consideration, as determined by the Sec-  
17          retary.

18          “(5) NO CONTRACTING AUTHORITY.—The au-  
19          thority vested in the Secretary by this part may be  
20          performed without regard to such provisions of law  
21          or regulations relating to the making, performance,  
22          amendment, or modification of contracts of the  
23          United States as the Secretary may determine to be  
24          inconsistent with the furtherance of the purpose of  
25          this title.

1       “(d) PROTECTIONS AGAINST FRAUD AND BENE-  
2 FICIARY PROTECTIONS.—

3           “(1) INSPECTION AND AUDIT.—Each contract  
4 under this section shall provide that the Secretary,  
5 or any person or organization designated by the Sec-  
6 retary—

7           “(A) shall have the right to inspect or oth-  
8 erwise evaluate (i) the quality, appropriateness,  
9 and timeliness of services performed under the  
10 contract and (ii) the facilities of the organiza-  
11 tion when there is reasonable evidence of some  
12 need for such inspection, and

13           “(B) shall have the right to audit and in-  
14 spect any books and records of the  
15 MedicarePlus organization that pertain (i) to  
16 the ability of the organization to bear the risk  
17 of potential financial losses, or (ii) to services  
18 performed or determinations of amounts pay-  
19 able under the contract.

20           “(2) ENROLLEE NOTICE AT TIME OF TERMI-  
21 NATION.—Each contract under this section shall re-  
22 quire the organization to provide (and pay for) writ-  
23 ten notice in advance of the contract’s termination,  
24 as well as a description of alternatives for obtaining

1 benefits under this title, to each individual enrolled  
2 with the organization under this part.

3 “(3) DISCLOSURE.—

4 “(A) IN GENERAL.—Each MedicarePlus  
5 organization shall, in accordance with regula-  
6 tions of the Secretary, report to the Secretary  
7 financial information which shall include the  
8 following:

9 “(i) Such information as the Sec-  
10 retary may require demonstrating that the  
11 organization has a fiscally sound operation.

12 “(ii) A copy of the report, if any, filed  
13 with the Health Care Financing Adminis-  
14 tration containing the information required  
15 to be reported under section 1124 by dis-  
16 closing entities.

17 “(iii) A description of transactions, as  
18 specified by the Secretary, between the or-  
19 ganization and a party in interest. Such  
20 transactions shall include—

21 “(I) any sale or exchange, or  
22 leasing of any property between the  
23 organization and a party in interest;

24 “(II) any furnishing for consider-  
25 ation of goods, services (including

1 management services), or facilities be-  
2 tween the organization and a party in  
3 interest, but not including salaries  
4 paid to employees for services pro-  
5 vided in the normal course of their  
6 employment and health services pro-  
7 vided to members by hospitals and  
8 other providers and by staff, medical  
9 group (or groups), individual practice  
10 association (or associations), or any  
11 combination thereof; and

12 “(III) any lending of money or  
13 other extension of credit between an  
14 organization and a party in interest.

15 The Secretary may require that information re-  
16 ported respecting an organization which con-  
17 trols, is controlled by, or is under common con-  
18 trol with, another entity be in the form of a  
19 consolidated financial statement for the organi-  
20 zation and such entity.

21 “(B) PARTY IN INTEREST DEFINED.—For  
22 the purposes of this paragraph, the term ‘party  
23 in interest’ means—

24 “(i) any director, officer, partner, or  
25 employee responsible for management or

1 administration of a MedicarePlus organiza-  
2 tion, any person who is directly or indi-  
3 rectly the beneficial owner of more than 5  
4 percent of the equity of the organization,  
5 any person who is the beneficial owner of  
6 a mortgage, deed of trust, note, or other  
7 interest secured by, and valuing more than  
8 5 percent of the organization, and, in the  
9 case of a MedicarePlus organization orga-  
10 nized as a nonprofit corporation, an incor-  
11 porator or member of such corporation  
12 under applicable State corporation law;

13 “(ii) any entity in which a person de-  
14 scribed in clause (i)—

15 “(I) is an officer or director;

16 “(II) is a partner (if such entity  
17 is organized as a partnership);

18 “(III) has directly or indirectly a  
19 beneficial interest of more than 5 per-  
20 cent of the equity; or

21 “(IV) has a mortgage, deed of  
22 trust, note, or other interest valuing  
23 more than 5 percent of the assets of  
24 such entity;

1           “(iii) any person directly or indirectly  
2           controlling, controlled by, or under com-  
3           mon control with an organization; and

4           “(iv) any spouse, child, or parent of  
5           an individual described in clause (i).

6           “(C) ACCESS TO INFORMATION.—Each  
7           MedicarePlus organization shall make the infor-  
8           mation reported pursuant to subparagraph (A)  
9           available to its enrollees upon reasonable re-  
10          quest.

11          “(5) LOAN INFORMATION.—The contract shall  
12          require the organization to notify the Secretary of  
13          loans and other special financial arrangements which  
14          are made between the organization and subcontrac-  
15          tors, affiliates, and related parties.

16          “(f) ADDITIONAL CONTRACT TERMS.—The contract  
17          shall contain such other terms and conditions not incon-  
18          sistent with this part (including requiring the organization  
19          to provide the Secretary with such information) as the  
20          Secretary may find necessary and appropriate.

21          “(g) INTERMEDIATE SANCTIONS.—

22                  “(1) IN GENERAL.—If the Secretary determines  
23          that a MedicarePlus organization with a contract  
24          under this section—

1           “(A) fails substantially to provide medi-  
2 cally necessary items and services that are re-  
3 quired (under law or under the contract) to be  
4 provided to an individual covered under the con-  
5 tract, if the failure has adversely affected (or  
6 has substantial likelihood of adversely affecting)  
7 the individual;

8           “(B) imposes premiums on individuals en-  
9 rolled under this part in excess of the premiums  
10 permitted;

11           “(C) acts to expel or to refuse to re-enroll  
12 an individual in violation of the provisions of  
13 this part;

14           “(D) engages in any practice that would  
15 reasonably be expected to have the effect of de-  
16 nying or discouraging enrollment (except as  
17 permitted by this part) by eligible individuals  
18 with the organization whose medical condition  
19 or history indicates a need for substantial fu-  
20 ture medical services;

21           “(E) misrepresents or falsifies information  
22 that is furnished—

23                   “(i) to the Secretary under this part,  
24                   or

1           “(ii) to an individual or to any other  
2           entity under this part;

3           “(F) fails to comply with the requirements  
4           of section 1852(f)(3); or

5           “(G) employs or contracts with any indi-  
6           vidual or entity that is excluded from participa-  
7           tion under this title under section 1128 or  
8           1128A for the provision of health care, utiliza-  
9           tion review, medical social work, or administra-  
10          tive services or employs or contracts with any  
11          entity for the provision (directly or indirectly)  
12          through such an excluded individual or entity of  
13          such services;

14          the Secretary may provide, in addition to any other  
15          remedies authorized by law, for any of the remedies  
16          described in paragraph (2).

17          “(2) REMEDIES.—The remedies described in  
18          this paragraph are—

19                 “(A) civil money penalties of not more  
20                 than \$25,000 for each determination under  
21                 paragraph (1) or, with respect to a determina-  
22                 tion under subparagraph (D) or (E)(i) of such  
23                 paragraph, of not more than \$100,000 for each  
24                 such determination, plus, with respect to a de-  
25                 termination under paragraph (1)(B), double the

1 excess amount charged in violation of such  
2 paragraph (and the excess amount charged  
3 shall be deducted from the penalty and returned  
4 to the individual concerned), and plus, with re-  
5 spect to a determination under paragraph  
6 (1)(D), \$15,000 for each individual not enrolled  
7 as a result of the practice involved,

8 “(B) suspension of enrollment of individ-  
9 uals under this part after the date the Sec-  
10 retary notifies the organization of a determina-  
11 tion under paragraph (1) and until the Sec-  
12 retary is satisfied that the basis for such deter-  
13 mination has been corrected and is not likely to  
14 recur, or

15 “(C) suspension of payment to the organi-  
16 zation under this part for individuals enrolled  
17 after the date the Secretary notifies the organi-  
18 zation of a determination under paragraph (1)  
19 and until the Secretary is satisfied that the  
20 basis for such determination has been corrected  
21 and is not likely to recur.

22 “(3) OTHER INTERMEDIATE SANCTIONS.—In  
23 the case of a MedicarePlus organization for which  
24 the Secretary makes a determination under sub-  
25 section (c)(2) the basis of which is not described in

1 paragraph (1), the Secretary may apply the follow-  
2 ing intermediate sanctions:

3 “(A) civil money penalties of not more  
4 than \$25,000 for each determination under  
5 subsection (c)(2) if the deficiency that is the  
6 basis of the determination has directly adversely  
7 affected (or has the substantial likelihood of ad-  
8 versely affecting) an individual covered under  
9 the organization’s contract;

10 “(B) civil money penalties of not more  
11 than \$10,000 for each week beginning after the  
12 initiation of procedures by the Secretary under  
13 subsection (h) during which the deficiency that  
14 is the basis of a determination under subsection  
15 (c)(2) exists; and

16 “(C) suspension of enrollment of individ-  
17 uals under this part after the date the Sec-  
18 retary notifies the organization of a determina-  
19 tion under subsection (c)(2) and until the Sec-  
20 retary is satisfied that the deficiency that is the  
21 basis for the determination has been corrected  
22 and is not likely to recur.

23 “(4) PROCEDURES FOR IMPOSING SANC-  
24 TIONS.—The provisions of section 1128A (other  
25 than subsections (a) and (b)) shall apply to a civil

1 money penalty under paragraph (1) or (2) in the  
2 same manner as they apply to a civil money penalty  
3 or proceeding under section 1128A(a).

4 “(h) PROCEDURES FOR IMPOSING SANCTIONS.—The  
5 Secretary may terminate a contract with a MedicarePlus  
6 organization under this section or may impose the inter-  
7 mediate sanctions described in subsection (g) on the orga-  
8 nization in accordance with formal investigation and com-  
9 pliance procedures established by the Secretary under  
10 which—

11 “(1) the Secretary provides the organization  
12 with the opportunity to develop and implement a  
13 corrective action plan to correct the deficiencies that  
14 were the basis of the Secretary’s determination  
15 under subsection (c)(2);

16 “(2) the Secretary shall impose more severe  
17 sanctions on organizations that have a history of de-  
18 ficiencies or that have not taken steps to correct de-  
19 ficiencies the Secretary has brought to their atten-  
20 tion;

21 “(3) there are no unreasonable or unnecessary  
22 delays between the finding of a deficiency and the  
23 imposition of sanctions; and

24 “(4) the Secretary provides the organization  
25 with reasonable notice and opportunity for hearing

1 (including the right to appeal an initial decision) be-  
2 fore imposing any sanction or terminating the con-  
3 tract.”.

4 (b) CONFORMING REFERENCES TO PREVIOUS PART  
5 C.—Any reference in law (in effect before the date of the  
6 enactment of this Act) to part C of title XVIII of the So-  
7 cial Security Act is deemed a reference to part D of such  
8 title (as in effect after such date).

9 (c) USE OF INTERIM, FINAL REGULATIONS.—In  
10 order to carry out the amendment made by subsection (a)  
11 in a timely manner, the Secretary of Health and Human  
12 Services may promulgate regulations that take effect on  
13 an interim basis, after notice and pending opportunity for  
14 public comment.

15 (d) ADVANCE DIRECTIVES.—Section 1866(f)(1) (42  
16 U.S.C. 1395cc(f)(1)) is amended—

17 (1) in paragraph (1)—

18 (A) by inserting “1853(g),” after  
19 “1833(s),”, and

20 (B) by inserting “, MedicarePlus organiza-  
21 tion,” after “provider of services”, and

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

1 “(4) Nothing in this subsection shall be construed to  
2 require the provision of information regarding assisted  
3 suicide, euthanasia, or mercy killing.”.

4 **SEC. 15003. DUPLICATION AND COORDINATION OF MEDI-**  
5 **CARE-RELATED PRODUCTS.**

6 (a) TREATMENT OF CERTAIN HEALTH INSURANCE  
7 POLICIES AS NONDUPLICATIVE.—

8 (1) IN GENERAL.—Effective as if included in  
9 the enactment of section 4354 of the Omnibus  
10 Budget Reconciliation Act of 1990, section  
11 1882(d)(3)(A) (42 U.S.C. 1395ss(d)(3)(A)) is  
12 amended—

13 (A) by amending clause (i) to read as fol-  
14 lows:

15 “(i) It is unlawful for a person to sell or issue to an  
16 individual entitled to benefits under part A or enrolled  
17 under part B of this title or electing a MedicarePlus prod-  
18 uct under section 1805—

19 “(I) a health insurance policy (other than a  
20 medicare supplemental policy) with knowledge that  
21 the policy duplicates health benefits to which the in-  
22 dividual is otherwise entitled under this title or title  
23 XIX,

24 “(II) in the case of an individual not electing a  
25 MedicarePlus product, a medicare supplemental pol-

1        1        2        3        4        5        6        7        8        9        10        11        12        13        14        15        16        17        18        19        20        21        22        23        24        25

icy with knowledge that the individual is entitled to  
benefits under another medicare supplemental policy,  
or

“(III) in the case of an individual electing a MedicarePlus product, a medicare supplemental policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under this title or under another medicare supplemental policy.”;

(B) in clause (iii), by striking “clause (i)” and inserting “clause (i)(II)”; and

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

“(iv) For purposes of this subparagraph a health insurance policy shall be considered to ‘duplicate’ benefits under this title only when, under its terms, the policy provides specific reimbursement for identical items and services to the extent paid for under this title, and a health insurance policy providing for benefits which are payable to or on behalf of an individual without regard to other health benefit coverage of such individual is not considered to ‘duplicate’ any health benefits under this title.

“(v) For purposes of this subparagraph, a health insurance policy (or a rider to an insurance contract which is not a health insurance policy), including a policy (such

1 as a long-term care insurance contract described in section  
2 7702B(b) of the Internal Revenue Code of 1986, as added  
3 by the Contract with America Tax Relief Act of 1995  
4 (H.R. 1215)) providing benefits for long-term care, nurs-  
5 ing home care, home health care, or community-based  
6 care, that coordinates against or excludes items and serv-  
7 ices available or paid for under this title and (for policies  
8 sold or issued after January 1, 1996) that discloses such  
9 coordination or exclusion in the policy's outline of cov-  
10 erage, is not considered to 'duplicate' health benefits  
11 under this title. For purposes of this clause, the terms 'co-  
12 ordinates' and 'coordination' mean, with respect to a pol-  
13 icy in relation to health benefits under this title, that the  
14 policy under its terms is secondary to, or excludes from  
15 payment, items and services to the extent available or paid  
16 for under this title.

17       “(vi) Notwithstanding any other provision of law, no  
18 criminal or civil penalty may be imposed at any time under  
19 this subparagraph and no legal action may be brought or  
20 continued at any time in any Federal or State court if  
21 the penalty or action is based on an act or omission that  
22 occurred after November 5, 1991, and before the date of  
23 the enactment of this clause, and relates to the sale, issu-  
24 ance, or renewal of any health insurance policy during

1 such period, if such policy is not meets the requirements  
2 of clause (iv) or (v).

3 “(vii) A State may not impose, with respect to the  
4 sale or issuance of a policy (or rider) that meets the re-  
5 quirements of this title pursuant to clause (iv) or (v) to  
6 an individual entitled to benefits under part A or enrolled  
7 under part B or enrolled under a MedicarePlus product  
8 under part C, any requirement based on the premise that  
9 such a policy or rider duplicates health benefits to which  
10 the individual is otherwise entitled under this title.”.

11 (2) CONFORMING AMENDMENTS.—Section  
12 1882(d)(3) (42 U.S.C. 1395ss(d)(3)) is amended—

13 (A) in subparagraph (B), by inserting  
14 “(including any MedicarePlus product)” after  
15 “health insurance policies”;

16 (B) in subparagraph (C)—

17 (i) by striking “with respect to (i)”  
18 and inserting “with respect to”, and

19 (ii) by striking “, (ii) the sale” and all  
20 that follows up to the period at the end;  
21 and

22 (C) by striking subparagraph (D).

23 (3) MEDICAREPLUS PRODUCTS NOT TREATED  
24 AS MEDICARE SUPPLEMENTARY POLICIES.—Section  
25 1882(g) (42 U.S.C. 1395ss(g)) is amended by in-

1       serting “a MedicarePlus product or” after “and does  
2       not include”

3               (4) REPORT ON DUPLICATION AND COORDINA-  
4       TION OF HEALTH INSURANCE POLICIES THAT ARE  
5       NOT MEDICARE SUPPLEMENTAL POLICIES.—Not  
6       later than 3 years after the date of the enactment  
7       of this Act, the Secretary of Health and Human  
8       Services shall prepare and submit to Congress a re-  
9       port on the advisability and feasibility of restricting  
10      the sale to medicare beneficiaries of health insurance  
11      policies that duplicate (within the meaning of section  
12      1882(d)(3)(A) of the Social Security Act) other  
13      health insurance policies that such a beneficiary may  
14      have. In preparing such report, the Secretary shall  
15      seek the advice of the National Association of Insur-  
16      ance Commissioners and shall take into account the  
17      standards established under section 1807 of the So-  
18      cial Security Act for the electronic coordination of  
19      benefits.

20              (b) ADDITIONAL RULES RELATING TO INDIVIDUALS  
21      ENROLLED IN MEDICAREPLUS PRODUCTS.—Section  
22      1882 (42 U.S.C. 1395ss) is further amended by adding  
23      at the end the following new subsection:

24              “(u)(1) Notwithstanding the previous provisions of  
25      this section, the following provisions shall not apply to a

1 health insurance policy (other than a medicare supple-  
2 mental policy) provided to an individual who has elected  
3 the MedicarePlus option under section 1805:

4 “(A) Subsections (o)(1), (o)(2), (p)(1)(A)(i),  
5 (p)(2), (p)(3), (p)(8), and (p)(9) (insofar as they re-  
6 late to limitations on benefits or groups of benefits  
7 that may be offered).

8 “(B) Subsection (r) (relating to loss-ratios).

9 “(2)(A) It is unlawful for a person to sell or issue  
10 a policy described in subparagraph (B) to an individual  
11 with knowledge that the individual has in effect under sec-  
12 tion 1805 an election of a high deductible/medisave prod-  
13 uct.

14 “(B) A policy described in this subparagraph is a  
15 health insurance policy that provides for coverage of ex-  
16 penses that are otherwise required to be counted toward  
17 meeting the annual deductible amount provided under the  
18 high deductible/medisave product.”.

19 **SEC. 15004. TRANSITIONAL RULES FOR CURRENT MEDI-**  
20 **CARE HMO PROGRAM.**

21 (a) TRANSITION FROM CURRENT CONTRACTS.—

22 (1) LIMITATION ON NEW CONTRACTS.—

23 (A) NO NEW RISK-SHARING CONTRACTS  
24 AFTER NEW STANDARDS ESTABLISHED.—The  
25 Secretary of Health and Human Services (in

1 this section referred to as the “Secretary”  
2 shall not enter into any risk-sharing contract  
3 under section 1876 of the Social Security Act  
4 with an eligible organization for any contract  
5 year beginning on or after the date standards  
6 for MedicarePlus organizations and products  
7 are first established under section 1856(a) of  
8 such Act with respect to MedicarePlus organi-  
9 zations that are insurer or health maintenance  
10 organizations unless such a contract had been  
11 in effect under section 1876 of such Act for the  
12 organization for the previous contract year.

13 (B) NO NEW COST REIMBURSEMENT CON-  
14 TRACTS.—The Secretary shall not enter into  
15 any cost reimbursement contract under section  
16 1876 of the Social Security Act beginning for  
17 any contract year beginning on or after the  
18 date of the enactment of this Act.

19 (2) TERMINATION OF CURRENT CONTRACTS.—

20 (A) RISK-SHARING CONTRACTS.—Notwith-  
21 standing any other provision of law, the Sec-  
22 retary shall not extend or continue any risk-  
23 sharing contract with an eligible organization  
24 under section 1876 of the Social Security Act  
25 (for which a contract was entered into consist-

1 ent with paragraph (1)(A)) for any contract  
2 year beginning on or after 1 year after the date  
3 standards described in paragraph (1)(A) are es-  
4 tablished.

5 (B) COST REIMBURSEMENT CONTRACTS.—

6 The Secretary shall not extend or continue any  
7 reasonable cost reimbursement contract with an  
8 eligible organization under section 1876 of the  
9 Social Security Act for any contract year begin-  
10 ning on or after January 1, 1998.

11 (b) CONFORMING PAYMENT RATES.—

12 (1) RISK-SHARING CONTRACTS.—Notwithstand-  
13 ing any other provision of law, the Secretary shall  
14 provide that payment amounts under risk-sharing  
15 contracts under section 1876(a) of the Social Secu-  
16 rity Act for months in a year (beginning with Janu-  
17 ary 1996) shall be computed—

18 (A) with respect to individuals both enti-  
19 tled to benefits under both parts A and B of  
20 title XVIII of such Act, by substituting pay-  
21 ment rates under section 1855(a) of such Act  
22 for the payment rates otherwise established  
23 under section 1876(a) of such Act, and

24 (B) with respect to individuals only enti-  
25 tled to benefits under part B of such title, by

1 substituting an appropriate proportion of such  
2 rates (reflecting the relative proportion of pay-  
3 ments under such title attributable to such  
4 part) for the payment rates otherwise estab-  
5 lished under section 1876(a) of such Act.

6 For purposes of carrying out this paragraph for pay-  
7 ment for months in 1996, the Secretary shall com-  
8 pute, announce, and apply the payment rates under  
9 section 1855(a) of such Act (notwithstanding any  
10 deadlines specified in such section) in as timely a  
11 manner as possible and may (to the extent nec-  
12 essary) provide for retroactive adjustment in pay-  
13 ments made not in accordance with such rates.

14 (2) COST CONTRACTS.—Notwithstanding any  
15 other provision of law, the Secretary shall provide  
16 that payment amounts under cost reimbursement  
17 contracts under section 1876(a) of the Social Secu-  
18 rity Act shall take into account adjustments in pay-  
19 ment amounts made in parts A and B of title XVIII  
20 of such Act pursuant to the amendments made by  
21 this title.

22 (c) ELIMINATION OF 50:50 RULE.—

23 (1) IN GENERAL.—Section 1876 (42 U.S.C.  
24 1395mm) is amended by striking subsection (f).

1           (2) CONFORMING AMENDMENTS.—Section 1876  
2           is further amended—

3                   (A) in subsection (c)(3)(A)(i), by striking  
4           “would result in failure to meet the require-  
5           ments of subsection (f)”, and

6                   (B) in subsection (i)(1)(C), by striking  
7           “(e), and (f)” and inserting “and (e)”.

8           (3) EFFECTIVE DATE.—The amendments made  
9           by this section shall apply to contract years begin-  
10          ning on or after January 1, 1996.

11       **PART 2—SPECIAL RULES FOR MEDICAREPLUS**

12                   **MEDICAL SAVINGS ACCOUNTS**

**SEC. 15011. MEDICAREPLUS MSA’S.**

(a) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to amounts specifically excluded from gross income) is amended by redesignating section 137 as section 138 and by inserting after section 136 the following new section:

**“SEC. 137. MEDICAREPLUS MSA’S.**

“(a) EXCLUSION.—Gross income shall not include any payment to the MedicarePlus MSA of an individual by the Secretary of Health and Human Services under section 1855(f)(1)(B) of the Social Security Act.

“(b) MEDICAREPLUS MSA.—For purposes of this section—

1           “(1)    MEDICAREPLUS    MSA.—The    term  
2           ‘MedicarePlus MSA’ means a trust created or orga-  
3           nized in the United States exclusively for the pur-  
4           pose of paying the qualified medical expenses of the  
5           account holder, but only if the written governing in-  
6           strument creating the trust meets the following re-  
7           quirements:

8                   “(A) Except in the case of a trustee-to-  
9                   trustee transfer described in subsection (d)(4),  
10                  no contribution will be accepted unless it is  
11                  made by the Secretary of Health and Human  
12                  Services under section 1855(f)(1)(B) of the So-  
13                  cial Security Act.

14                  “(B) The trustee is a bank (as defined in  
15                  section 408(n)), an insurance company (as de-  
16                  fined in section 816), or another person who  
17                  demonstrates to the satisfaction of the Sec-  
18                  retary that the manner in which such person  
19                  will administer the trust will be consistent with  
20                  the requirements of this section.

21                  “(C) No part of the trust assets will be in-  
22                  vested in life insurance contracts.

23                  “(D) The assets of the trust will not be  
24                  commingled with other property except in a

1 common trust fund or common investment  
2 fund.

3 “(E) The interest of an individual in the  
4 balance in his account is nonforfeitable.

5 “(F) Trustee-to-trustee transfers described  
6 in subsection (d)(4) may be made to and from  
7 the trust.

8 “(2) QUALIFIED MEDICAL EXPENSES.—

9 “(A) IN GENERAL.—The term ‘qualified  
10 medical expenses’ means, with respect to an ac-  
11 count holder, amounts paid by such holder—

12 “(i) for medical care (as defined in  
13 section 213(d)) for the account holder, but  
14 only to the extent such amounts are not  
15 compensated for by insurance or otherwise,  
16 or

17 “(ii) for long-term care insurance for  
18 the account holder.

19 “(B) HEALTH INSURANCE MAY NOT BE  
20 PURCHASED FROM ACCOUNT.—Subparagraph  
21 (A)(i) shall not apply to any payment for insur-  
22 ance.

23 “(3) ACCOUNT HOLDER.—The term ‘account  
24 holder’ means the individual on whose behalf the  
25 MedicarePlus MSA is maintained.

1           “(4) CERTAIN RULES TO APPLY.—Rules similar  
2 to the rules of subsections (g) and (h) of section 408  
3 shall apply for purposes of this section.

4           “(c) TAX TREATMENT OF ACCOUNTS.—

5           “(1) IN GENERAL.—A MedicarePlus MSA is ex-  
6 empt from taxation under this subtitle unless such  
7 MSA has ceased to be a MedicarePlus MSA by rea-  
8 son of paragraph (2). Notwithstanding the preceding  
9 sentence, any such MSA is subject to the taxes im-  
10 posed by section 511 (relating to imposition of tax  
11 on unrelated business income of charitable, etc. or-  
12 ganizations).

13           “(2) ACCOUNT ASSETS TREATED AS DISTRIB-  
14 UTED IN THE CASE OF PROHIBITED TRANSACTIONS  
15 OR ACCOUNT PLEDGED AS SECURITY FOR LOAN.—  
16 Rules similar to the rules of paragraphs (2) and (4)  
17 of section 408(e) shall apply to MedicarePlus  
18 MSA’s, and any amount treated as distributed under  
19 such rules shall be treated as not used to pay quali-  
20 fied medical expenses.

21           “(d) TAX TREATMENT OF DISTRIBUTIONS.—

22           “(1) INCLUSION OF AMOUNTS NOT USED FOR  
23 QUALIFIED MEDICAL EXPENSES.—No amount shall  
24 be included in the gross income of the account hold-  
25 er by reason of a payment or distribution from a

1 MedicarePlus MSA which is used exclusively to pay  
2 the qualified medical expenses of the account holder.  
3 Any amount paid or distributed from a  
4 MedicarePlus MSA which is not so used shall be in-  
5 cluded in the gross income of such holder.

6 “(2) PENALTY FOR DISTRIBUTIONS NOT USED  
7 FOR QUALIFIED MEDICAL EXPENSES IF MINIMUM  
8 BALANCE NOT MAINTAINED.—

9 “(A) IN GENERAL.—The tax imposed by  
10 this chapter for any taxable year in which there  
11 is a payment or distribution from a  
12 MedicarePlus MSA which is not used exclu-  
13 sively to pay the qualified medical expenses of  
14 the account holder shall be increased by 50 per-  
15 cent of the excess (if any) of—

16 “(i) the amount of such payment or  
17 distribution, over

18 “(ii) the excess (if any) of—

19 “(I) the fair market value of the  
20 assets in the MedicarePlus MSA as of  
21 the close of the calendar year preced-  
22 ing the calendar year in which the  
23 taxable year begins, over

24 “(II) an amount equal to 60 per-  
25 cent of the deductible under the cata-

1           strophic health plan covering the ac-  
2           count holder as of January 1 of the  
3           calendar year in which the taxable  
4           year begins.

5           “(B) EXCEPTIONS.—Subparagraph (A)  
6           shall not apply if the payment or distribution is  
7           made on or after the date the account holder—

8                   “(i) becomes disabled within the  
9                   meaning of section 72(m)(7), or

10                   “(ii) dies.

11           “(C) SPECIAL RULES.—For purposes of  
12           subparagraph (A)—

13                   “(i) all MedicarePlus MSA’s of the ac-  
14                   count holder shall be treated as 1 account,

15                   “(ii) all payments and distributions  
16                   not used exclusively to pay the qualified  
17                   medical expenses of the account holder  
18                   during any taxable year shall be treated as  
19                   1 distribution, and

20                   “(iii) any distribution of property  
21                   shall be taken into account at its fair mar-  
22                   ket value on the date of the distribution.

23           “(3) WITHDRAWAL OF ERRONEOUS CONTRIBU-  
24           TIONS.—Paragraphs (1) and (2) shall not apply to  
25           any payment or distribution from a MedicarePlus

1 MSA to the Secretary of Health and Human Serv-  
2 ices of an erroneous contribution to such MSA and  
3 of the net income attributable to such contribution.

4 “(4) TRUSTEE-TO-TRUSTEE TRANSFERS.—  
5 Paragraphs (1) and (2) shall not apply to any trust-  
6 ee-to-trustee transfer from a MedicarePlus MSA of  
7 an account holder to another MedicarePlus MSA of  
8 such account holder.

9 “(5) COORDINATION WITH MEDICAL EXPENSE  
10 DEDUCTION.—For purposes of section 213, any pay-  
11 ment or distribution out of a MedicarePlus MSA for  
12 qualified medical expenses shall not be treated as an  
13 expense paid for medical care.

14 “(e) TREATMENT OF ACCOUNT AFTER DEATH OF  
15 ACCOUNT HOLDER.—

16 “(1) TREATMENT IF DESIGNATED BENEFICIARY  
17 IS SPOUSE.—

18 “(A) IN GENERAL.—In the case of an ac-  
19 count holder’s interest in a MedicarePlus MSA  
20 which is payable to (or for the benefit of) such  
21 holder’s spouse upon the death of such holder,  
22 such MedicarePlus MSA shall be treated as a  
23 MedicarePlus MSA of such spouse as of the  
24 date of such death.

1           “(B) SPECIAL RULES IF SPOUSE NOT MED-  
2           ICARE ELIGIBLE.—If, as of the date of such  
3           death, such spouse is not entitled to benefits  
4           under title XVIII of the Social Security Act,  
5           then after the date of such death—

6                   “(i) the Secretary of Health and  
7                   Human Services may not make any pay-  
8                   ments to such MedicarePlus MSA, other  
9                   than payments attributable to periods be-  
10                  fore such date,

11                   “(ii) in applying subsection (b)(2)  
12                   with respect to such MedicarePlus MSA,  
13                   references to the account holder shall be  
14                   treated as including references to any de-  
15                   pendent (as defined in section 152) of such  
16                   spouse and any subsequent spouse of such  
17                   spouse, and

18                   “(iii) in lieu of applying subsection  
19                   (d)(2), the rules of section 220(f)(2) shall  
20                   apply.

21           “(2) TREATMENT IF DESIGNATED BENEFICIARY  
22           IS NOT SPOUSE.—In the case of an account holder’s  
23           interest in a MedicarePlus MSA which is payable to  
24           (or for the benefit of) any person other than such  
25           holder’s spouse upon the death of such holder—

1           “(A) such account shall cease to be a  
2 MedicarePlus MSA as of the date of death, and

3           “(B) an amount equal to the fair market  
4 value of the assets in such account on such date  
5 shall be includible—

6                   “(i) if such person is not the estate of  
7 such holder, in such person’s gross income  
8 for the taxable year which includes such  
9 date, or

10                   “(ii) if such person is the estate of  
11 such holder, in such holder’s gross income  
12 for last taxable year of such holder.

13           “(f) REPORTS.—

14                   “(1) IN GENERAL.—The trustee of a  
15 MedicarePlus MSA shall make such reports regard-  
16 ing such account to the Secretary and to the account  
17 holder with respect to—

18                           “(A) the fair market value of the assets in  
19 such MedicarePlus MSA as of the close of each  
20 calendar year, and

21                           “(B) contributions, distributions, and other  
22 matters,  
23 as the Secretary may require by regulations.

24                   “(2) TIME AND MANNER OF REPORTS.—The re-  
25 ports required by this subsection—

1           “(A) shall be filed at such time and in  
2 such manner as the Secretary prescribes in  
3 such regulations, and

4           “(B) shall be furnished to the account  
5 holder—

6                   “(i) not later than January 31 of the  
7 calendar year following the calendar year  
8 to which such reports relate, and

9                   “(ii) in such manner as the Secretary  
10 prescribes in such regulations.”

11       (b) EXCLUSION OF MEDICAREPLUS MSA’S FROM  
12 ESTATE TAX.—Part IV of subchapter A of chapter 11 of  
13 such Code is amended by adding at the end the following  
14 new section:

15 **“SEC. 2057. MEDICAREPLUS MSA’S.**

16       “For purposes of the tax imposed by section 2001,  
17 the value of the taxable estate shall be determined by de-  
18 ducting from the value of the gross estate an amount  
19 equal to the value of any MedicarePlus MSA (as defined  
20 in section 137(b)) included in the gross estate.”

21       (c) TAX ON PROHIBITED TRANSACTIONS.—

22           (1) Section 4975 of such Code (relating to tax  
23 on prohibited transactions) is amended by adding at  
24 the end of subsection (c) the following new para-  
25 graph:

1           “(5) SPECIAL RULE FOR MEDICAREPLUS  
2 MSA’S.—An individual for whose benefit a  
3 MedicarePlus MSA (within the meaning of section  
4 137(b)) is established shall be exempt from the tax  
5 imposed by this section with respect to any trans-  
6 action concerning such account (which would other-  
7 wise be taxable under this section) if, with respect  
8 to such transaction, the account ceases to be a  
9 MedicarePlus MSA by reason of the application of  
10 section 137(c)(2) to such account.”

11           (2) Paragraph (1) of section 4975(e) of such  
12 Code is amended to read as follows:

13           “(1) PLAN.—For purposes of this section, the  
14 term ‘plan’ means—

15           “(A) a trust described in section 401(a)  
16 which forms a part of a plan, or a plan de-  
17 scribed in section 403(a), which trust or plan is  
18 exempt from tax under section 501(a),

19           “(B) an individual retirement account de-  
20 scribed in section 408(a),

21           “(C) an individual retirement annuity de-  
22 scribed in section 408(b),

23           “(D) a medical savings account described  
24 in section 220(d),

1           “(E) a MedicarePlus MSA described in  
2 section 137(b), or

3           “(F) a trust, plan, account, or annuity  
4 which, at any time, has been determined by the  
5 Secretary to be described in any preceding sub-  
6 paragraph of this paragraph.”

7           (d) FAILURE TO PROVIDE REPORTS ON  
8 MEDICAREPLUS MSA’S.—

9           (1) Subsection (a) of section 6693 of such Code  
10 (relating to failure to provide reports on individual  
11 retirement accounts or annuities) is amended to read  
12 as follows:

13           “(a) REPORTS.—

14           “(1) IN GENERAL.—If a person required to file  
15 a report under a provision referred to in paragraph  
16 (2) fails to file such report at the time and in the  
17 manner required by such provision, such person  
18 shall pay a penalty of \$50 for each failure unless it  
19 is shown that such failure is due to reasonable  
20 cause.

21           “(2) PROVISIONS.—The provisions referred to  
22 in this paragraph are—

23           “(A) subsections (i) and (l) of section 408  
24 (relating to individual retirement plans),

1           “(B) section 220(h) (relating to medical  
2 savings accounts), and

3           “(C) section 137(f) (relating to  
4 MedicarePlus MSA’s).”

5           (2) The section heading for section 6693 of  
6 such Code is amended to read as follows:

7 **“SEC. 6693. FAILURE TO FILE REPORTS ON INDIVIDUAL RE-**  
8 **TIREMENT PLANS AND CERTAIN OTHER TAX-**  
9 **FAVORED ACCOUNTS; PENALTIES RELATING**  
10 **TO DESIGNATED NONDEDUCTIBLE CON-**  
11 **TRIBUTIONS.”**

12 (e) CLERICAL AMENDMENTS.—

13           (1) The table of sections for part III of sub-  
14 chapter B of chapter 1 of such Code is amended by  
15 striking the last item and inserting the following:

“Sec. 137. MedicarePlus MSA’s.  
“Sec. 138. Cross references to other Acts.”

16           (2) The table of sections for subchapter B of  
17 chapter 68 of such Code is amended by striking the  
18 item relating to section 6693 and inserting the fol-  
19 lowing new item:

“Sec. 6693. Failure to file reports on individual retirement plans  
and certain other tax-favored accounts; penalties re-  
lating to designated nondeductible contributions.”

20           (3) The table of sections for part IV of sub-  
21 chapter A of chapter 11 of such Code is amended by  
22 adding at the end the following new item:

“Sec. 2057. MedicarePlus MSA’s.”

1 (f) EFFECTIVE DATE.—The amendments made by  
2 this section shall apply to taxable years beginning after  
3 December 31, 1996.

4 **SEC. 15012. CERTAIN REBATES EXCLUDED FROM GROSS IN-**  
5 **COME.**

6 (a) IN GENERAL.—Section 105 of the Internal Reve-  
7 nue Code of 1986 (relating to amounts received under ac-  
8 cident and health plans) is amended by adding at the end  
9 the following new subsection:

10 “(j) CERTAIN REBATES UNDER SOCIAL SECURITY  
11 ACT.—Gross income does not include any rebate received  
12 under section 1852(e)(1)(A) of the Social Security Act  
13 during the taxable year.”

14 (b) EFFECTIVE DATE.—The amendment made by  
15 subsection (a) shall apply to amounts received after the  
16 date of the enactment of this Act.

17 **PART 3—SPECIAL ANTITRUST RULE FOR**  
18 **PROVIDER SERVICE NETWORKS**

19 **SEC. 15021. APPLICATION OF ANTITRUST RULE OF REASON**  
20 **TO PROVIDER SERVICE NETWORKS.**

21 (a) RULE OF REASON STANDARD.—In any action  
22 under the antitrust laws, or under any State law similar  
23 to the antitrust laws—

24 (1) the conduct of a provider service network in  
25 negotiating, making, or performing a contract (in-

1 including the establishment and modification of a fee  
2 schedule and the development of a panel of physi-  
3 cians), to the extent such contract is for the purpose  
4 of providing health care services to individuals under  
5 the terms of a MedicarePlus PSO product, and

6 (2) the conduct of any member of such network  
7 for the purpose of providing such health care serv-  
8 ices under such contract to such extent,

9 shall not be deemed illegal per se. Such conduct shall be  
10 judged on the basis of its reasonableness, taking into ac-  
11 count all relevant factors affecting competition, including  
12 the effects on competition in properly defined markets.

13 (b) DEFINITIONS.—For purposes of subsection (a):

14 (1) ANTITRUST LAWS.—The term “antitrust  
15 laws” has the meaning given it in subsection (a) of  
16 the first section of the Clayton Act (15 U.S.C. 12),  
17 except that such term includes section 5 of the Fed-  
18 eral Trade Commission Act (15 U.S.C. 45) to the  
19 extent that such section 5 applies to unfair methods  
20 of competition.

21 (2) HEALTH CARE PROVIDER.—The term  
22 “health care provider” means any individual or en-  
23 tity that is engaged in the delivery of health care  
24 services in a State and that is required by State law  
25 or regulation to be licensed or certified by the State

1 to engage in the delivery of such services in the  
2 State.

3 (3) HEALTH CARE SERVICE.—The term “health  
4 care service” means any service for which payment  
5 may be made under a MedicarePlus PSO product in-  
6 cluding services related to the delivery or adminis-  
7 tration of such service.

8 (4) MEDICAREPLUS PROGRAM.—The term  
9 “MedicarePlus program” means the program under  
10 part C of title XVIII of the Social Security Act.

11 (5) MEDICAREPLUS PSO PRODUCT.—The term  
12 “MedicarePlus PSO product” means a MedicarePlus  
13 product offered by a provider-sponsored organization  
14 under part C of title XVIII of the Social Security  
15 Act.

16 (6) PROVIDER SERVICE NETWORK.—The term  
17 “provider service network” means an organization  
18 that—

19 (A) is organized by, operated by, and com-  
20 posed of members who are health care providers  
21 and for purposes that include providing health  
22 care services,

23 (B) is funded in part by capital contribu-  
24 tions made by the members of such organiza-  
25 tion,

1 (C) with respect to each contract made by  
2 such organization for the purpose of providing  
3 a type of health care service to individuals  
4 under the terms of a MedicarePlus PSO prod-  
5 uct—

6 (i) requires all members of such orga-  
7 nization who engage in providing such type  
8 of health care service to agree to provide  
9 health care services of such type under  
10 such contract,

11 (ii) receives the compensation paid for  
12 the health care services of such type pro-  
13 vided under such contract by such mem-  
14 bers, and

15 (iii) provides for the distribution of  
16 such compensation,

17 (D) has established, consistent with the re-  
18 quirements of the MedicarePlus program for  
19 provider-sponsored organizations, a program to  
20 review, pursuant to written guidelines, the qual-  
21 ity, efficiency, and appropriateness of treatment  
22 methods and setting of services for all health  
23 care providers and all patients participating in  
24 such product, along with internal procedures to

1 correct identified deficiencies relating to such  
2 methods and such services,

3 (E) has established, consistent with the re-  
4 quirements of the MedicarePlus program for  
5 provider-sponsored organizations, a program to  
6 monitor and control utilization of health care  
7 services provided under such product, for the  
8 purpose of improving efficient, appropriate care  
9 and eliminating the provision of unnecessary  
10 health care services,

11 (F) has established a management pro-  
12 gram to coordinate the delivery of health care  
13 services for all health care providers and all pa-  
14 tients participating in such product, for the  
15 purpose of achieving efficiencies and enhancing  
16 the quality of health care services provided, and

17 (G) has established, consistent with the re-  
18 quirements of the MedicarePlus program for  
19 provider-sponsored organizations, a grievance  
20 and appeal process for such organization de-  
21 signed to review and promptly resolve bene-  
22 ficiary or patient grievances and complaints.

23 Such term may include a provider-sponsored organi-  
24 zation.

1 (7) PROVIDER-SPONSORED ORGANIZATION.—  
 2 The term “provider-sponsored organization” means  
 3 a MedicarePlus organization under the MedicarePlus  
 4 program that is a provider-sponsored organization  
 5 (as defined in section \_\_\_\_ of the Social Security  
 6 Act).

7 (8) STATE.—The term “State” has the mean-  
 8 ing given it in section 4G(2) of the Clayton Act (15  
 9 U.S.C. 15g(2)).

10 (c) ISSUANCE OF GUIDELINES.—Not later than 120  
 11 days after the date of the enactment of this Act, the Attor-  
 12 ney General and the Federal Trade Commission shall  
 13 issue jointly guidelines specifying the enforcement policies  
 14 and analytical principles that will be applied by the De-  
 15 partment of Justice and the Commission with respect to  
 16 the operation of subsection (a).

17 **PART 4—COMMISSIONS**

18 **SEC. 15031. MEDICARE PAYMENT REVIEW COMMISSION.**

19 (a) IN GENERAL.—Title XVIII, as amended by sec-  
 20 tion 15001(a), is amended by inserting after section 1805  
 21 the following new section:

22 “MEDICARE PAYMENT REVIEW COMMISSION

23 “SEC. 1806. (a) ESTABLISHMENT.—There is hereby  
 24 established the Medicare Payment Review Commission (in  
 25 this section referred to as the ‘Commission’).

26 “(b) DUTIES.—

1           “(1) GENERAL DUTIES AND REPORTS.—The  
 2 Commission shall review, and make recommenda-  
 3 tions to Congress concerning, payment policies under  
 4 this title. By not later than June 1 of each year, the  
 5 Commission shall submit a report to Congress con-  
 6 taining an examination of issues affecting the medi-  
 7 care program, including the implications of changes  
 8 in health care delivery in the United States and in  
 9 the market for health care services on the medicare  
 10 program. The Commission may submit to Congress  
 11 from time to time such other reports as the Commis-  
 12 sion deems appropriate. The Secretary shall respond  
 13 to recommendations of the Commission in notices of  
 14 rulemaking proceedings under this title.

15           “(2) SPECIFIC DUTIES RELATING TO  
 16 MEDICAREPLUS PROGRAM.—Specifically, the Com-  
 17 mission shall review, with respect to the  
 18 MedicarePlus program under part C—

19                   “(A) the appropriateness of the methodol-  
 20 ogy for making payment to plans under such  
 21 program, including the making of differential  
 22 payments and the distribution of differential  
 23 updates among different payment areas,

24                   “(B) the appropriateness of the mecha-  
 25 nisms used to adjust payments for risk and the

1           need to adjust such mechanisms to take into ac-  
2           count health status of beneficiaries,

3           “(C) the implications of risk selection both  
4           among MedicarePlus organizations and between  
5           the MedicarePlus option and the non-  
6           MedicarePlus option,

7           “(D) in relation to payment under part C,  
8           the development and implementation of mecha-  
9           nisms to assure the quality of care for those en-  
10          rolled with MedicarePlus organizations,

11          “(E) the impact of the MedicarePlus pro-  
12          gram on access to care for medicare bene-  
13          ficiaries, and

14          “(F) other major issues in implementation  
15          and further development of the MedicarePlus  
16          program.

17          “(3) SPECIFIC DUTIES RELATING TO THE  
18          FAILSAFE BUDGET MECHANISM.—Specifically, the  
19          Commission shall review, with respect to the failsafe  
20          budget mechanism described in section 1895—

21                 “(A) the appropriateness of the expendi-  
22                 ture projections by the Secretary under section  
23                 1895(c) for each medicare sector;

1           “(B) the appropriateness of the growth  
2 factors for each sector and the ability to take  
3 into account substitution across sectors;

4           “(C) the appropriateness of the mecha-  
5 nisms for implementing reductions in payment  
6 amounts for different sectors, including any ad-  
7 justments to reflect changes in volume or inten-  
8 sity resulting for any payment reductions;

9           “(D) the impact of the mechanism on pro-  
10 vider participation in parts A and B and in the  
11 MedicarePlus program; and

12           “(E) the appropriateness of the medicare  
13 benefit budget (under section 1895(c)(2)(C) of  
14 the Social Security Act), particularly for fiscal  
15 years after fiscal year 2002.

16           “(4) SPECIFIC DUTIES RELATING TO THE FEE-  
17 FOR-SERVICE SYSTEM.—Specifically, the Commission  
18 shall review payment policies under parts A and B,  
19 including—

20           “(A) the factors affecting expenditures for  
21 services in different sectors, including the proc-  
22 ess for updating hospital, physician, and other  
23 fees,

24           “(B) payment methodologies; and

1           “(C) the impact of payment policies on ac-  
2           cess and quality of care for medicare bene-  
3           ficiaries.

4           “(5) SPECIFIC DUTIES RELATING TO INTER-  
5           ACTION OF PAYMENT POLICIES WITH HEALTH CARE  
6           DELIVERY GENERALLY.—Specifically the Commis-  
7           sion shall review the effect of payment policies under  
8           this title on the delivery of health care services  
9           under this title and assess the implications of  
10          changes in the health services market on the medi-  
11          care program.

12          “(c) MEMBERSHIP.—

13           “(1) NUMBER AND APPOINTMENT.—The Com-  
14           mission shall be composed of 15 members appointed  
15           by Comptroller General.

16           “(2) QUALIFICATIONS.—The membership of the  
17           Commission shall include individuals with national  
18           recognition for their expertise in health finance and  
19           economics, health facility management, health plans  
20           and integrated delivery systems, reimbursement of  
21           health facilities, physicians, and other providers of  
22           services, and other related fields, who provide a mix  
23           of different professionals, broad geographic represen-  
24           tation, and a balance between urban and rural rep-  
25           resentatives, including physicians and other health

1 professionals, employers, third party payors, individ-  
2 uals skilled in the conduct and interpretation of bio-  
3 medical, health services, and health economics re-  
4 search and expertise in outcomes and effectiveness  
5 research and technology assessment. Such member-  
6 ship shall also include representatives of consumers  
7 and the elderly.

8 “(3) CONSIDERATIONS IN INITIAL APPOINT-  
9 MENT.—To the extent possible, in first appointing  
10 members to the Commission shall consider appoint-  
11 ing individuals who (as of the date of the enactment  
12 of this section) were serving on the Prospective Pay-  
13 ment Assessment Commission or the Physician Pay-  
14 ment Review Commission.

15 “(4) TERMS.—

16 “(A) IN GENERAL.—The terms of mem-  
17 bers of the Commission shall be for 3 years ex-  
18 cept that the Comptroller General shall des-  
19 ignate staggered terms for the members first  
20 appointed.

21 “(B) VACANCIES.—Any member appointed  
22 to fill a vacancy occurring before the expiration  
23 of the term for which the member’s predecessor  
24 was appointed shall be appointed only for the  
25 remainder of that term. A member may serve

1 after the expiration of that member's term until  
2 a successor has taken office. A vacancy in the  
3 Commission shall be filled in the manner in  
4 which the original appointment was made.

5 “(5) COMPENSATION.—While serving on the  
6 business of the Commission (including traveltime), a  
7 member of the Commission shall be entitled to com-  
8 pensation at the per diem equivalent of the rate pro-  
9 vided for level IV of the Executive Schedule under  
10 section 5315 of title 5, United States Code; and  
11 while so serving away from home and member's reg-  
12 ular place of business, a member may be allowed  
13 travel expenses, as authorized by the Chairman of  
14 the Commission. Physicians serving as personnel of  
15 the Commission may be provided a physician com-  
16 parability allowance by the Commission in the same  
17 manner as Government physicians may be provided  
18 such an allowance by an agency under section 5948  
19 of title 5, United States Code, and for such purpose  
20 subsection (i) of such section shall apply to the Com-  
21 mission in the same manner as it applies to the Ten-  
22 nessee Valley Authority. For purposes of pay (other  
23 than pay of members of the Commission) and em-  
24 ployment benefits, rights, and privileges, all person-

1 nel of the Commission shall be treated as if they  
2 were employees of the United States Senate.

3 “(6) CHAIRMAN; VICE CHAIRMAN.—The Comp-  
4 troller General shall designate a member of the  
5 Commission, at the time of appointment of the mem-  
6 ber, as Chairman and a member as Vice Chairman  
7 for that term of appointment.

8 “(7) MEETINGS.—The Commission shall meet  
9 at the call of the Chairman. Section 10(a)(1) of the  
10 Federal Advisory Committee Act shall not apply to  
11 any portion of a Commission meeting if the Commis-  
12 sion, by majority vote, determines that such portion  
13 of such meeting should be closed.

14 “(d) DIRECTOR AND STAFF; EXPERTS AND CON-  
15 SULTANTS.—Subject to such review as the Comptroller  
16 General deems necessary to assure the efficient adminis-  
17 tration of the Commission, the Commission may—

18 “(1) employ and fix the compensation of an Ex-  
19 ecutive Director (subject to the approval of the  
20 Comptroller General) and such other personnel as  
21 may be necessary to carry out its duties (without re-  
22 gard to the provisions of title 5, United States Code,  
23 governing appointments in the competitive service);

1           “(2) seek such assistance and support as may  
2           be required in the performance of its duties from ap-  
3           propriate Federal departments and agencies;

4           “(3) enter into contracts or make other ar-  
5           rangements, as may be necessary for the conduct of  
6           the work of the Commission (without regard to sec-  
7           tion 3709 of the Revised Statutes (41 U.S.C. 5));

8           “(4) make advance, progress, and other pay-  
9           ments which relate to the work of the Commission;

10           “(5) provide transportation and subsistence for  
11           persons serving without compensation; and

12           “(6) prescribe such rules and regulations as it  
13           deems necessary with respect to the internal organi-  
14           zation and operation of the Commission.

15           “(e) POWERS.—

16           “(1) OBTAINING OFFICIAL DATA.—The Com-  
17           mission may secure directly from any department or  
18           agency of the United States information necessary  
19           to enable it to carry out this section. Upon request  
20           of the Chairman, the head of that department or  
21           agency shall furnish that information to the Com-  
22           mission on an agreed upon schedule.

23           “(2) DATA COLLECTION.—In order to carry out  
24           its functions, the Commission shall collect and as-  
25           sess information to—

1           “(A) utilize existing information, both pub-  
2           lished and unpublished, where possible, collected  
3           and assessed either by its own staff or under  
4           other arrangements made in accordance with  
5           this section,

6           “(B) carry out, or award grants or con-  
7           tracts for, original research and experimen-  
8           tation, where existing information is inad-  
9           equate, and

10           “(C) adopt procedures allowing any inter-  
11           ested party to submit information for the Com-  
12           mission’s use in making reports and rec-  
13           ommendations.

14           “(3) ACCESS OF GAO TO INFORMATION.—The  
15           Comptroller General shall have unrestricted access  
16           to all deliberations, records, and data of the Com-  
17           mission, immediately upon request.

18           “(4) PERIODIC AUDIT.—The Commission shall  
19           be subject to periodic audit by the General Account-  
20           ing Office.

21           “(f) AUTHORIZATION OF APPROPRIATIONS.—

22           “(1) REQUEST FOR APPROPRIATIONS.—The  
23           Commission shall submit requests for appropriations  
24           in the same manner as the Comptroller General sub-  
25           mits requests for appropriations, but amounts ap-

1       appropriated for the Commission shall be separate  
2       from amounts appropriated for the Comptroller Gen-  
3       eral.

4               “(2) AUTHORIZATION.—There are authorized to  
5       be appropriated such sums as may be necessary to  
6       carry out the provisions of this section. 60 percent  
7       of such appropriation shall be payable from the Fed-  
8       eral Hospital Insurance Trust Fund, and 40 percent  
9       of such appropriation shall be payable from the Fed-  
10      eral Supplementary Medical Insurance Trust  
11      Fund.”.

12      (b) ABOLITION OF PROPAC AND PPRC.—

13              (1) PROPAC.—

14                      (A) IN GENERAL.—Section 1886(e) (42  
15              U.S.C. 1395ww(e)) is amended—

16                              (i) by striking paragraphs (2) and (6);

17                              and

18                              (ii) in paragraph (3), by striking “(A)  
19              The Commission” and all that follows  
20              through “(B)”.

21                      (B) CONFORMING AMENDMENT.—Section  
22              1862 (42 U.S.C. 1395y) is amended by striking  
23              “Prospective Payment Assessment Commis-  
24              sion” each place it appears in subsection

1 (a)(1)(D) and subsection (i) and inserting  
2 “Medicare Payment Review Commission”.

3 (2) PPRC.—

4 (A) IN GENERAL.—Title XVIII is amended  
5 by striking section 1845 (42 U.S.C. 1395w-1).

6 (B) CONFORMING AMENDMENTS.—

7 (i) Section 1834(b)(2) (42 U.S.C.  
8 1395m(b)(2)) is amended by striking  
9 “Physician Payment Review Commission”  
10 and inserting “Medicare Payment Review  
11 Commission”.

12 (ii) Section 1842(b) (42 U.S.C.  
13 1395u(b)) is amended by striking “Physi-  
14 cian Payment Review Commission” each  
15 place it appears in paragraphs (2)(C),  
16 (9)(D), and (14)(C)(i) and inserting “Med-  
17 icare Payment Review Commission”.

18 (iii) Section 1848 (42 U.S.C. 1395w-  
19 4) is amended by striking “Physician Pay-  
20 ment Review Commission” and inserting  
21 “Medicare Payment Review Commission”  
22 each place it appears in paragraph  
23 (2)(A)(ii), (2)(B)(iii), and (5) of subsection  
24 (c), subsection (d)(2)(F), paragraphs  
25 (1)(B), (3), and (4)(A) of subsection (f),

1                   and paragraphs (6)(C) and (7)(C) of sub-  
2                   section (g).

3           (c) EFFECTIVE DATE; TRANSITION.—

4                   (1) IN GENERAL.—The Comptroller General  
5                   shall first provide for appointment of members to  
6                   the Medicare Payment Review Commission (in this  
7                   subsection referred to as “MPRC”) by not later  
8                   than March 31, 1996.

9                   (2) TRANSITION.—Effective on a date (not later  
10                   than 30 days after the date a majority of members  
11                   of the MPRC have first been appointed, the Pro-  
12                   spective Payment Assessment Commission (in this  
13                   subsection referred to as “ProPAC”) and the Physi-  
14                   cian Payment Review Commission (in this subsection  
15                   referred to as “PPRC”), and amendments made by  
16                   subsection (b), are terminated. The Comptroller  
17                   General, to the maximum extent feasible, shall pro-  
18                   vide for the transfer to the MPRC of assets and  
19                   staff of ProPAC and PPRC, without any loss of  
20                   benefits or seniority by virtue of such transfers.  
21                   Fund balances available to the ProPAC or PPRC  
22                   for any period shall be available to the MPRC for  
23                   such period for like purposes.

24                   (3) CONTINUING RESPONSIBILITY FOR RE-  
25                   PORTS.—The MPRC shall be responsible for the

1 preparation and submission of reports required by  
2 law to be submitted (and which have not been sub-  
3 mitted by the date of establishment of the MPRC)  
4 by the ProPAC and PPRC, and, for this purpose,  
5 any reference in law to either such Commission is  
6 deemed, after the appointment of the MPRC to refer  
7 to the MPRC.

8 **SEC. 15032. COMMISSION ON THE EFFECT OF THE BABY**  
9 **BOOM GENERATION ON THE MEDICARE PRO-**  
10 **GRAM.**

11 (a) ESTABLISHMENT.—There is established a com-  
12 mission to be known as the Commission on the Effect of  
13 the Baby Boom Generation on the Medicare Program (in  
14 this section referred to as the “Commission”).

15 (b) DUTIES.—

16 (1) IN GENERAL.—The Commission shall—

17 (A) examine the financial impact on the  
18 medicare program of the significant increase in  
19 the number of medicare eligible individuals  
20 which will occur beginning approximately dur-  
21 ing 2010 and lasting for approximately 25  
22 years, and

23 (B) make specific recommendations to the  
24 Congress respecting a comprehensive approach  
25 to preserve the medicare program for the period

1           during which such individuals are eligible for  
2           medicare.

3           (2) CONSIDERATIONS IN MAKING REC-  
4           COMMENDATIONS.—In making its recommendations,  
5           the Commission shall consider the following:

6                   (A) The amount and sources of Federal  
7                   funds to finance the medicare program, includ-  
8                   ing the potential use of innovative financing  
9                   methods.

10                   (B) The most efficient and effective man-  
11                   ner of administering the program, including the  
12                   appropriateness of continuing the application of  
13                   the failsafe budget mechanism under section  
14                   1895 of the Social Security Act for fiscal years  
15                   after fiscal year 2002 and the appropriate long-  
16                   term growth rates for contributions electing  
17                   coverage under MedicarePlus under part C of  
18                   title XVIII of such Act.

19                   (C) Methods used by other nations to re-  
20                   spond to comparable demographic patterns in  
21                   eligibility for health care benefits for elderly  
22                   and disabled individuals.

23                   (D) Modifying age-based eligibility to cor-  
24                   respond to changes in age-based eligibility  
25                   under the OASDI program.

1           (E) Trends in employment-related health  
2           care for retirees, including the use of medical  
3           savings accounts and similar financing devices.

4           (c) MEMBERSHIP.—

5           (1) APPOINTMENT.—The Commission shall be  
6           composed of 15 members appointed as follows:

7           (A) The President shall appoint 3 mem-  
8           bers.

9           (B) The Majority Leader of the Senate  
10          shall appoint, after consultation with the minor-  
11          ity leader of the Senate, 6 members, of whom  
12          not more than 4 may be of the same political  
13          party.

14          (C) The Speaker of the House of Rep-  
15          resentatives shall appoint, after consultation  
16          with the minority leader of the House of Rep-  
17          resentatives, 6 members, of whom not more  
18          than 4 may be of the same political party.

19          (2) CHAIRMAN AND VICE CHAIRMAN.—The  
20          Commission shall elect a Chairman and Vice Chair-  
21          man from among its members.

22          (3) VACANCIES.—Any vacancy in the member-  
23          ship of the Commission shall be filled in the manner  
24          in which the original appointment was made and

1 shall not affect the power of the remaining members  
2 to execute the duties of the Commission.

3 (4) QUORUM.—A quorum shall consist of 8  
4 members of the Commission, except that 4 members  
5 may conduct a hearing under subsection (e).

6 (5) MEETINGS.—The Commission shall meet at  
7 the call of its Chairman or a majority of its mem-  
8 bers.

9 (6) COMPENSATION AND REIMBURSEMENT OF  
10 EXPENSES.—Members of the Commission are not  
11 entitled to receive compensation for service on the  
12 Commission. Members may be reimbursed for travel,  
13 subsistence, and other necessary expenses incurred  
14 in carrying out the duties of the Commission.

15 (d) STAFF AND CONSULTANTS.—

16 (1) STAFF.—The Commission may appoint and  
17 determine the compensation of such staff as may be  
18 necessary to carry out the duties of the Commission.  
19 Such appointments and compensation may be made  
20 without regard to the provisions of title 5, United  
21 States Code, that govern appointments in the com-  
22 petitive services, and the provisions of chapter 51  
23 and subchapter III of chapter 53 of such title that  
24 relate to classifications and the General Schedule  
25 pay rates.

1           (2) CONSULTANTS.—The Commission may pro-  
2           cure such temporary and intermittent services of  
3           consultants under section 3109(b) of title 5, United  
4           States Code, as the Commission determines to be  
5           necessary to carry out the duties of the Commission.

6           (e) POWERS.—

7           (1) HEARINGS AND OTHER ACTIVITIES.—For  
8           the purpose of carrying out its duties, the Commis-  
9           sion may hold such hearings and undertake such  
10          other activities as the Commission determines to be  
11          necessary to carry out its duties.

12          (2) STUDIES BY GAO.—Upon the request of the  
13          Commission, the Comptroller General shall conduct  
14          such studies or investigations as the Commission de-  
15          termines to be necessary to carry out its duties.

16          (3) COST ESTIMATES BY CONGRESSIONAL  
17          BUDGET OFFICE.—

18                 (A) Upon the request of the Commission,  
19                 the Director of the Congressional Budget Office  
20                 shall provide to the Commission such cost esti-  
21                 mates as the Commission determines to be nec-  
22                 essary to carry out its duties.

23                 (B) The Commission shall reimburse the  
24                 Director of the Congressional Budget Office for  
25                 expenses relating to the employment in the of-

1           fice of the Director of such additional staff as  
2           may be necessary for the Director to comply  
3           with requests by the Commission under sub-  
4           paragraph (A).

5           (4) DETAIL OF FEDERAL EMPLOYEES.—Upon  
6           the request of the Commission, the head of any Fed-  
7           eral agency is authorized to detail, without reim-  
8           bursement, any of the personnel of such agency to  
9           the Commission to assist the Commission in carry-  
10          ing out its duties. Any such detail shall not interrupt  
11          or otherwise affect the civil service status or privi-  
12          leges of the Federal employee.

13          (5) TECHNICAL ASSISTANCE.—Upon the re-  
14          quest of the Commission, the head of a Federal  
15          agency shall provide such technical assistance to the  
16          Commission as the Commission determines to be  
17          necessary to carry out its duties.

18          (6) USE OF MAILS.—The Commission may use  
19          the United States mails in the same manner and  
20          under the same conditions as Federal agencies and  
21          shall, for purposes of the frank, be considered a  
22          commission of Congress as described in section 3215  
23          of title 39, United States Code.

24          (7) OBTAINING INFORMATION.—The Commis-  
25          sion may secure directly from any Federal agency

1 information necessary to enable it to carry out its  
2 duties, if the information may be disclosed under  
3 section 552 of title 5, United States Code. Upon re-  
4 quest of the Chairman of the Commission, the head  
5 of such agency shall furnish such information to the  
6 Commission.

7 (8) ADMINISTRATIVE SUPPORT SERVICES.—  
8 Upon the request of the Commission, the Adminis-  
9 trator of General Services shall provide to the Com-  
10 mission on a reimbursable basis such administrative  
11 support services as the Commission may request.

12 (9) ACCEPTANCE OF DONATIONS.—The Com-  
13 mission may accept, use, and dispose of gifts or do-  
14 nations of services or property.

15 (10) PRINTING.—For purposes of costs relating  
16 to printing and binding, including the cost of per-  
17 sonnel detailed from the Government Printing Of-  
18 fice, the Commission shall be deemed to be a com-  
19 mittee of the Congress.

20 (f) REPORT.—Not later than May 1, 1997, the Com-  
21 mission shall submit to Congress a report containing its  
22 findings and recommendations regarding how to protect  
23 and preserve the medicare program in a financially solvent  
24 manner until 2030 (or, if later, throughout the period of  
25 projected solvency of the Federal Old-Age and Survivors

1 Insurance Trust Fund). The report shall include detailed  
2 recommendations for appropriate legislative initiatives re-  
3 specting how to accomplish this objective.

4 (g) TERMINATION.—The Commission shall terminate  
5 60 days after the date of submission of the report required  
6 in subsection (f).

7 (h) AUTHORIZATION OF APPROPRIATIONS.—There  
8 are authorized to be appropriated \$1,500,000 to carry out  
9 this section. Amounts appropriated to carry out this sec-  
10 tion shall remain available until expended.

11 **SEC. 15033. CHANGE IN APPOINTMENT OF ADMINISTRATOR**  
12 **OF HCFA.**

13 (a) IN GENERAL.—Section 1117 (42 U.S.C. 1317)  
14 is amended by striking “President by and with the advice  
15 and consent of the Senate” and inserting “Secretary of  
16 Health and Human Services”.

17 (b) EFFECTIVE DATE.—The amendment made by  
18 subsection (a) shall take effect on the date of the enact-  
19 ment of this Act and shall apply to Administrators ap-  
20 pointed on or after the date of the enactment of this Act.

1     **Subtitle B—Preventing Fraud and**  
2                                     **Abuse**

3     **SEC. 15101. INCREASING AWARENESS OF FRAUD AND**  
4                                     **ABUSE.**

5             (a) **BENEFICIARY OUTREACH EFFORTS.**—The Sec-  
6     retary of Health and Human Services (acting through the  
7     Administrator of the Health Care Financing Administra-  
8     tion and the Inspector General of the Department of  
9     Health and Human Services) shall make ongoing efforts  
10    (through public service announcements, publications, and  
11    other appropriate methods) to alert individuals entitled to  
12    benefits under the medicare program of the existence of  
13    fraud and abuse committed against the program and the  
14    costs to the program of such fraud and abuse, and of the  
15    existence of the toll-free telephone line operated by the  
16    Secretary to receive information on fraud and abuse com-  
17    mitted against the program.

18            (b) **CLARIFICATION OF REQUIREMENT TO PROVIDE**  
19    **EXPLANATION OF MEDICARE BENEFITS.**—The Secretary  
20    shall provide an explanation of benefits under the medi-  
21    care program with respect to each item or service for  
22    which payment may be made under the program which  
23    is furnished to an individual, without regard to whether  
24    or not a deductible or coinsurance may be imposed against  
25    the individual with respect to the item or service.

1 (c) PROVIDER OUTREACH EFFORTS; PUBLICATION  
2 OF FRAUD ALERTS.—

3 (1) SPECIAL FRAUD ALERTS.—

4 (A) IN GENERAL.—

5 (i) REQUEST FOR SPECIAL FRAUD  
6 ALERTS.—Any person may present, at any  
7 time, a request to the Secretary to issue  
8 and publish a special fraud alert.

9 (ii) SPECIAL FRAUD ALERT DE-  
10 FINED.—In this section, a “special fraud  
11 alert” is a notice which informs the public  
12 of practices which the Secretary considers  
13 to be suspect or of particular concern  
14 under the medicare program or a State  
15 health care program (as defined in section  
16 1128(h) of the Social Security Act).

17 (B) ISSUANCE AND PUBLICATION OF SPE-  
18 CIAL FRAUD ALERTS.—

19 (i) INVESTIGATION.—Upon receipt of  
20 a request for a special fraud alert under  
21 subparagraph (A), the Secretary shall in-  
22 vestigate the subject matter of the request  
23 to determine whether a special fraud alert  
24 should be issued. If appropriate, the Sec-  
25 retary (in consultation with the Attorney

1 General) shall issue a special fraud alert in  
2 response to the request. All special fraud  
3 alerts issued pursuant to this subpara-  
4 graph shall be published in the Federal  
5 Register.

6 (ii) CRITERIA FOR ISSUANCE.—In de-  
7 termining whether to issue a special fraud  
8 alert upon a request under subparagraph  
9 (A), the Secretary may consider—

10 (I) whether and to what extent  
11 the practices that would be identified  
12 in the special fraud alert may result  
13 in any of the consequences described  
14 in 15214(b); and

15 (II) the extent and frequency of  
16 the conduct that would be identified  
17 in the special fraud alert.

18 (2) PUBLICATION OF ALL HCFA FRAUD ALERTS  
19 IN FEDERAL REGISTER.—Each notice issued by the  
20 Health Care Financing Administration which in-  
21 forms the public of practices which the Secretary  
22 considers to be suspect or of particular concern  
23 under the medicare program or a State health care  
24 program (as defined in section 1128(h) of the Social  
25 Security Act) shall be published in the Federal Reg-

1       ister, without regard to whether or not the notice is  
2       issued by a regional office of the Health Care Fi-  
3       nancing Administration.

4       **SEC. 15102. BENEFICIARY INCENTIVE PROGRAMS.**

5       (a) PROGRAM TO COLLECT INFORMATION ON FRAUD  
6       AND ABUSE.—

7               (1) ESTABLISHMENT OF PROGRAM.—Not later  
8       than 3 months after the date of the enactment of  
9       this Act, the Secretary shall establish a program  
10       under which the Secretary shall encourage individ-  
11       uals to report to the Secretary information on indi-  
12       viduals and entities who are engaging or who have  
13       engaged in acts or omissions which constitute  
14       grounds for the imposition of a sanction under sec-  
15       tion 1128, section 1128A, or section 1128B of the  
16       Social Security Act, or who have otherwise engaged  
17       in fraud and abuse against the medicare program.

18               (2) PAYMENT OF PORTION OF AMOUNTS COL-  
19       LECTED.—If an individual reports information to  
20       the Secretary under the program established under  
21       paragraph (1) which serves as the basis for the col-  
22       lection by the Secretary or the Attorney General of  
23       any amount of at least \$100 (other than any  
24       amount paid as a penalty under section 1128B of  
25       the Social Security Act), the Secretary may pay a

1 portion of the amount collected to the individual  
2 (under procedures similar to those applicable under  
3 section 7623 of the Internal Revenue Code of 1986  
4 to payments to individuals providing information on  
5 violations of such Code).

6 (b) PROGRAM TO COLLECT INFORMATION ON PRO-  
7 GRAM EFFICIENCY.—

8 (1) ESTABLISHMENT OF PROGRAM.—Not later  
9 than 3 months after the date of the enactment of  
10 this Act, the Secretary shall establish a program  
11 under which the Secretary shall encourage individ-  
12 uals to submit to the Secretary suggestions on meth-  
13 ods to improve the efficiency of the medicare pro-  
14 gram.

15 (2) PAYMENT OF PORTION OF PROGRAM SAV-  
16 INGS.—If an individual submits a suggestion to the  
17 Secretary under the program established under  
18 paragraph (1) which is adopted by the Secretary and  
19 which results in savings to the program, the Sec-  
20 retary may make a payment to the individual of  
21 such amount as the Secretary considers appropriate.

22 **SEC. 15103. INTERMEDIATE SANCTIONS FOR MEDICARE**  
23 **HEALTH MAINTENANCE ORGANIZATIONS.**

24 (a) APPLICATION OF INTERMEDIATE SANCTIONS FOR  
25 ANY PROGRAM VIOLATIONS.—

1           (1) IN GENERAL.—Section 1876(i)(1) (42  
2 U.S.C. 1395mm(i)(1)) is amended by striking “the  
3 Secretary may terminate” and all that follows and  
4 inserting the following: “in accordance with proce-  
5 dures established under paragraph (9), the Secretary  
6 may at any time terminate any such contract or may  
7 impose the intermediate sanctions described in para-  
8 graph (6)(B) or (6)(C) (whichever is applicable) on  
9 the eligible organization if the Secretary determines  
10 that the organization—

11           “(A) has failed substantially to carry out the  
12 contract;

13           “(B) is carrying out the contract in a manner  
14 inconsistent with the efficient and effective adminis-  
15 tration of this section;

16           “(C) is operating in a manner that is not in the  
17 best interests of the individuals covered under the  
18 contract; or

19           “(D) no longer substantially meets the applica-  
20 ble conditions of subsections (b), (c), (e), and (f).”.

21           (2) OTHER INTERMEDIATE SANCTIONS FOR  
22 MISCELLANEOUS PROGRAM VIOLATIONS.—Section  
23 1876(i)(6) (42 U.S.C. 1395mm(i)(6)) is amended by  
24 adding at the end the following new subparagraph:

1 “(C) In the case of an eligible organization for which  
2 the Secretary makes a determination under paragraph (1)  
3 the basis of which is not described in subparagraph (A),  
4 the Secretary may apply the following intermediate sanc-  
5 tions:

6 “(i) civil money penalties of not more than  
7 \$25,000 for each determination under paragraph (1)  
8 if the deficiency that is the basis of the determina-  
9 tion has directly adversely affected (or has the sub-  
10 stantial likelihood of adversely affecting) an individ-  
11 ual covered under the organization’s contract;

12 “(ii) civil money penalties of not more than  
13 \$10,000 for each week beginning after the initiation  
14 of procedures by the Secretary under paragraph (9)  
15 during which the deficiency that is the basis of a de-  
16 termination under paragraph (1) exists; and

17 “(iii) suspension of enrollment of individuals  
18 under this section after the date the Secretary noti-  
19 fies the organization of a determination under para-  
20 graph (1) and until the Secretary is satisfied that  
21 the deficiency that is the basis for the determination  
22 has been corrected and is not likely to recur.”.

23 (3) PROCEDURES FOR IMPOSING SANCTIONS.—  
24 Section 1876(i) (42 U.S.C. 1395mm(i)) is amended  
25 by adding at the end the following new paragraph:

1       “(9) The Secretary may terminate a contract with an  
2 eligible organization under this section or may impose the  
3 intermediate sanctions described in paragraph (6) on the  
4 organization in accordance with formal investigation and  
5 compliance procedures established by the Secretary under  
6 which—

7               “(A) the Secretary provides the organization  
8 with the opportunity to develop and implement a  
9 corrective action plan to correct the deficiencies that  
10 were the basis of the Secretary’s determination  
11 under paragraph (1);

12               “(B) the Secretary shall impose more severe  
13 sanctions on organizations that have a history of de-  
14 ficiencies or that have not taken steps to correct de-  
15 ficiencies the Secretary has brought to their atten-  
16 tion;

17               “(C) there are no unreasonable or unnecessary  
18 delays between the finding of a deficiency and the  
19 imposition of sanctions; and

20               “(D) the Secretary provides the organization  
21 with reasonable notice and opportunity for hearing  
22 (including the right to appeal an initial decision) be-  
23 fore imposing any sanction or terminating the con-  
24 tract.”.

1           (4) CONFORMING AMENDMENTS.—(A) Section  
2           1876(i)(6)(B) (42 U.S.C. 1395mm(i)(6)(B)) is  
3           amended by striking the second sentence.

4           (B) Section 1876(i)(6) (42 U.S.C.  
5           1395mm(i)(6)) is further amended by adding at the  
6           end the following new subparagraph:

7           “(D) The provisions of section 1128A (other than  
8           subsections (a) and (b)) shall apply to a civil money pen-  
9           alty under subparagraph (A) or (B) in the same manner  
10          as they apply to a civil money penalty or proceeding under  
11          section 1128A(a).”.

12          (b) EFFECTIVE DATE.—The amendments made by  
13          this section shall apply with respect to contract years be-  
14          ginning on or after January 1, 1996.

15          **SEC. 15104. VOLUNTARY DISCLOSURE PROGRAM.**

16          Title XI (42 U.S.C. 1301 et seq.) is amended by in-  
17          serting after section 1128B the following new section:

18          “VOLUNTARY DISCLOSURE OF ACTS OR OMISSIONS  
19          “SEC. 1129. (a) ESTABLISHMENT OF VOLUNTARY  
20          DISCLOSURE PROGRAM.—Not later than 3 months after  
21          the date of the enactment of this section, the Secretary  
22          shall establish a program to encourage individuals and en-  
23          tities to voluntarily disclose to the Secretary information  
24          on acts or omissions of the individual or entity which con-  
25          stitute grounds for the imposition of a sanction described  
26          in section 1128, 1128A, or 1128B.

1       “(b) EFFECT OF VOLUNTARY DISCLOSURE.—If an  
2 individual or entity voluntarily discloses information with  
3 respect to an act or omission to the Secretary under sub-  
4 section (a), the following rules shall apply:

5           “(1) The Secretary may waive, reduce, or other-  
6 wise mitigate any sanction which would otherwise be  
7 applicable to the individual or entity under section  
8 1128, 1128A, or 1128B as a result of the act or  
9 omission involved.

10          “(2) No qui tam action may be brought pursu-  
11 ant to chapter 37 of title 31, United States Code,  
12 against the individual or entity with respect to the  
13 act or omission involved.”.

14 **SEC. 15105. REVISIONS TO CURRENT SANCTIONS.**

15       (a) DOUBLING THE AMOUNT OF CIVIL MONETARY  
16 PENALTIES.—The maximum amount of civil monetary  
17 penalties specified in section 1128A of the Social Security  
18 Act or under title XVIII of such Act (as in effect on the  
19 day before the date of the enactment of this Act) shall,  
20 effective for violations occurring after the date of the en-  
21 actment of this Act, be double the amount otherwise pro-  
22 vided as of such date.

23       (b) ESTABLISHMENT OF MINIMUM PERIOD OF EX-  
24 CLUSION FOR CERTAIN INDIVIDUALS AND ENTITIES SUB-  
25 JECT TO PERMISSIVE EXCLUSION.—Section 1128(c)(3)

1 (42 U.S.C. 1320a-7(c)(3)) is amended by adding at the  
2 end the following new subparagraphs:

3 “(D) In the case of an exclusion of an individual or  
4 entity under paragraph (1), (2), or (3) of subsection (b),  
5 the period of the exclusion shall be 3 years, unless the  
6 Secretary determines in accordance with published regula-  
7 tions that a shorter period is appropriate because of miti-  
8 gating circumstances or that a longer period is appro-  
9 priate because of aggravating circumstances.

10 “(E) In the case of an exclusion of an individual or  
11 entity under subsection (b)(4) or (b)(5), the period of the  
12 exclusion shall not be less than the period during which  
13 the individual’s or entity’s license to provide health care  
14 is revoked, suspended, or surrendered, or the individual  
15 or the entity is excluded or suspended from a Federal or  
16 State health care program.

17 “(F) In the case of an exclusion of an individual or  
18 entity under subsection (b)(6)(B), the period of the exclu-  
19 sion shall be not less than 1 year.”.

20 (c) EFFECTIVE DATE.—The amendments made by  
21 this section shall apply with respect to acts or omissions  
22 occurring on or after January 1, 1996.

1 **SEC. 15106. CONSOLIDATED FUNDING FOR ANTI-FRAUD**  
2 **AND ABUSE ACTIVITIES UNDER MEDICARE**  
3 **INTEGRITY PROGRAM.**

4 (a) ESTABLISHMENT OF MEDICARE INTEGRITY PRO-  
5 GRAM.—Title XVIII is amended by adding at the end the  
6 following new section:

7 “MEDICARE INTEGRITY PROGRAM

8 “SEC. 1893. (a) ESTABLISHMENT OF PROGRAM.—  
9 There is hereby established the Medicare Integrity Pro-  
10 gram (hereafter in this section referred to as the ‘Pro-  
11 gram’) under which the Secretary shall promote the integ-  
12 rity of the medicare program by entering into contracts  
13 in accordance with this section with eligible private entities  
14 to carry out the activities described in subsection (b).

15 “(b) ACTIVITIES DESCRIBED.—The activities de-  
16 scribed in this subsection are as follows:

17 “(1) Review of activities of providers of services  
18 or other individuals and entities furnishing items  
19 and services for which payment may be made under  
20 this title (including skilled nursing facilities and  
21 home health agencies), including medical and utiliza-  
22 tion review and fraud review (employing similar  
23 standards, processes, and technologies used by pri-  
24 vate health plans, including equipment and software  
25 technologies which surpass the capability of the  
26 equipment and technologies used in the review of

1 claims under this title as of the date of the enact-  
2 ment of this section).

3 “(2) Audit of cost reports.

4 “(3) Determinations as to whether payment  
5 should not be, or should not have been, made under  
6 this title by reason of section 1862(b), and recovery  
7 of payments that should not have been made.

8 “(4) Education of providers of services, bene-  
9 ficiaries, and other persons with respect to payment  
10 integrity and benefit quality assurance issues.

11 “(c) ELIGIBILITY OF ENTITIES.—An entity is eligible  
12 to enter into a contract under the Program to carry out  
13 any of the activities described in subsection (b) if—

14 “(1) the entity has demonstrated capability to  
15 carry out such activities;

16 “(2) in carrying out such activities, the entity  
17 agrees to cooperate with the Inspector General of  
18 the Department of Health and Human Services, the  
19 Attorney General of the United States, and other  
20 law enforcement agencies, as appropriate, in the in-  
21 vestigation and deterrence of fraud and abuse in re-  
22 lation to this title and in other cases arising out of  
23 such activities;

24 “(3) the entity’s financial holdings, interests, or  
25 relationships will not interfere with its ability to per-

1 form the functions to be required by the contract in  
2 an effective and impartial manner; and

3 “(4) the entity meets such other requirements  
4 as the Secretary may impose.

5 “(d) PROCESS FOR ENTERING INTO CONTRACTS.—  
6 The Secretary shall enter into contracts under the Pro-  
7 gram in accordance with such procedures as the Secretary  
8 may by regulation establish, except that such procedures  
9 shall include the following:

10 “(1) The Secretary shall determine the appro-  
11 priate number of separate contracts which are nec-  
12 essary to carry out the Program and the appropriate  
13 times at which the Secretary shall enter into such  
14 contracts.

15 “(2) The provisions of section 1153(e)(1) shall  
16 apply to contracts and contracting authority under  
17 this section, except that competitive procedures must  
18 be used when entering into new contracts under this  
19 section, or at any other time considered appropriate  
20 by the Secretary.

21 “(3) A contract under this section may be re-  
22 newed without regard to any provision of law requir-  
23 ing competition if the contractor has met or ex-  
24 ceeded the performance requirements established in  
25 the current contract.

1       “(e) LIMITATION ON CONTRACTOR LIABILITY.—The  
2 Secretary shall by regulation provide for the limitation of  
3 a contractor’s liability for actions taken to carry out a con-  
4 tract under the Program, and such regulation shall, to the  
5 extent the Secretary finds appropriate, employ the same  
6 or comparable standards and other substantive and proce-  
7 dural provisions as are contained in section 1157.

8       “(f) TRANSFER OF AMOUNTS TO MEDICARE ANTI-  
9 FRAUD AND ABUSE TRUST FUND.—For each fiscal year,  
10 the Secretary shall transfer from the Federal Hospital In-  
11 surance Trust Fund and the Federal Supplementary Med-  
12 ical Insurance Trust Fund to the Medicare Anti-Fraud  
13 and Abuse Trust Fund under subsection (g) such amounts  
14 as are necessary to carry out the activities described in  
15 subsection (b). Such transfer shall be in an allocation as  
16 reasonably reflects the proportion of such expenditures as-  
17 sociated with part A and part B.

18       “(g) MEDICARE ANTI-FRAUD AND ABUSE TRUST  
19 FUND.—

20               “(1) ESTABLISHMENT.—

21                       “(A) IN GENERAL.—There is hereby estab-  
22 lished in the Treasury of the United States the  
23 Anti-Fraud and Abuse Trust Fund (hereafter  
24 in this subsection referred to as the ‘Trust  
25 Fund’). The Trust Fund shall consist of such

1 gifts and bequests as may be made as provided  
2 in subparagraph (B) and such amounts as may  
3 be deposited in the Trust Fund as provided in  
4 subsection (f), paragraph (3), and title XI.

5 “(B) AUTHORIZATION TO ACCEPT GIFTS  
6 AND BEQUESTS.—The Trust Fund is author-  
7 ized to accept on behalf of the United States  
8 money gifts and bequests made unconditionally  
9 to the Trust Fund, for the benefit of the Trust  
10 Fund or any activity financed through the  
11 Trust Fund.

12 “(2) INVESTMENT.—

13 “(A) IN GENERAL.—The Secretary of the  
14 Treasury shall invest such amounts of the Fund  
15 as such Secretary determines are not required  
16 to meet current withdrawals from the Fund in  
17 government account serial securities.

18 “(B) USE OF INCOME.—Any interest de-  
19 rived from investments under subparagraph (A)  
20 shall be credited to the Fund.

21 “(3) AMOUNTS DEPOSITED INTO TRUST  
22 FUND.—In addition to amounts transferred under  
23 subsection (f), there shall be deposited in the Trust  
24 Fund—

1           “(A) that portion of amounts recovered in  
2 relation to section 1128A arising out of a claim  
3 under title XVIII as remains after application  
4 of subsection (f)(2) (relating to repayment of  
5 the Federal Hospital Insurance Trust Fund or  
6 the Federal Supplementary Medical Insurance  
7 Trust Fund) of that section, as may be applica-  
8 ble,

9           “(B) fines imposed under section 1128B  
10 arising out of a claim under this title, and

11           “(C) penalties and damages imposed (other  
12 than funds awarded to a relator or for restitu-  
13 tion) under sections 3729 through 3732 of title  
14 31, United States Code (pertaining to false  
15 claims) in cases involving claims relating to pro-  
16 grams under title XVIII or XIX.

17           “(4) DIRECT APPROPRIATION OF FUNDS TO  
18 CARRY OUT PROGRAM.—

19           “(A) IN GENERAL.—There are appro-  
20 priated from the Trust Fund for each fiscal  
21 year such amounts as are necessary to carry  
22 out the Medicare Integrity Program under this  
23 section, subject to subparagraph (B).

1           “(B) AMOUNTS SPECIFIED.—The amount  
2 appropriated under subparagraph (A) for a fis-  
3 cal year is as follows:

4           “(i) For fiscal year 1996, such  
5 amount shall be not less than  
6 \$430,000,000 and not more than  
7 \$440,000,000.

8           “(ii) For fiscal year 1997, such  
9 amount shall be not less than  
10 \$490,000,000 and not more than  
11 \$500,000,000.

12           “(iii) For fiscal year 1998, such  
13 amount shall be not less than  
14 \$550,000,000 and not more than  
15 \$560,000,000.

16           “(iv) For fiscal year 1999, such  
17 amount shall be not less than  
18 \$620,000,000 and not more than  
19 \$630,000,000.

20           “(v) For fiscal year 2000, such  
21 amount shall be not less than  
22 \$670,000,000 and not more than  
23 \$680,000,000.

24           “(vi) For fiscal year 2001, such  
25 amount shall be not less than

1           \$690,000,000 and not more than  
2           \$700,000,000.

3           “(vii) For fiscal year 2002, such  
4           amount shall be not less than  
5           \$710,000,000 and not more than  
6           \$720,000,000.

7           “(5) ANNUAL REPORT.—The Secretary shall  
8           submit an annual report to Congress on the amount  
9           of revenue which is generated and disbursed by the  
10          Trust Fund in each fiscal year.”.

11          (b) ELIMINATION OF FI AND CARRIER RESPONSIBIL-  
12          ITY FOR CARRYING OUT ACTIVITIES SUBJECT TO PRO-  
13          GRAM.—

14               (1)       RESPONSIBILITIES       OF       FISCAL  
15               INTERMEDIARIES UNDER PART A.—Section 1816  
16               (42 U.S.C. 1395h) is amended by adding at the end  
17               the following new subsection:

18               “(l) No agency or organization may carry out (or re-  
19               ceive payment for carrying out) any activity pursuant to  
20               an agreement under this section to the extent that the ac-  
21               tivity is carried out pursuant to a contract under the Med-  
22               icare Integrity Program under section 1893.”.

23               (2)       RESPONSIBILITIES OF CARRIERS UNDER  
24               PART B.—Section 1842(c) (42 U.S.C. 1395u(c)) is

1 amended by adding at the end the following new  
2 paragraph:

3 “(6) No carrier may carry out (or receive payment  
4 for carrying out) any activity pursuant to a contract under  
5 this subsection to the extent that the activity is carried  
6 out pursuant to a contract under the Medicare Integrity  
7 Program under section 1893.”.

8 (c) CONFORMING AMENDMENT.—Section  
9 1128A(f)(3) (42 U.S.C. 1320a-7a(f)(3)) is amended by  
10 striking “as miscellaneous receipts of the Treasury of the  
11 United States” and inserting “in the Anti-Fraud and  
12 Abuse Trust Fund established under section 1145”.

13 **SEC. 15107. PERMITTING CARRIERS TO CARRY OUT PRIOR**  
14 **AUTHORIZATION FOR CERTAIN ITEMS OF DU-**  
15 **RABLE MEDICAL EQUIPMENT.**

16 (a) IN GENERAL.—Section 1834(a)(15) (42 U.S.C.  
17 1395m(a)(15)), as amended by section 135(b) of the So-  
18 cial Security Act Amendments of 1994, is amended by  
19 adding at the end the following new subparagraphs:

20 “(D) APPLICATION BY CARRIERS.—A car-  
21 rier may develop (and periodically update) a list  
22 of items under subparagraph (A) and a list of  
23 suppliers under subparagraph (B) in the same  
24 manner as the Secretary may develop (and peri-  
25 odically update) such lists.

1           “(E) WAIVER OF PUBLICATION REQUIRE-  
2           MENT.—A carrier may make an advance deter-  
3           mination under subparagraph (C) with respect  
4           to an item or supplier on a list developed by the  
5           Secretary or the carrier without regard to  
6           whether or not the Secretary has promulgated  
7           a regulation with respect to the list, except that  
8           the carrier may not make such an advance de-  
9           termination with respect to an item or supplier  
10          on a list until the expiration of the 30-day pe-  
11          riod beginning on the date the Secretary or the  
12          carrier places the item or supplier on the list.”.

13          (b) EFFECTIVE DATE.—The amendment made by  
14          subsection (a) shall take effect as if included in the enact-  
15          ment of the Social Security Act Amendments of 1994.

16          **SEC. 15108. ESTABLISHMENT OF HEALTH CARE ANTI-**  
17          **FRAUD TASK FORCE.**

18          (a) IN GENERAL.—Not later than 120 days after the  
19          date of the enactment of this Act, the Attorney General  
20          shall establish (in consultation with the Advisory Group  
21          described in subsection (c)) within the Department of Jus-  
22          tice a task force (similar to the Organized Crime Drug  
23          Enforcement Task Force) to be known as the “Health  
24          Care Anti-Fraud Task Force” (hereafter in this section  
25          referred to as the “Task Force”) to prosecute health care

1 fraud offenses. Nothing in this section may be construed  
2 as affecting the powers of the Attorney General or any  
3 other individual.

4 (b) OPERATIONS OF TASK FORCE.—The Attorney  
5 General shall establish and operate the Task Force in a  
6 manner such that—

7 (1) at least one fully staffed operational seg-  
8 ment of the Task Force (including at least one Fed-  
9 eral representative engaged in Task Force activities  
10 on a full-time basis) shall operate in each judicial  
11 district of the United States; and

12 (2) the Task Force maintains separate account-  
13 ing of its finances, personnel, case load, and resolu-  
14 tion of claims and actions.

15 (c) ADVISORY GROUP DESCRIBED.—The Advisory  
16 Group described in this subsection is a group consisting  
17 of the following individuals (or their designees):

18 (1) The Secretary of Health and Human Serv-  
19 ices.

20 (2) The Secretary of the Treasury.

21 (3) The Secretary of Veterans' Affairs.

22 (4) The Chair of the Board of Governors of the  
23 United States Postal Service.

1 **SEC. 15109. STUDY OF ADEQUACY OF PRIVATE QUALITY AS-**  
 2 **SURANCE PROGRAMS.**

3 (a) IN GENERAL.—The Administrator of the Health  
 4 Care Financing Administration (acting through the Direc-  
 5 tor of the Office of Research and Development) shall enter  
 6 into an agreement with a private entity to conduct a study  
 7 during the 5-year period beginning on the date of the en-  
 8 actment of this Act of the adequacy of the quality assur-  
 9 ance programs and consumer protections used by plans  
 10 enrolling medicare beneficiaries under part C of title  
 11 XVIII of the Social Security Act (as inserted by section  
 12 15002(a)), and shall include in the study an analysis of  
 13 the effectiveness of such programs in protecting plan en-  
 14 rollees against the risk of insufficient provision of benefits  
 15 which may result from utilization controls.

16 (b) REPORT.—Not later than 6 months after the con-  
 17 clusion of the 5-year period described in subsection (a),  
 18 the Administrator shall submit a report to Congress on  
 19 the study conducted under subsection (a).

20 **Subtitle C—Regulatory Relief**

21 **PART 1—PHYSICIAN OWNERSHIP REFERRAL**

22 **REFORM**

23 **SEC. 15201. REPEAL OF PROHIBITIONS BASED ON COM-**  
 24 **PENSATION ARRANGEMENTS.**

25 (a) IN GENERAL.—Section 1877(a)(2) (42 U.S.C.  
 26 1395nn(a)(2)) is amended by striking “is—” and all that

1 follows through “equity,” and inserting the following: “is  
2 (except as provided in subsection (c)) an ownership or in-  
3 vestment interest in the entity through equity,”.

4 (b) CONFORMING AMENDMENTS.—Section 1877 (42  
5 U.S.C. 1395nn) is amended as follows:

6 (1) In subsection (b)—

7 (A) in the heading, by striking “TO BOTH  
8 OWNERSHIP AND COMPENSATION ARRANGE-  
9 MENT PROVISIONS” and inserting “WHERE FI-  
10 NANCIAL RELATIONSHIP EXISTS”; and

11 (B) by redesignating paragraph (4) as  
12 paragraph (7).

13 (2) In subsection (c)—

14 (A) by amending the heading to read as  
15 follows: “EXCEPTION FOR OWNERSHIP OR IN-  
16 VESTMENT INTEREST IN PUBLICLY TRADED  
17 SECURITIES AND MUTUAL FUNDS”; and

18 (B) in the matter preceding paragraph (1),  
19 by striking “subsection (a)(2)(A)” and inserting  
20 “subsection (a)(2)”.

21 (3) In subsection (d)—

22 (A) by striking the matter preceding para-  
23 graph (1);

24 (B) in paragraph (3), by striking “para-  
25 graph (1)” and inserting “paragraph (4)”; and

1 (C) by redesignating paragraphs (1), (2),  
2 and (3) as paragraphs (4), (5), and (6), and by  
3 transferring and inserting such paragraphs  
4 after paragraph (3) of subsection (b).

5 (4) By striking subsection (e).

6 (5) In subsection (f)(2), as amended by section  
7 152(a) of the Social Security Act Amendments of  
8 1994—

9 (A) in the matter preceding paragraph (1),  
10 by striking “ownership, investment, and com-  
11 pensation” and inserting “ownership and in-  
12 vestment”;

13 (B) in paragraph (2), by striking “sub-  
14 section (a)(2)(A)” and all that follows through  
15 “subsection (a)(2)(B),” and inserting “sub-  
16 section (a)(2),”; and

17 (C) in paragraph (2), by striking “or who  
18 have such a compensation relationship with the  
19 entity”.

20 (6) In subsection (h)—

21 (A) by striking paragraphs (1), (2), and  
22 (3);

23 (B) in paragraph (4)(A), by striking  
24 clauses (iv) and (vi);

1 (C) in paragraph (4)(B), by striking  
2 “RULES.—” and all that follows through “(ii)  
3 FACULTY” and inserting “RULES FOR FAC-  
4 ULTY; and

5 (D) by adding at the end of paragraph (4)  
6 the following new subparagraph:

7 “(C) MEMBER OF A GROUP.—A physician  
8 is a ‘member’ of a group if the physician is an  
9 owner or a bona fide employee, or both, of the  
10 group.”.

11 **SEC. 15202. REVISION OF DESIGNATED HEALTH SERVICES**

12 **SUBJECT TO PROHIBITION.**

13 (a) IN GENERAL.—Section 1877(h)(6) (42 U.S.C.  
14 1395nn(h)(6)) is amended by striking subparagraphs (B)  
15 through (K) and inserting the following:

16 “(B) Items and services furnished by a  
17 community pharmacy (as defined in paragraph  
18 (1)).

19 “(C) Magnetic resonance imaging and  
20 computerized tomography services.

21 “(D) Outpatient physical therapy serv-  
22 ices.”.

23 (b) COMMUNITY PHARMACY DEFINED.—Section  
24 1877(h) (42 U.S.C. 1395nn(h)), as amended by section

1 15201(b)(6), is amended by inserting before paragraph  
2 (4) the following new paragraph:

3 “(1) COMMUNITY PHARMACY.—The term ‘com-  
4 munity pharmacy’ means any entity licensed or cer-  
5 tified to dispense prescription drugs by the State in  
6 which the entity is located (including an entity which  
7 dispenses such drugs by mail order).”.

8 (c) CONFORMING AMENDMENTS.—

9 (1) Section 1877(b)(2) (42 U.S.C.  
10 1395nn(b)(2)) is amended in the matter preceding  
11 subparagraph (A) by striking “services” and all that  
12 follows through “supplies)—” and inserting “serv-  
13 ices—”.

14 (2) Section 1877(h)(5)(C) (42 U.S.C.  
15 1395nn(h)(5)(C)) is amended—

16 (A) by striking “, a request by a radiolo-  
17 gist for diagnostic radiology services, and a re-  
18 quest by a radiation oncologist for radiation  
19 therapy,” and inserting “and a request by a ra-  
20 diologist for magnetic resonance imaging or for  
21 computerized tomography”, and

22 (B) by striking “radiologist, or radiation  
23 oncologist” and inserting “or radiologist”.

1 **SEC. 15203. DELAY IN IMPLEMENTATION UNTIL PROMUL-**  
2 **GATION OF REGULATIONS.**

3 (a) IN GENERAL.—Section 13562(b) of OBRA–1993  
4 (42 U.S.C. 1395nn note) is amended—

5 (1) in paragraph (1), by striking “paragraph  
6 (2)” and inserting “paragraphs (2) and (3)”; and

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

9 “(3) PROMULGATION OF REGULATIONS.—Not-  
10 withstanding paragraphs (1) and (2), the amend-  
11 ments made by this section shall not apply to any  
12 referrals made before the effective date of final regu-  
13 lations promulgated by the Secretary of Health and  
14 Human Services to carry out such amendments.”.

15 (b) EFFECTIVE DATE.—The amendments made by  
16 subsection (a) shall take effect as if included in the enact-  
17 ment of OBRA–1993.

18 **SEC. 15204. EXCEPTIONS TO PROHIBITION.**

19 (a) REVISIONS TO EXCEPTION FOR IN-OFFICE AN-  
20 CILLARY SERVICES.—

21 (1) REPEAL OF SITE-OF-SERVICE REQUIRE-  
22 MENT.—Section 1877 (42 U.S.C. 1395nn) is amend-  
23 ed—

24 (A) by amending subparagraph (A) of sub-  
25 section (b)(2) to read as follows:

1           “(A) that are furnished personally by the  
2           referring physician, personally by a physician  
3           who is a member of the same group practice as  
4           the referring physician, or personally by individ-  
5           uals who are under the general supervision of  
6           the physician or of another physician in the  
7           group practice, and”, and

8           (B) by adding at the end of subsection (h)  
9           the following new paragraph:

10           “(7) GENERAL SUPERVISION.—An individual is  
11           considered to be under the ‘general supervision’ of a  
12           physician if the physician (or group practice of  
13           which the physician is a member) is legally respon-  
14           sible for the services performed by the individual and  
15           for ensuring that the individual meets licensure and  
16           certification requirements, if any, applicable under  
17           other provisions of law, regardless of whether or not  
18           the physician is physically present when the individ-  
19           ual furnishes an item or service.”.

20           (2) CLARIFICATION OF TREATMENT OF PHYSI-  
21           CIAN OWNERS OF GROUP PRACTICE.—Section  
22           1877(b)(2)(B) (42 U.S.C. 1395nn(b)(2)(B)) is  
23           amended by striking “physician or such group prac-  
24           tice” and inserting “physician, such group practice,  
25           or the physician owners of such group practice”.

1           (3) CONFORMING AMENDMENT.—Section  
2           1877(b)(2) (42 U.S.C. 1395nn(b)(2)) is amended by  
3           amending the heading to read as follows: “ANCIL-  
4           LARY SERVICES FURNISHED PERSONALLY OR  
5           THROUGH GROUP PRACTICE.—”.

6           (b) CLARIFICATION OF EXCEPTION FOR SERVICES  
7           FURNISHED IN A RURAL AREA.—Paragraph (5) of section  
8           1877(b) (42 U.S.C. 1395nn(b)), as transferred by section  
9           15201(b)(3)(C), is amended by striking “substantially all”  
10          and inserting “not less than 75 percent”.

11          (c) REVISION OF EXCEPTION FOR CERTAIN MAN-  
12          AGED CARE ARRANGEMENTS.—Section 1877(b)(3) (42  
13          U.S.C. 1395nn(b)(3)) is amended—

14               (1) in the heading by inserting “MANAGED  
15               CARE ARRANGEMENTS” after “PREPAID PLANS”;

16               (2) in the matter preceding subparagraph (A),  
17               by striking “organization—” and inserting “organi-  
18               zation, directly or through contractual arrangements  
19               with other entities, to individuals enrolled with the  
20               organization—”;

21               (3) in subparagraph (A), by inserting “or part  
22               C” after “section 1876”;

23               (4) by striking “or” at the end of subparagraph  
24               (C);

1           (5) by striking the period at the end of sub-  
2 paragraph (D) and inserting a comma; and

3           (6) by adding at the end the following new sub-  
4 paragraphs:

5                   “(E) with a contract with a State to pro-  
6 vide services under the State plan under title  
7 XIX (in accordance with section 1903(m)) or a  
8 State MediGrant plan under title XXI; or

9                   “(F) which—

10                           “(i) provides health care items or  
11 services directly or through one or more  
12 subsidiary entities or arranges for the pro-  
13 vision of health care items or services sub-  
14 stantially through the services of health  
15 care providers under contract with the or-  
16 ganization, and

17                           “(ii) (I) assumes financial risk for the  
18 provision of health services through mecha-  
19 nisms (such as capitation, risk pools, with-  
20 holds, and per diem payments) or offers its  
21 network of contract health providers to an  
22 entity (including self-insured employers  
23 and indemnity plans) which assumes finan-  
24 cial risk for the provision of such health  
25 services, or

1           “(II) has in effect a written agree-  
2           ment with the provider of services under  
3           which the provider is at significant finan-  
4           cial risk (whether through a withhold, capi-  
5           tation, incentive pool, per diem payments,  
6           or similar risk sharing arrangement) for  
7           the cost or utilization of services that the  
8           provider is obligated to provide.”.

9           (d) NEW EXCEPTION FOR SHARED FACILITY SERV-  
10          ICES.—

11           (1) IN GENERAL.—Section 1877(b) (42 U.S.C.  
12           1395nn(b)), as amended by section 15201(b)(3)(C),  
13           is amended—

14           (A) by redesignating paragraphs (4)  
15           through (7) as paragraphs (5) through (8); and

16           (B) by inserting after paragraph (3) the  
17           following new paragraph:

18           “(4) SHARED FACILITY SERVICES.—In the case  
19           of a designated health service consisting of a shared  
20           facility service of a shared facility—

21           “(A) that is furnished—

22           “(i) personally by the referring physi-  
23           cian who is a shared facility physician or  
24           personally by an individual directly em-

1           employed or under the general supervision of  
2           such a physician,

3                   “(ii) by a shared facility in a building  
4                   in which the referring physician furnishes  
5                   substantially all of the services of the phy-  
6                   sician that are unrelated to the furnishing  
7                   of shared facility services, and

8                   “(iii) to a patient of a shared facility  
9                   physician; and

10                   “(B) that is billed by the referring physi-  
11                   cian or a group practice of which the physician  
12                   is a member.”.

13           (2) DEFINITIONS.—Section 1877(h) (42 U.S.C.  
14           1395nn(h)), as amended by section 15201(b)(6) and  
15           section 15202(b), is amended by inserting after  
16           paragraph (1) the following new paragraph:

17                   “(2) SHARED FACILITY RELATED DEFINI-  
18                   TIONS.—

19                   “(A) SHARED FACILITY SERVICE.—The  
20                   term ‘shared facility service’ means, with re-  
21                   spect to a shared facility, a designated health  
22                   service furnished by the facility to patients of  
23                   shared facility physicians.

24                   “(B) SHARED FACILITY.—The term  
25                   ‘shared facility’ means an entity that furnishes

1 shared facility services under a shared facility  
2 arrangement.

3 “(C) SHARED FACILITY PHYSICIAN.—The  
4 term ‘shared facility physician’ means, with re-  
5 spect to a shared facility, a physician (or a  
6 group practice of which the physician is a mem-  
7 ber) who has a financial relationship under a  
8 shared facility arrangement with the facility.

9 “(D) SHARED FACILITY ARRANGEMENT.—  
10 The term ‘shared facility arrangement’ means,  
11 with respect to the provision of shared facility  
12 services in a building, a financial arrange-  
13 ment—

14 “(i) which is only between physicians  
15 who are providing services (unrelated to  
16 shared facility services) in the same build-  
17 ing,

18 “(ii) in which the overhead expenses  
19 of the facility are shared, in accordance  
20 with methods previously determined by the  
21 physicians in the arrangement, among the  
22 physicians in the arrangement, and

23 “(iii) which, in the case of a corpora-  
24 tion, is wholly owned and controlled by  
25 shared facility physicians.”.

1 (e) NEW EXCEPTION FOR SERVICES FURNISHED IN  
2 COMMUNITIES WITH NO ALTERNATIVE PROVIDERS.—  
3 Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by  
4 section 15201(b)(3)(C) and subsection (d)(1), is amend-  
5 ed—

6 (1) by redesignating paragraphs (5) through  
7 (8) as paragraphs (6) through (9); and

8 (2) by inserting after paragraph (4) the follow-  
9 ing new paragraph:

10 “(5) NO ALTERNATIVE PROVIDERS IN AREA.—  
11 In the case of a designated health service furnished  
12 in any area with respect to which the Secretary de-  
13 termines that individuals residing in the area do not  
14 have reasonable access to such a designated health  
15 service for which subsection (a)(1) does not apply.”.

16 (f) NEW EXCEPTION FOR SERVICES FURNISHED IN  
17 AMBULATORY SURGICAL CENTERS.—Section 1877(b) (42  
18 U.S.C. 1395nn(b)), as amended by section  
19 15201(b)(3)(C), subsection (d)(1), and subsection (e)(1),  
20 is amended—

21 (1) by redesignating paragraphs (6) through  
22 (9) as paragraphs (7) through (10); and

23 (2) by inserting after paragraph (5) the follow-  
24 ing new paragraph:

1           “(6) SERVICES FURNISHED IN AMBULATORY  
2           SURGICAL CENTERS.—In the case of a designated  
3           health service furnished in an ambulatory surgical  
4           center described in section 1832(a)(2)(F)(i).”.

5           (g) NEW EXCEPTION FOR SERVICES FURNISHED IN  
6           RENAL DIALYSIS FACILITIES.—Section 1877(b) (42  
7           U.S.C. 1395nn(b)), as amended by section  
8           15201(b)(3)(C), subsection (d)(1), subsection (e)(1), and  
9           subsection (f), is amended—

10           (1) by redesignating paragraphs (7) through  
11           (10) as paragraphs (8) through (11); and

12           (2) by inserting after paragraph (6) the follow-  
13           ing new paragraph:

14           “(7) SERVICES FURNISHED IN RENAL DIALYSIS  
15           FACILITIES.—In the case of a designated health  
16           service furnished in a renal dialysis facility under  
17           section 1881.”.

18           (h) NEW EXCEPTION FOR SERVICES FURNISHED IN  
19           A HOSPICE.—Section 1877(b) (42 U.S.C. 1395nn(b)), as  
20           amended by section 15201(b)(3)(C), subsection (d)(1),  
21           subsection (e)(1), subsection (f), and subsection (g), is  
22           amended—

23           (1) by redesignating paragraphs (8) through  
24           (11) as paragraphs (9) through (12); and

1           (2) by inserting after paragraph (7) the follow-  
2           ing new paragraph:

3           “(8) SERVICES FURNISHED BY A HOSPICE PRO-  
4           GRAM.—In the case of a designated health service  
5           furnished by a hospice program under section  
6           1861(dd)(2).”.

7           (i) NEW EXCEPTION FOR SERVICES FURNISHED IN  
8           A COMPREHENSIVE OUTPATIENT REHABILITATION FA-  
9           CILITY.—Section 1877(b) (42 U.S.C. 1395nn(b)), as  
10          amended by section 15201(b)(3)(C), subsection (d)(1),  
11          subsection (e)(1), subsection (f), subsection (g), and sub-  
12          section (h), is amended—

13           (1) by redesignating paragraphs (9) through  
14           (12) as paragraphs (10) through (13); and

15           (2) by inserting after paragraph (8) the follow-  
16           ing new paragraph:

17           “(9) SERVICES FURNISHED IN A COMPREHEN-  
18           SIVE OUTPATIENT REHABILITATION FACILITY.—In  
19           the case of a designated health service furnished in  
20           a comprehensive outpatient rehabilitation facility (as  
21           defined in section 1861(cc)(2)).”.

22           (i) DEFINITION OF REFERRAL.—Section  
23           1877(h)(5)(A) (42 U.S.C. 1395nn(h)(5)(A)) is amend-  
24           ed—

1 (1) by striking “an item or service” and insert-  
2 ing “a designated health service”, and

3 (2) by striking “the item or service” and insert-  
4 ing “the designated health service”.

5 **SEC. 15205. REPEAL OF REPORTING REQUIREMENTS.**

6 Section 1877 (42 U.S.C. 1395nn) is amended—

7 (1) by striking subsection (f); and

8 (2) by striking subsection (g)(5).

9 **SEC. 15206. PREEMPTION OF STATE LAW.**

10 Section 1877 (42 U.S.C. 1395nn) is amended by add-  
11 ing at the end the following new subsection:

12 “(i) PREEMPTION OF STATE LAW.—This section pre-  
13 empts State law to the extent State law is inconsistent  
14 with this section.”.

15 **SEC. 15207. EFFECTIVE DATE.**

16 Except as provided in section 15203(b), the amend-  
17 ments made by this part shall apply to referrals made on  
18 or after August 14, 1995, regardless of whether or not  
19 regulations are promulgated to carry out such amend-  
20 ments.

1           **PART 2—OTHER MEDICARE REGULATORY**

2                           **RELIEF**

3   **SEC. 15211. REPEAL OF MEDICARE AND MEDICAID COV-**  
4                           **ERAGE DATA BANK.**

5           (a) IN GENERAL.—Section 1144 (42 U.S.C. 1320b–  
6 14), as added by section 13581(a) of OBRA–93, is re-  
7 pealed.

8           (b) CONFORMING AMENDMENTS.—

9                   (1) MEDICARE.—Section 1862(b)(5) of such  
10 Act (42 U.S.C. 1395y(b)(5)), as amended by section  
11 13581(b)(1) of OBRA–93, is amended—

12                           (A) in subparagraph (B), by striking the  
13 dash and all that follows through the end and  
14 inserting “subparagraph (A) for purposes of  
15 carrying out this subsection.”, and

16                           (B) in subparagraph (C)(i), by striking  
17 “subparagraph (B)(i)” and inserting “subpara-  
18 graph (B)”.

19                   (2) MEDICAID.—Section 1902(a)(25)(A)(i) of  
20 such Act (42 U.S.C. 1396a(a)(25)(A)(i)), as amend-  
21 ed by section 13581(b)(2) of OBRA–93, is amended  
22 by striking “including the use of” and all that fol-  
23 lows through “any additional measures”.

24                   (3) ERISA.—Section 101(f) of the Employee  
25 Retirement Income Security Act of 1974 (29 U.S.C.  
26 1021(f)) is repealed.

1           (4) INTERNAL REVENUE CODE PROVISION.—  
2       Section 6103(l) of the Internal Revenue Code of  
3       1986 is amended by striking paragraph (12).

4           (5) DATA MATCHES.—Section 552a(a)(8)(B) of  
5       title 5, United States Code, as amended by section  
6       13581(c) of OBRA-93, is amended—

7           (A) by adding “or” at the end of clause  
8       (v),

9           (B) by striking “or” at the end of clause  
10       (vi), and

11          (C) by striking clause (vii).

12 **SEC. 15212. CLARIFICATION OF LEVEL OF INTENT RE-**  
13 **QUIRED FOR IMPOSITION OF SANCTIONS.**

14       (a) CLARIFICATION OF LEVEL OF KNOWLEDGE RE-  
15       QUIRED FOR IMPOSITION OF CIVIL MONETARY PEN-  
16       ALTIES.—

17           (1) IN GENERAL.—Section 1128A(a) (42  
18       U.S.C. 1320a-7a(a)) is amended—

19           (A) in paragraphs (1) and (2), by inserting  
20       “knowingly” before “presents” each place it ap-  
21       pears; and

22           (B) in paragraph (3), by striking “gives”  
23       and inserting “knowingly gives or causes to be  
24       given”.

1           (2) DEFINITION OF STANDARD.—Section  
2           1128A(i) (42 U.S.C. 1320a–7a(i)) is amended by  
3           adding at the end the following new paragraph:

4           “(6) The term ‘should know’ means that a per-  
5           son, with respect to information—

6                   “(A) acts in deliberate ignorance of the  
7                   truth or falsity of the information; or

8                   “(B) acts in reckless disregard of the truth  
9                   or falsity of the information,

10           and no proof of specific intent to defraud is re-  
11           quired.”.

12           (b) CLARIFICATION OF EFFECT AND APPLICATION  
13           OF SAFE HARBOR EXCEPTIONS.—For purposes of section  
14           1128B(b)(3) of the Social Security Act, the specification  
15           of any payment practice in regulations promulgated pur-  
16           suant to section 14(a) of the Medicare and Medicaid Pro-  
17           gram Patient Protection Act of 1987 is—

18                   (1) solely for the purpose of adding additional  
19                   exceptions to the types of conduct which are not  
20                   subject to an anti-kickback penalty under such sec-  
21                   tion and not for the purpose of limiting the scope of  
22                   such exceptions; and

23                   (2) for the purpose of prescribing criteria for  
24                   qualifying for such an exception notwithstanding the  
25                   intent of the party involved.

1 (c) LIMITING IMPOSITION OF ANTI-KICKBACK PEN-  
2 ALTIES TO ACTIONS WITH SIGNIFICANT PURPOSE TO IN-  
3 DUCE REFERRALS.—Section 1128B(b)(2) (42 U.S.C.  
4 1320a-7b(b)(2)) is amended in the matter preceding sub-  
5 paragraph (A) by striking “to induce” and inserting “for  
6 the significant purpose of inducing”.

7 (d) EFFECTIVE DATE.—The amendments made by  
8 this section shall apply to acts or omissions occurring on  
9 or after January 1, 1996.

10 **SEC. 15213. CLARIFICATION OF AND ADDITIONS TO EXCEP-**  
11 **TIONS TO ANTI-KICKBACK PENALTIES.**

12 (a) DISCOUNTS, RISK-SHARING AND OTHER MAN-  
13 AGED CARE ARRANGEMENTS.—Section 1128B(b)(3) (42  
14 U.S.C. 1320a-7b(b)(3)) is amended—

15 (1) by amending subparagraph (A) to read as  
16 follows:

17 “(A) any discount or other reduction in price  
18 (including a reduction in price applied to a combina-  
19 tion of items and services and a reduction made  
20 available as part of capitation, risk sharing, disease  
21 management, or a similar program) obtained by a  
22 provider of service or other entity under title XVIII  
23 or a State health care program if—

24 “(i) the reduction in price is properly dis-  
25 closed and appropriately reflected in the costs

1           claimed or charges made by the provider or en-  
2           tity under such title or program, or

3           “(ii) in the case of an entity which does  
4           not report its costs on a cost report, the entity  
5           separately claims an item or service for pay-  
6           ment, payment under such title or program is  
7           not based on actual acquisition costs, and the  
8           price reduction on the item or service is prop-  
9           erly disclosed and appropriately reflected by  
10          providing full and accurate information con-  
11          cerning the price reduction at the time the  
12          value of the reduction is known, at the request  
13          of the Secretary or a State agency;”;

14          (2) by striking “and” at the end of subpara-  
15          graph (D);

16          (3) by striking the period at the end of sub-  
17          paragraph (E) and inserting “; and”; and

18          (4) by adding at the end the following new sub-  
19          paragraph:

20               “(F) any reduction in cost sharing or increased  
21               benefits given to an individual, any amounts paid by  
22               or on behalf of an organization described in clause  
23               (i) or (ii) to a provider in connection with an item  
24               or service furnished to an individual, any discount or  
25               reduction in price given by the provider for such an

1 item or service, or any other remuneration if the  
2 item or service is provided through an organization  
3 which—

4 “(i) provides health care items or services  
5 directly or through one or more subsidiary enti-  
6 ties or arranges for the provision of health care  
7 items or services substantially through the serv-  
8 ices of health care providers under contract  
9 with the organization, and

10 “(ii)(I) assumes financial risk for the pro-  
11 vision of health services through mechanisms  
12 (such as capitation, risk pools, withholds, and  
13 per diem payments) or offers its network of  
14 contract health providers to an entity (including  
15 self-insured employers and indemnity plans)  
16 which assumes financial risk for the provision  
17 of such health services, or

18 “(II) has in effect a written agreement  
19 with the provider of services under which the  
20 provider is at significant financial risk (whether  
21 through a withhold, capitation, incentive pool,  
22 per diem payments, or similar risk sharing ar-  
23 rangement) for the cost or utilization of services  
24 that the provider is obligated to provide.”.

1 (b) EFFECTIVE DATE.—The amendments made by  
2 this section shall apply to acts or omissions occurring on  
3 or after January 1, 1996.

4 **SEC. 15214. SOLICITATION AND PUBLICATION OF MODI-**  
5 **FICATIONS TO EXISTING SAFE HARBORS AND**  
6 **NEW SAFE HARBORS.**

7 (a) IN GENERAL.—

8 (1) SOLICITATIONS.—Not later than January 1,  
9 1996, and not less than annually thereafter, the Sec-  
10 retary of Health and Human Services shall publish  
11 a notice in the Federal Register soliciting proposals,  
12 which will be accepted during a 60-day period, for—

13 (A) modifications to existing safe harbors  
14 issued pursuant to section 14(a) of the Medi-  
15 care and Medicaid Patient and Program Protec-  
16 tion Act of 1987;

17 (B) additional safe harbors specifying pay-  
18 ment practices that shall not be treated as a  
19 criminal offense under section 1128B(b) of the  
20 Social Security Act and shall not serve as the  
21 basis for an exclusion under section 1128(b)(7)  
22 of such Act; and

23 (C) special fraud alerts to be issued pursu-  
24 ant to section 15101(c).

1           (2) PUBLICATION OF PROPOSED MODIFICA-  
2           TIONS AND PROPOSED ADDITIONAL SAFE HAR-  
3           BORS.—Not later than 120 days after receiving the  
4           proposals described in subparagraphs (A) and (B) of  
5           paragraph (1), the Secretary, after considering such  
6           proposals in consultation with the Attorney General,  
7           shall publish in the Federal Register proposed modi-  
8           fications to existing safe harbors and proposed addi-  
9           tional safe harbors, if appropriate, with a 60-day  
10          comment period. After considering any public com-  
11          ments received during this period, the Secretary  
12          shall issue final rules modifying the existing safe  
13          harbors and establishing new safe harbors, as appro-  
14          priate.

15          (3) REPORT.—The Inspector General shall, in  
16          an annual report to Congress or as part of the year-  
17          end semiannual report required by section 5 of the  
18          Inspector General Act of 1978, describe the propos-  
19          als received under subparagraphs (A) and (B) of  
20          paragraph (1) and explain which proposals were in-  
21          cluded in the publication described in paragraph (2),  
22          which proposals were not included in that publica-  
23          tion, and the reasons for the rejection of the propos-  
24          als that were not included.

1 (b) CRITERIA FOR MODIFYING AND ESTABLISHING  
2 SAFE HARBORS.—In modifying and establishing safe har-  
3 bors under subsection (a)(2), the Secretary may consider  
4 the extent to which providing a safe harbor for the speci-  
5 fied payment practice may result in any of the following:

6 (1) An increase or decrease in access to health  
7 care services.

8 (2) An increase or decrease in the quality of  
9 health care services.

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

12 (4) An increase or decrease in competition  
13 among health care providers.

14 (5) An increase or decrease in the cost to health  
15 care programs of the Federal Government.

16 (6) An increase or decrease in the potential  
17 overutilization of health care services.

18 (7) Any other factors the Secretary deems ap-  
19 propriate in the interest of preventing fraud and  
20 abuse in health care programs of the Federal Gov-  
21 ernment.

1 **SEC. 15215. ISSUANCE OF ADVISORY OPINIONS UNDER**  
2 **TITLE XI.**

3 (a) IN GENERAL.—Title XI (42 U.S.C. 1301 et seq.),  
4 as amended by section 15104(a), is amended by inserting  
5 after section 1129 the following new section:

6 “ADVISORY OPINIONS  
7 “SEC. 1130. (a) ISSUANCE OF ADVISORY OPIN-  
8 IONS.—The Secretary shall issue written advisory opinions  
9 as provided in this section.

10 “(b) MATTERS SUBJECT TO ADVISORY OPINIONS.—  
11 The Secretary shall issue advisory opinions as to the fol-  
12 lowing matters:

13 “(1) What constitutes prohibited remuneration  
14 within the meaning of section 1128B(b).

15 “(2) Whether an arrangement or proposed ar-  
16 rangement satisfies the criteria set forth in section  
17 1128B(b)(3) for activities which do not result in  
18 prohibited remuneration.

19 “(3) Whether an arrangement or proposed ar-  
20 rangement satisfies the criteria which the Secretary  
21 has established, or shall establish by regulation for  
22 activities which do not result in prohibited remu-  
23 neration.

24 “(4) What constitutes an inducement to reduce  
25 or limit services to individuals entitled to benefits

1 under title XVIII or title XIX within the meaning  
2 of section 1128B(b).

3 “(5) Whether any activity or proposed activity  
4 constitutes grounds for the imposition of a sanction  
5 under section 1128, 1128A, or 1128B.

6 “(c) MATTERS NOT SUBJECT TO ADVISORY OPIN-  
7 IONS.—Such advisory opinions shall not address the fol-  
8 lowing matters:

9 “(1) Whether the fair market value shall be, or  
10 was paid or received for any goods, services or prop-  
11 erty.

12 “(2) Whether an individual is a bona fide em-  
13 ployee within the requirements of section 3121(d)(2)  
14 of the Internal Revenue Code of 1986.

15 “(d) EFFECT OF ADVISORY OPINIONS.—

16 “(1) BINDING AS TO SECRETARY AND PARTIES  
17 INVOLVED.—Each advisory opinion issued by the  
18 Secretary shall be binding as to the Secretary and  
19 the party or parties requesting the opinion.

20 “(2) FAILURE TO SEEK OPINION.—The failure  
21 of a party to seek an advisory opinion may not be  
22 introduced into evidence to prove that the party in-  
23 tended to violate the provisions of sections 1128,  
24 1128A, or 1128B.

25 “(e) REGULATIONS.—

1           “(1) IN GENERAL.—Not later than 180 days  
2 after the date of the enactment of this section, the  
3 Secretary shall issue regulations to carry out this  
4 section. Such regulations shall provide for—

5                   “(A) the procedure to be followed by a  
6 party applying for an advisory opinion;

7                   “(B) the procedure to be followed by the  
8 Secretary in responding to a request for an ad-  
9 visory opinion;

10                  “(C) the interval in which the Secretary  
11 shall respond;

12                  “(D) the reasonable fee to be charged to  
13 the party requesting an advisory opinion; and

14                  “(E) the manner in which advisory opin-  
15 ions will be made available to the public.

16           “(2) SPECIFIC CONTENTS.—Under the regula-  
17 tions promulgated pursuant to paragraph (1)—

18                   “(A) the Secretary shall be required to re-  
19 spond to a party requesting an advisory opinion  
20 by not later than 30 days after the request is  
21 made; and

22                   “(B) the fee charged to the party request-  
23 ing an advisory opinion shall be equal to the  
24 costs incurred by the Secretary in responding to  
25 the request.”.

1 (b) EFFECTIVE DATE.—The amendment made by  
2 subsection (a) shall apply to requests for advisory opinions  
3 made on or after January 1, 1996.

4 **SEC. 15216. PRIOR NOTICE OF CHANGES IN BILLING AND**  
5 **CLAIMS PROCESSING REQUIREMENTS FOR**  
6 **PHYSICIANS' SERVICES.**

7 Except as may be specifically provided by Congress,  
8 the Secretary of Health and Human Services may not im-  
9 plement any change in the requirements imposed on the  
10 billing and processing of claims for payment for physi-  
11 cians' services under part B of the medicare program un-  
12 less the Secretary notifies the individuals furnishing such  
13 services of the change not later than 120 days before the  
14 effective date of the change.

15 **PART 3—PROMOTING PHYSICIAN SELF-POLICING**  
16 **SEC. 15221. EXEMPTION FROM ANTITRUST LAWS FOR CER-**  
17 **TAIN ACTIVITIES OF MEDICAL SELF-REGU-**  
18 **LATORY ENTITIES.**

19 (a) EXEMPTION DESCRIBED.—An activity relating to  
20 the provision of health care services shall be exempt from  
21 the antitrust laws, and any State law similar to the anti-  
22 trust laws, if the activity is within the safe harbor de-  
23 scribed in subsection (b).

24 (b) SAFE HARBOR FOR ACTIVITIES OF MEDICAL  
25 SELF-REGULATORY ENTITIES.—

1           (1) IN GENERAL.—Subject to paragraph (2),  
2           any activity of a medical self-regulatory entity relat-  
3           ing to standard setting or standard enforcement ac-  
4           tivities that are designed to promote the quality of  
5           health care services provided to patients.

6           (2) EXCEPTION.—No activity of a medical self-  
7           regulatory entity may be deemed to fall under the  
8           safe harbor established under paragraph (1) if the  
9           activity—

10                   (A) is conducted for purposes of financial  
11                   gain, or

12                   (B) interferes with the provision of health  
13                   care services by any health care provider who is  
14                   not a member of the specific profession which  
15                   is subject to the authority of the medical self-  
16                   regulatory entity.

17           (c) DEFINITIONS.—For purposes of this section:

18                   (1) ANTITRUST LAWS.—The term “antitrust  
19                   laws” has the meaning given it in subsection (a) of  
20                   the first section of the Clayton Act (15 U.S.C.  
21                   12(a)), except that such term includes section 5 of  
22                   the Federal Trade Commission Act (15 U.S.C. 45)  
23                   to the extent such section applies to unfair methods  
24                   of competition.

1           (2) HEALTH BENEFIT PLAN.—The term  
2 “health benefit plan” means—

3           (A) a hospital or medical expense incurred  
4 policy or certificate,

5           (B) a hospital or medical service plan con-  
6 tract,

7           (C) a health maintenance subscriber con-  
8 tract,

9           (D) a multiple employer welfare arrange-  
10 ment or employee benefit plan (as defined  
11 under the Employee Retirement Income Secu-  
12 rity Act of 1974), or

13           (E) a MedicarePlus product (offered under  
14 part C of title XVIII of the Social Security  
15 Act),

16 that provides benefits with respect to health care  
17 services.

18           (3) HEALTH CARE SERVICE.—the term “health  
19 care service” means any service for which payment  
20 may be made under a health benefit plan including  
21 services related to the delivery or administration of  
22 such service.

23           (4) MEDICAL SELF-REGULATORY ENTITY.—the  
24 term “medical self-regulatory entity” means a medi-  
25 cal society or association, a specialty board, a recog-

1 nized accrediting agency, or a hospital medical staff,  
2 and includes the members, officers, employees, con-  
3 sultants, and volunteers or committees of such an  
4 entity.

5 (5) HEALTH CARE PROVIDER.—The term  
6 “health care provider” means any individual or en-  
7 tity that is engaged in the delivery of health care  
8 services in a State and that is required by State law  
9 or regulation to be licensed or certified by the State  
10 to engage in the delivery of such services in the  
11 State.

12 (6) STANDARD SETTING OR STANDARD EN-  
13 FORCEMENT ACTIVITIES.—The term “standard set-  
14 ting or standard enforcement activities” means—

15 (A) accreditation of health care practition-  
16 ers, health care providers, medical education in-  
17 stitutions, or medical education programs,

18 (B) technology assessment and risk man-  
19 agement activities,

20 (C) the development and implementation of  
21 practice guidelines or practice parameters, or

22 (D) official peer review proceedings under-  
23 taken by a hospital medical staff (or committee  
24 thereof) or a medical society or association for  
25 purposes of evaluating the professional conduct

1 or quality of health care provided by a medical  
2 professional.

3 **Subtitle D—Medical Liability**  
4 **Reform**

5 **PART 1—GENERAL PROVISIONS**

6 **SEC. 15301. FEDERAL REFORM OF HEALTH CARE LIABILITY**  
7 **ACTIONS.**

8 (a) **APPLICABILITY.**—This subtitle shall apply with  
9 respect to any health care liability action brought in any  
10 State or Federal court, except that this subtitle shall not  
11 apply to an action for damages arising from a vaccine-  
12 related injury or death to the extent that title XXI of the  
13 Public Health Service Act applies to the action.

14 (b) **PREEMPTION.**—This subtitle shall preempt any  
15 State law to the extent such law is inconsistent with the  
16 limitations contained in this subtitle. This subtitle shall  
17 not preempt any State law that provides for defenses or  
18 places limitations on a person’s liability in addition to  
19 those contained in this subtitle or otherwise imposes great-  
20 er restrictions than those provided in this subtitle.

21 (c) **EFFECT ON SOVEREIGN IMMUNITY AND CHOICE**  
22 **OF LAW OR VENUE.**—Nothing in subsection (b) shall be  
23 construed to—

1           (1) waive or affect any defense of sovereign im-  
2           munity asserted by any State under any provision of  
3           law;

4           (2) waive or affect any defense of sovereign im-  
5           munity asserted by the United States;

6           (3) affect the applicability of any provision of  
7           the Foreign Sovereign Immunities Act of 1976;

8           (4) preempt State choice-of-law rules with re-  
9           spect to claims brought by a foreign nation or a citi-  
10          zen of a foreign nation; or

11          (5) affect the right of any court to transfer  
12          venue or to apply the law of a foreign nation or to  
13          dismiss a claim of a foreign nation or of a citizen  
14          of a foreign nation on the ground of inconvenient  
15          forum.

16          (d) AMOUNT IN CONTROVERSY.—In an action to  
17          which this subtitle applies and which is brought under sec-  
18          tion 1332 of title 28, United States Code, the amount of  
19          noneconomic damages or punitive damages, and attorneys’  
20          fees or costs, shall not be included in determining whether  
21          the matter in controversy exceeds the sum or value of  
22          \$50,000.

23          (e) FEDERAL COURT JURISDICTION NOT ESTAB-  
24          LISHED ON FEDERAL QUESTION GROUNDS.—Nothing in  
25          this subtitle shall be construed to establish any jurisdiction

1 in the district courts of the United States over health care  
2 liability actions on the basis of section 1331 or 1337 of  
3 title 28, United States Code.

4 **SEC. 15302. DEFINITIONS.**

5 As used in this subtitle:

6 (1) ACTUAL DAMAGES.—The term “actual dam-  
7 ages” means damages awarded to pay for economic  
8 loss.

9 (2) ALTERNATIVE DISPUTE RESOLUTION SYS-  
10 TEM; ADR.—The term “alternative dispute resolution  
11 system” or “ADR” means a system established  
12 under Federal or State law that provides for the res-  
13 olution of health care liability claims in a manner  
14 other than through health care liability actions.

15 (3) CLAIMANT.—The term “claimant” means  
16 any person who brings a health care liability action  
17 and any person on whose behalf such an action is  
18 brought. If such action is brought through or on be-  
19 half of an estate, the term includes the claimant’s  
20 decedent. If such action is brought through or on be-  
21 half of a minor or incompetent, the term includes  
22 the claimant’s legal guardian.

23 (4) CLEAR AND CONVINCING EVIDENCE.—The  
24 term “clear and convincing evidence” is that meas-  
25 ure or degree of proof that will produce in the mind

1 of the trier of fact a firm belief or conviction as to  
2 the truth of the allegations sought to be established,  
3 except that such measure or degree of proof is more  
4 than that required under preponderance of the evi-  
5 dence but less than that required for proof beyond  
6 a reasonable doubt.

7 (5) COLLATERAL SOURCE PAYMENTS.—The  
8 term “collateral source payments” means any  
9 amount paid or reasonably likely to be paid in the  
10 future to or on behalf of a claimant, or any service,  
11 product, or other benefit provided or reasonably like-  
12 ly to be provided in the future to or on behalf of a  
13 claimant, as a result of an injury or wrongful death,  
14 pursuant to—

15 (A) any State or Federal health, sickness,  
16 income-disability, accident or workers’ com-  
17 pensation Act;

18 (B) any health, sickness, income-disability,  
19 or accident insurance that provides health bene-  
20 fits or income-disability coverage;

21 (C) any contract or agreement of any  
22 group, organization, partnership, or corporation  
23 to provide, pay for, or reimburse the cost of  
24 medical, hospital, dental, or income disability  
25 benefits; and

1 (D) any other publicly or privately funded  
2 program.

3 (6) ECONOMIC LOSS.—The term “economic  
4 loss” means any pecuniary loss resulting from harm  
5 (including the loss of earnings, medical expense loss,  
6 replacement services loss, loss due to death, and bur-  
7 ial costs), to the extent recovery for such loss is al-  
8 lowed under applicable State law.

9 (7) HARM.—The term “harm” means any le-  
10 gally cognizable wrong or injury for which punitive  
11 damages may be imposed.

12 (8) HEALTH CARE LIABILITY ACTION.—The  
13 term “health care liability action” means a civil ac-  
14 tion brought in a State or Federal court against a  
15 health care provider, an entity which is obligated to  
16 provide or pay for health benefits under any health  
17 plan (including any person or entity acting under a  
18 contract or arrangement to provide or administer  
19 any health benefit), or the manufacturer, distributor,  
20 supplier, marketer, promoter, or seller of a medical  
21 product, in which the claimant alleges a claim (in-  
22 cluding third party claims, cross claims, counter  
23 claims, or distribution claims) based upon the provi-  
24 sion of (or the failure to provide or pay for) health  
25 care services or the use of a medical product, re-

1        regardless of the theory of liability on which the claim  
2        is based or the number of plaintiffs, or defendants  
3        or causes of action.

4            (9) HEALTH CARE LIABILITY CLAIM.—The  
5        term “health care liability claim” means a claim in  
6        which the claimant alleges that injury was caused by  
7        the provision of (or the failure to provide) health  
8        care services.

9            (10) HEALTH CARE PROVIDER.—The term  
10       “health care provider” means any individual, organi-  
11       zation, or institution that is engaged in the delivery  
12       of health care services in a State and that is re-  
13       quired by the laws or regulations of the State to be  
14       licensed or certified by the State to engage in the  
15       delivery of such services in the State.

16           (11) NONECONOMIC DAMAGES.—The term  
17       “noneconomic damages” means damages paid to an  
18       individual for pain and suffering, inconvenience,  
19       emotional distress, mental anguish, loss of consor-  
20       tium, injury to reputation, humiliation, and other  
21       nonpecuniary losses.

22           (12) PERSON.—The term “person” means any  
23       individual, corporation, company, association, firm,  
24       partnership, society, joint stock company, or any  
25       other entity, including any governmental entity.

1           (13) PUNITIVE DAMAGES.—The term “punitive  
2 damages” means damages awarded against any per-  
3 son not to compensate for actual injury suffered, but  
4 to punish or deter such person or others from en-  
5 gaging in similar behavior in the future.

6           (14) STATE.—The term “State” means each of  
7 the several States, the District of Columbia, the  
8 Commonwealth of Puerto Rico, the Virgin Islands,  
9 Guam, American Samoa, the Northern Mariana Is-  
10 lands, the Trust Territories of the Pacific Islands,  
11 and any other territory or possession of the United  
12 States.

13 **SEC. 15303. EFFECTIVE DATE.**

14           This subtitle will apply to any health care liability ac-  
15 tion brought in a Federal or State court and to any health  
16 care liability claim subject to an alternative dispute resolu-  
17 tion system, that is initiated on or after the date of enact-  
18 ment of this subtitle, except that any health care liability  
19 claim or action arising from an injury occurring prior to  
20 the date of enactment of this subtitle shall be governed  
21 by the applicable statute of limitations provisions in effect  
22 at the time the injury occurred.

1     **PART 2—UNIFORM STANDARDS FOR HEALTH**

2                     **CARE LIABILITY ACTIONS**

3     **SEC. 15311. STATUTE OF LIMITATIONS.**

4         A health care liability action may not be brought  
5 after the expiration of the 2-year period that begins on  
6 the date on which the alleged injury that is the subject  
7 of the action was discovered or should reasonably have  
8 been discovered, but in no case after the expiration of the  
9 5-year period that begins on the date the alleged injury  
10 occurred.

11     **SEC. 15312. CALCULATION AND PAYMENT OF DAMAGES.**

12         (a) TREATMENT OF NONECONOMIC DAMAGES.—

13             (1) LIMITATION ON NONECONOMIC DAMAGES.—

14         The total amount of noneconomic damages that may  
15 be awarded to a claimant for losses resulting from  
16 the injury which is the subject of a health care liabil-  
17 ity action may not exceed \$250,000, regardless of  
18 the number of parties against whom the action is  
19 brought or the number of actions brought with re-  
20 spect to the injury.

21             (2) JOINT AND SEVERAL LIABILITY.—In any  
22 health care liability action brought in State or Fed-  
23 eral court, a defendant shall be liable only for the  
24 amount of noneconomic damages attributable to  
25 such defendant in direct proportion to such defend-  
26 ant's share of fault or responsibility for the claim-

1 ant's actual damages, as determined by the trier of  
2 fact. In all such cases, the liability of a defendant  
3 for noneconomic damages shall be several and not  
4 joint.

5 (b) TREATMENT OF PUNITIVE DAMAGES.—

6 (1) GENERAL RULE.—Punitive damages may,  
7 to the extent permitted by applicable State law, be  
8 awarded in any health care liability action for harm  
9 in any Federal or State court against a defendant if  
10 the claimant establishes by clear and convincing evi-  
11 dence that the harm suffered was result of con-  
12 duct—

13 (A) specifically intended to cause harm, or

14 (B) conduct manifesting a conscious, fla-  
15 grant indifference to the rights or safety of oth-  
16 ers.

17 (2) PROPORTIONAL AWARDS.—The amount of  
18 punitive damages that may be awarded in any health  
19 care liability action subject to this subtitle shall not  
20 exceed 3 times the amount of damages awarded to  
21 the claimant for economic loss, or \$250,000, which-  
22 ever is greater. This section shall be applied by the  
23 court and shall not be disclosed to the jury.

24 (c) APPLICABILITY.—This section shall apply to any  
25 health care liability action brought in any Federal or State

1 court on any theory where punitive damages are sought.  
2 This section does not create a cause of action for punitive  
3 damages. This section does not preempt or supersede any  
4 State or Federal law to the extent that such law would  
5 further limit the award of punitive damages.

6 (d) BIFURCATION.—At the request of any party, the  
7 trier of fact shall consider in a separate proceeding wheth-  
8 er punitive damages are to be awarded and the amount  
9 of such award. If a separate proceeding is requested, evi-  
10 dence relevant only to the claim of punitive damages, as  
11 determined by applicable State law, shall be inadmissible  
12 in any proceeding to determine whether actual damages  
13 are to be awarded.

14 (e) DRUGS AND DEVICES.—

15 (1)(A) Punitive damages shall not be awarded  
16 against a manufacturer or product seller of a drug  
17 (as defined in section 201(g)(1) of the Federal  
18 Food, Drug, and Cosmetic Act (21 U.S.C.  
19 321(g)(1)) or medical device (as defined in section  
20 201(h) of the Federal Food, Drug, and Cosmetic  
21 Act (21 U.S.C. 321(h)) which caused the claimant's  
22 harm where—

23 (i) such drug or device was subject to pre-  
24 market approval by the Food and Drug Admin-  
25 istration with respect to the safety of the for-

1           mulation or performance of the aspect of such  
2           drug or device which caused the claimant's  
3           harm or the adequacy of the packaging or label-  
4           ing of such drug or device, and such drug was  
5           approved by the Food and Drug Administra-  
6           tion; or

7                   (ii) the drug is generally recognized as safe  
8                   and effective pursuant to conditions established  
9                   by the Food and Drug Administration and ap-  
10                  pplicable regulations, including packaging and la-  
11                  beling regulations.

12           (B) Subparagraph (A) shall not apply in any  
13           case in which the defendant, before or after pre-  
14           market approval of a drug or device—

15                   (i) intentionally and wrongfully withheld  
16                   from or misrepresented to the Food and Drug  
17                   Administration information concerning such  
18                   drug or device required to be submitted under  
19                   the Federal Food, Drug, and Cosmetic Act (21  
20                   U.S.C. 301 et seq.) or section 351 of the Public  
21                   Health Service Act (42 U.S.C. 262) that is ma-  
22                   terial and relevant to the harm suffered by the  
23                   claimant, or

24                   (ii) made an illegal payment to an official  
25                   or employee of the Food and Drug Administra-

1           tion for the purpose of securing or maintaining  
2           approval of such drug or device.

3           (2) PACKAGING.—In a health care liability ac-  
4           tion for harm which is alleged to relate to the ade-  
5           quacy of the packaging (or labeling relating to such  
6           packaging) of a drug which is required to have tam-  
7           per-resistant packaging under regulations of the  
8           Secretary of Health and Human Services (including  
9           labeling regulations related to such packaging), the  
10          manufacturer of the drug shall not be held liable for  
11          punitive damages unless the drug is found by the  
12          court by clear and convincing evidence to be sub-  
13          stantially out of compliance with such regulations.

14          (f) PERIODIC PAYMENTS FOR FUTURE LOSSES.—

15           (1) GENERAL RULE.—In any health care liabil-  
16          ity action in which the damages awarded for future  
17          economic and noneconomic loss exceeds \$50,000, a  
18          person shall not be required to pay such damages in  
19          a single, lump-sum payment, but shall be permitted  
20          to make such payments periodically based on when  
21          the damages are found likely to occur, as such pay-  
22          ments are determined by the court.

23           (2) FINALITY OF JUDGMENT.—The judgment  
24          of the court awarding periodic payments under this  
25          subsection may not, in the absence of fraud, be re-

1 opened at any time to contest, amend, or modify the  
2 schedule or amount of the payments.

3 (3) LUMP-SUM SETTLEMENTS.—This sub-  
4 section shall not be construed to preclude a settle-  
5 ment providing for a single, lump-sum payment.

6 (g) TREATMENT OF COLLATERAL SOURCE PAY-  
7 MENTS.—

8 (1) INTRODUCTION INTO EVIDENCE.—In any  
9 health care liability action, any defendant may intro-  
10 duce evidence of collateral source payments. If any  
11 defendant elects to introduce such evidence, the  
12 claimant may introduce evidence of any amount paid  
13 or contributed or reasonably likely to be paid or con-  
14 tributed in the future by or on behalf of the claim-  
15 ant to secure the right to such collateral source pay-  
16 ments.

17 (2) NO SUBROGATION.—No provider of collat-  
18 eral source payments shall recover any amount  
19 against the claimant or receive any lien or credit  
20 against the claimant's recovery or be equitably or le-  
21 gally subrogated the right of the claimant in a  
22 health care liability action. This subsection shall  
23 apply to an action that is settled as well as an action  
24 that is resolved by a fact finder.

1 **SEC. 15313. ALTERNATIVE DISPUTE RESOLUTION.**

2 Any ADR used to resolve a health care liability action  
3 or claim shall contain provisions relating to statute of limi-  
4 tations, non-economic damages, joint and several liability,  
5 punitive damages, collateral source rule, and periodic pay-  
6 ments which are identical to the provisions relating to  
7 such matters in this subtitle.

8 **Subtitle E—Teaching Hospitals and**  
9 **Graduate Medical Education**

10 **PART 1—TEACHING HOSPITAL AND GRADUATE**  
11 **MEDICAL EDUCATION TRUST FUND**

12 **SEC. 15401. ESTABLISHMENT OF FUND; PAYMENTS TO**  
13 **TEACHING HOSPITALS.**

14 The Social Security Act (42 U.S.C. 300 et seq.) is  
15 amended by adding after title XXI the following title:

16 “TITLE XXII—TEACHING HOSPITAL AND  
17 GRADUATE MEDICAL EDUCATION TRUST FUND

18 “PART A—ESTABLISHMENT OF FUND

19 “**SEC. 2201. ESTABLISHMENT OF FUND.**

20 “(a) IN GENERAL.—There is established in the  
21 Treasury of the United States a fund to be known as the  
22 Teaching Hospital and Graduate Medical Education Trust  
23 Fund (in this title referred to as the ‘Fund’), consisting  
24 of amounts appropriated to the Fund in subsection (d)  
25 and subsection (e)(3), amounts transferred to the Fund  
26 under section 1886(j), and such gifts and bequests as may

1 be deposited in the Fund pursuant to subsection (f).

2 Amounts in the Fund are available until expended.

3 “(b) EXPENDITURES FROM FUND.—Amounts in the  
4 Fund are available to the Secretary for making payments  
5 under section 2211.

6 “(c) ACCOUNTS IN FUND.—There is established with-  
7 in the Fund the following accounts:

8 “(1) The Indirect-Costs Medical Education Ac-  
9 count.

10 “(2) The Medicare Direct-Costs Medical Edu-  
11 cation Account.

12 “(3) The General Direct-Costs Medical Edu-  
13 cation Account.

14 “(d) GENERAL TRANSFERS TO FUND.—

15 “(1) IN GENERAL.—For fiscal year 1997 and  
16 each subsequent fiscal year, there are appropriated  
17 to the Fund (effective on the applicable date under  
18 paragraph (2)), out of any money in the Treasury  
19 not otherwise appropriated, the following amounts  
20 (as applicable to the fiscal year involved):

21 “(A) For fiscal year 1997, \$400,000,000.

22 “(B) For fiscal year 1998, \$600,000,000.

23 “(C) For fiscal year 1999, \$2,000,000,000.

24 “(D) For fiscal year 2000,  
25 \$3,000,000,000.

1           “(E) For fiscal year 2001,  
2           \$4,000,000,000.

3           “(F) For fiscal year 2002,  
4           \$5,800,000,000.

5           “(G) For fiscal year 2003 and each subse-  
6           quent fiscal year, the greater of the amount ap-  
7           propriated for the preceding fiscal year or an  
8           amount equal to the product of—

9                   “(i) the amount appropriated for the  
10                   preceding fiscal year; and

11                   “(ii) 1 plus the percentage increase in  
12                   the nominal gross domestic product for the  
13                   one-year period ending upon July 1 of such  
14                   preceding fiscal year.

15           “(2) EFFECTIVE DATE FOR ANNUAL APPRO-  
16           PRIATION.—For purposes of paragraph (1) (and for  
17           purposes of section 2221(a)(1), and subsections  
18           (b)(1)(A) and (c)(1)(A) of section 2231)), the appli-  
19           cable date for a fiscal year is the first day of the fis-  
20           cal year, exclusive of Saturdays, Sundays, and Fed-  
21           eral holidays.

22           “(3) ALLOCATION AMONG CERTAIN AC-  
23           COUNTS.—Of the amount appropriated in paragraph  
24           (1) for a fiscal year—

1           “(A) there shall be allocated to the Indi-  
2           rect-Costs Medical Education Account the per-  
3           centage determined under paragraph (4)(B);  
4           and

5           “(B) there shall be allocated to the Gen-  
6           eral Direct-Costs Medical Education Account  
7           the percentage determined under paragraph  
8           (4)(C).

9           “(4) DETERMINATION OF PERCENTAGES.—The  
10          Secretary of Health and Human Services, acting  
11          through the Administrator of the Health Care Fi-  
12          nancing Administration, shall determine the follow-  
13          ing:

14                 “(A) The total amount of payments that  
15                 were made under subsections (d)(5)(B) and (h)  
16                 of section 1886 for fiscal year 1994.

17                 “(B) The percentage of such total that was  
18                 constituted by payments under subsection  
19                 (d)(5)(B) of such section.

20                 “(C) The percentage of such total that was  
21                 constituted by payments under subsection (h) of  
22                 such section.

23          “(e) INVESTMENT.—

24                 “(1) IN GENERAL.—The Secretary of the  
25          Treasury shall invest such amounts of the Fund as

1 such Secretary determines are not required to meet  
2 current withdrawals from the Fund. Such invest-  
3 ments may be made only in interest-bearing obliga-  
4 tions of the United States. For such purpose, such  
5 obligations may be acquired on original issue at the  
6 issue price, or by purchase of outstanding obliga-  
7 tions at the market price.

8 “(2) SALE OF OBLIGATIONS.—Any obligation  
9 acquired by the Fund may be sold by the Secretary  
10 of the Treasury at the market price.

11 “(3) AVAILABILITY OF INCOME.—Any interest  
12 derived from obligations acquired by the Fund, and  
13 proceeds from any sale or redemption of such obliga-  
14 tions, are hereby appropriated to the Fund.

15 “(f) ACCEPTANCE OF GIFTS AND BEQUESTS.—The  
16 Fund may accept on behalf of the United States money  
17 gifts and bequests made unconditionally to the Fund for  
18 the benefit of the Fund or any activity financed through  
19 the Fund.

20 “PART B—PAYMENTS TO TEACHING HOSPITALS

21 “Subpart 1—Requirement of Payments

22 “SEC. 2211. FORMULA PAYMENTS TO TEACHING HOS-  
23 PITALS.

24 “(a) IN GENERAL.—Subject to subsection (d), in the  
25 case of each teaching hospital that in accordance with sub-

1 section (b) submits to the Secretary a payment document  
2 for fiscal year 1997 or any subsequent fiscal year, the Sec-  
3 retary shall make payments for the year to the teaching  
4 hospital for the costs of operating approved medical resi-  
5 dency training programs. Such payments shall be made  
6 from the Fund, and the total of the payments to the hos-  
7 pital for the fiscal year shall equal the sum of the follow-  
8 ing:

9           “(1) An amount determined under section 2221  
10       (relating to the indirect costs of graduate medical  
11       education).

12           “(2) An amount determined under section 2231  
13       (relating to the direct costs of graduate medical edu-  
14       cation).

15       “(b) PAYMENT DOCUMENT.—For purposes of sub-  
16 section (a), a payment document is a document containing  
17 such information as may be necessary for the Secretary  
18 to make payments under such subsection to a teaching  
19 hospital for a fiscal year. The document is submitted in  
20 accordance with this subsection if the document is submit-  
21 ted not later than the date specified by the Secretary, and  
22 the document is in such form and is made in such manner  
23 as the Secretary may require. The Secretary may require  
24 that information under this subsection be submitted to the  
25 Secretary in periodic reports.

1       “(c) ADMINISTRATOR OF PROGRAMS.—This part,  
2 and the subsequent parts of this title, shall be carried out  
3 by the Secretary acting through the Administrator of the  
4 Health Care Financing Administration.

5       “(d) SPECIAL RULES.—

6           “(1) AUTHORITY REGARDING PAYMENTS TO  
7 CONSORTIA OF PROVIDERS.—In the case of pay-  
8 ments under subsection (a) that are determined  
9 under section 2231:

10           “(A) The requirement under such sub-  
11 section to make the payments to teaching hos-  
12 pitals is subject to the authority of the Sec-  
13 retary under section 2233(a) to make payments  
14 to qualifying consortia.

15           “(B) If the Secretary authorizes such a  
16 consortium for purposes of section 2233(a),  
17 subsections (a) and (b) of this section apply to  
18 the consortium to the same extent and in the  
19 same manner as the subsections apply to teach-  
20 ing hospitals.

21           “(2) CERTAIN HOSPITALS.—Paragraph (1) of  
22 subsection (a) is subject to sections 2222 and 2223  
23 of subpart 2. Paragraph (2) of subsection (a) is sub-  
24 ject to sections 2232 through 2234 of subpart 3.



1 be) on a pro rata basis to the extent necessary to  
2 ensure that the sum of the percentages determined  
3 under this paragraph for all teaching hospitals is  
4 equal to 100 percent. The preceding sentence is sub-  
5 ject to sections 2222 and 2223.

6 “(2) APPLICABLE PERIOD REGARDING REL-  
7 EVANT DATA; FISCAL YEARS 1992 THROUGH 1994.—  
8 For purposes of this part, the term ‘applicable pe-  
9 riod’ means the period beginning on the first day of  
10 fiscal year 1992 and continuing through the end of  
11 fiscal year 1994.

12 “(3) RESPECTIVE DETERMINATIONS FOR FIS-  
13 CAL YEARS OF APPLICABLE PERIOD.—For purposes  
14 of paragraph (1), the percentage determined under  
15 this paragraph for a teaching hospital for a fiscal  
16 year of the applicable period is the percentage con-  
17 stituted by the ratio of—

18 “(A) the total amount of payments re-  
19 ceived by the hospital under section  
20 1886(d)(5)(B) for discharges occurring during  
21 the fiscal year involved; to

22 “(B) the sum of the respective amounts  
23 determined under subparagraph (A) for the fis-  
24 cal year for all teaching hospitals.

1       “(c) AVAILABILITY OF DATA.—If a teaching hospital  
2 received the payments specified in subsection (b)(3)(A)  
3 during the applicable period but a complete set of the rel-  
4 evant data is not available to the Secretary for purposes  
5 of determining an amount under such subsection for the  
6 fiscal year involved, the Secretary shall for purposes of  
7 such subsection make an estimate on the basis of such  
8 data as is available to the Secretary for the applicable pe-  
9 riod.

10       **“SEC. 2222. INDIRECT COSTS; SPECIAL RULES REGARDING**  
11                               **DETERMINATION OF HOSPITAL-SPECIFIC**  
12                               **PERCENTAGE.**

13       “(a) SPECIAL RULE REGARDING FISCAL YEARS  
14 1995 AND 1996.—

15               “(1) IN GENERAL.—In the case of a teaching  
16 hospital whose first payments under 1886(d)(5)(B)  
17 were for discharges occurring in fiscal year 1995 or  
18 in fiscal year 1996 (referred to in this subsection in-  
19 dividually as a ‘first payment year’), the percentage  
20 determined under paragraph (2) for the hospital is  
21 deemed to be the percentage applicable under section  
22 2221(b) to the hospital, except that the percentage  
23 under paragraph (2) shall be adjusted in accordance  
24 with section 2221(b)(1) to the extent determined by

1 the Secretary to be necessary with respect to a sum  
2 that equals 100 percent.

3 “(2) DETERMINATION OF PERCENTAGE.—For  
4 purposes of paragraph (1), the percentage deter-  
5 mined under this paragraph for a teaching hospital  
6 is the percentage constituted by the ratio of the  
7 amount determined under subparagraph (A) to the  
8 amount determined under subparagraph (B), as fol-  
9 lows:

10 “(A)(i) If the first payment year for the  
11 hospital is fiscal year 1995, the amount deter-  
12 mined under this subparagraph is the total  
13 amount of payments received by the hospital  
14 under section 1886(d)(5)(B) for discharges oc-  
15 ccurring during fiscal year 1995.

16 “(ii) If the first payment year for the hos-  
17 pital is fiscal year 1996, the amount determined  
18 under this subparagraph is an amount equal to  
19 an estimate by the Secretary of the total  
20 amount of payments that would have been paid  
21 to the hospital under section 1886(d)(5)(B) for  
22 discharges occurring during fiscal year 1995 if  
23 such section, as in effect for fiscal year 1996,  
24 had applied to the hospital for discharges occur-  
25 ring during fiscal year 1995.

1           “(B)(i) If the first payment year for the  
2           hospital is fiscal year 1995, the amount deter-  
3           mined under this subparagraph is the aggregate  
4           total of the payments received by teaching hos-  
5           pitals under section 1886(d)(5)(B) for dis-  
6           charges occurring during fiscal year 1995.

7           “(ii) If the first payment year for the hos-  
8           pital is fiscal year 1996—

9                   “(I) the Secretary shall make an esti-  
10                  mate in accordance with subparagraph  
11                  (A)(ii) for all teaching hospitals; and

12                   “(II) the amount determined under  
13                  this subparagraph is the sum of the esti-  
14                  mates made by the Secretary under  
15                  subclause (I).

16           “(b) NEW TEACHING HOSPITALS.—

17                   “(1) IN GENERAL.—In the case of a teaching  
18                  hospital that did not receive payments under section  
19                  1886(d)(5)(B) for any of the fiscal years 1992  
20                  through 1996, the percentage determined under  
21                  paragraph (3) for the hospital is deemed to be the  
22                  percentage applicable under section 2221(b) to the  
23                  hospital, except that the percentage under paragraph  
24                  (3) shall be adjusted in accordance with section  
25                  2221(b)(1) to the extent determined by the Sec-

1       retary to be necessary with respect to a sum that  
2       equals 100 percent.

3               “(2) DESIGNATED FISCAL YEAR REGARDING  
4       DATA.—The determination under paragraph (3) of a  
5       percentage for a teaching hospital described in para-  
6       graph (1) shall be made for the most recent fiscal  
7       year for which the Secretary has sufficient data to  
8       make the determination (referred to in this sub-  
9       section as the ‘designated fiscal year’).

10              “(3) DETERMINATION OF PERCENTAGE.—For  
11       purposes of paragraph (1), the percentage deter-  
12       mined under this paragraph for the teaching hos-  
13       pital involved is the percentage constituted by the  
14       ratio of the amount determined under subparagraph  
15       (A) to the amount determined under subparagraph  
16       (B), as follows:

17              “(A) The amount determined under this  
18       subparagraph is an amount equal to an esti-  
19       mate by the Secretary of the total amount of  
20       payments that would have been paid to the hos-  
21       pital under section 1886(d)(5)(B) for the des-  
22       ignated fiscal year if such section, as in effect  
23       for the first fiscal year for which payments pur-  
24       suant to this subsection are to be made to the

1 hospital, had applied to the hospital for the des-  
2 ignated fiscal year.

3 “(B) The Secretary shall make an estimate  
4 in accordance with subparagraph (A) for all  
5 teaching hospitals. The amount determined  
6 under this subparagraph is the sum of the esti-  
7 mates made by the Secretary under the preced-  
8 ing sentence.

9 “(c) CONSOLIDATIONS AND MERGERS.—In the case  
10 of two or more teaching hospitals that have each received  
11 payments pursuant to section 2221 for one or more fiscal  
12 years and that undergo a consolidation or merger, the per-  
13 centage applicable to the resulting teaching hospital for  
14 purposes of section 2221(b) is the sum of the respective  
15 percentages that would have applied pursuant to such sec-  
16 tion if the hospitals had not undergone the consolidation  
17 or merger.

18 **“SEC. 2223. INDIRECT COSTS; ALTERNATIVE PAYMENTS RE-**  
19 **GARDING TEACHING HOSPITALS IN CERTAIN**  
20 **STATES.**

21 “(a) IN GENERAL.—In the case of a teaching hospital  
22 in a State for which a demonstration project under section  
23 1814(b)(3) is in effect, this section applies in lieu of sec-  
24 tion 2221. For purposes of section 2211(a)(1), the amount

1 determined for a teaching hospital for a fiscal year is the  
2 product of—

3 “(1) the amount in the Indirect-Costs Medical  
4 Education Account for the fiscal year pursuant to  
5 the allocation under section 2201(d)(3)(A) for the  
6 year; and

7 “(2) the percentage determined under sub-  
8 section (b) for the hospital.

9 “(b) DETERMINATION OF PERCENTAGE.—For pur-  
10 poses of subsection (a)(2):

11 “(1) The Secretary shall make an estimate of  
12 the total amount of payments that would have been  
13 received under section 1886(d)(5)(B) by the hospital  
14 involved with respect to each of the fiscal years of  
15 the applicable period if such section (as in effect for  
16 such fiscal years) had applied to the hospital for  
17 such years.

18 “(2) The percentage determined under this sub-  
19 section for the hospital for a fiscal year is a mean  
20 average percentage determined for the hospital in  
21 accordance with the methodology of section  
22 2221(b)(1), except that the estimate made by the  
23 Secretary under paragraph (1) of this subsection for  
24 a fiscal year of the applicable period is deemed to be

1 the amount that applies for purposes of section  
2 2221(b)(3)(A) for such year.

3 “(c) RULE REGARDING PAYMENTS FROM CERTAIN  
4 AMOUNTS.—In the case of a teaching hospital in a State  
5 for which a demonstration project under section  
6 1814(b)(3) is in effect, this section does not provide any  
7 payment to the hospital from amounts transferred to the  
8 Fund under section 1886(j).

9 “(d) ADJUSTMENT REGARDING PAYMENTS TO  
10 OTHER HOSPITALS.—In the case of a fiscal year for which  
11 payments pursuant to subsection (a) are made to one or  
12 more teaching hospitals, the following applies:

13 “(1) The Secretary shall determine a percent-  
14 age equal to the sum of the respective percentages  
15 determined for the hospitals under subsection (b).

16 “(2) The Secretary shall determine an amount  
17 equal to the product of—

18 “(A) the percentage determined under  
19 paragraph (1); and

20 “(B) the amount in the Indirect-Costs  
21 Medical Education Account for the fiscal year  
22 pursuant to the transfer under section  
23 1886(j)(1).

24 “(3) The Secretary shall, for each hospital  
25 (other than hospitals described in subsection (a)),

1 make payments to the hospital whose sum is equal  
2 to the product of—

3 “(A) the amount determined under para-  
4 graph (2); and

5 “(B) the percentage that applies to the  
6 hospital for purposes of section 2221(b).

7 “Subpart 3—Amount Relating to Direct Costs of  
8 Graduate Medical Education

9 **“SEC. 2231. DETERMINATION OF AMOUNT RELATING TO DI-**  
10 **RECT COSTS.**

11 “(a) IN GENERAL.—For purposes of section  
12 2211(a)(2), the amount determined under this section for  
13 a teaching hospital for a fiscal year is the sum of—

14 “(1) the amount determined under subsection  
15 (b) (relating to the General Direct-Costs Medical  
16 Education Account); and

17 “(2) the amount determined under subsection  
18 (c) (relating to the Medicare Direct-Costs Medical  
19 Education Account).

20 “(b) PAYMENT FROM GENERAL ACCOUNT.—

21 “(1) IN GENERAL.—For purposes of subsection  
22 (a)(1), the amount determined under this subsection  
23 for a teaching hospital for a fiscal year is the prod-  
24 uct of—

1           “(A) the amount in the General Direct-  
2 Costs Medical Education Account on the appli-  
3 cable date under section 2201(d) (once the ap-  
4 propriation under such section is made); and

5           “(B) the percentage determined for the  
6 hospital under paragraph (2).

7           “(2) HOSPITAL-SPECIFIC PERCENTAGE.—

8           “(A) IN GENERAL.—For purposes of para-  
9 graph (1)(B), the percentage determined under  
10 this paragraph for a teaching hospital is the  
11 mean average of the respective percentages de-  
12 termined under subparagraph (B) for each fis-  
13 cal year of the applicable period (as defined in  
14 section 2221(b)(2)), adjusted by the Secretary  
15 (upward or downward, as the case may be) on  
16 a pro rata basis to the extent necessary to en-  
17 sure that the sum of the percentages deter-  
18 mined under this subparagraph for all teaching  
19 hospitals is equal to 100 percent. The preceding  
20 sentence is subject to sections 2232 through  
21 2234.

22           “(B) RESPECTIVE DETERMINATIONS FOR  
23 FISCAL YEARS OF APPLICABLE PERIOD.—For  
24 purposes of subparagraph (A), the percentage  
25 determined under this subparagraph for a

1 teaching hospital for a fiscal year of the appli-  
2 cable period is the percentage constituted by  
3 the ratio of—

4 “(i) the total amount of payments re-  
5 ceived by the hospital under section  
6 1886(h) for cost reporting periods begin-  
7 ning during the fiscal year involved; to

8 “(ii) the sum of the respective  
9 amounts determined under clause (i) for  
10 the fiscal year for all teaching hospitals.

11 “(3) AVAILABILITY OF DATA.—If a teaching  
12 hospital received the payments specified in para-  
13 graph (2)(B)(i) during the applicable period but a  
14 complete set of the relevant data is not available to  
15 the Secretary for purposes of determining an  
16 amount under such paragraph for the fiscal year in-  
17 volved, the Secretary shall for purposes of such  
18 paragraph make an estimate on the basis of such  
19 data as is available to the Secretary for the applica-  
20 ble period.

21 “(c) PAYMENT FROM MEDICARE ACCOUNT.—

22 “(1) IN GENERAL.—For purposes of subsection  
23 (a)(2), the amount determined under this subsection  
24 for a teaching hospital for a fiscal year is the prod-  
25 uct of—

1           “(A) the amount in the Medicare Direct-  
2           Costs Medical Education Account on the appli-  
3           cable date under section 2201(d) (once the ap-  
4           propriation under such section is made); and

5           “(B) the percentage determined for the  
6           hospital under paragraph (2).

7           “(2) HOSPITAL-SPECIFIC PERCENTAGE.—For  
8           purposes of paragraph (1)(B), the percentage deter-  
9           mined under this subsection for a teaching hospital  
10          for a fiscal year is the percentage constituted by the  
11          ratio of—

12           “(A) the estimate made by the Secretary  
13           for the hospital for the fiscal year under section  
14           1886(j)(2)(B); to

15           “(B) the sum of the respective estimates  
16           referred to in subparagraph (A) for all teaching  
17           hospitals.

18   **“SEC. 2232. DIRECT COSTS; SPECIAL RULES REGARDING**  
19                   **DETERMINATION OF HOSPITAL-SPECIFIC**  
20                   **PERCENTAGE.**

21           “(a) SPECIAL RULE REGARDING FISCAL YEARS  
22    1995 AND 1996.—

23           “(1) IN GENERAL.—In the case of a teaching  
24           hospital whose first payments under 1886(h) were  
25           for cost reporting period beginning in fiscal year

1 1995 or in fiscal year 1996 (referred to in this sub-  
2 section individually as a ‘first payment year’), the  
3 percentage determined under paragraph (2) for the  
4 hospital is deemed to be the percentage applicable  
5 under section 2231(b)(2) to the hospital, except that  
6 the percentage under paragraph (2) shall be ad-  
7 justed in accordance with section 2231(b)(2)(A) to  
8 the extent determined by the Secretary to be nec-  
9 essary with respect to a sum that equals 100 per-  
10 cent.

11 “(2) DETERMINATION OF PERCENTAGE.—For  
12 purposes of paragraph (1), the percentage deter-  
13 mined under this paragraph for a teaching hospital  
14 is the percentage constituted by the ratio of the  
15 amount determined under subparagraph (A) to the  
16 amount determined under subparagraph (B), as fol-  
17 lows:

18 “(A)(i) If the first payment year for the  
19 hospital is fiscal year 1995, the amount deter-  
20 mined under this subparagraph is the total  
21 amount of payments received by the hospital  
22 under section 1886(h) for cost reporting periods  
23 beginning in fiscal year 1995.

24 “(ii) If the first payment year for the hos-  
25 pital is fiscal year 1996, the amount determined

1 under this subparagraph is an amount equal to  
2 an estimate by the Secretary of the total  
3 amount of payments that would have been paid  
4 to the hospital under section 1886(h) for cost  
5 reporting periods beginning in fiscal year 1995  
6 if such section, as in effect for fiscal year 1996,  
7 had applied to the hospital for fiscal year 1995.

8 “(B)(i) If the first payment year for the  
9 hospital is fiscal year 1995, the amount deter-  
10 mined under this subparagraph is the aggregate  
11 total of the payments received by teaching hos-  
12 pitals under section 1886(h) for cost reporting  
13 periods beginning in fiscal year 1995.

14 “(ii) If the first payment year for the hos-  
15 pital is fiscal year 1996—

16 “(I) the Secretary shall make an esti-  
17 mate in accordance with subparagraph  
18 (A)(ii) for all teaching hospitals; and

19 “(II) the amount determined under  
20 this subparagraph is the sum of the esti-  
21 mates made by the Secretary under  
22 subclause (I).

23 “(b) NEW TEACHING HOSPITALS.—

24 “(1) IN GENERAL.—In the case of a teaching  
25 hospital that did not receive payments under section

1 1886(h) for any of the fiscal years 1992 through  
2 1996, the percentage determined under paragraph  
3 (3) for the hospital is deemed to be the percentage  
4 applicable under section 2231(b)(2) to the hospital,  
5 except that the percentage under paragraph (3) shall  
6 be adjusted in accordance with section  
7 2231(b)(2)(A) to the extent determined by the Sec-  
8 retary to be necessary with respect to a sum that  
9 equals 100 percent.

10 “(2) DESIGNATED FISCAL YEAR REGARDING  
11 DATA.—The determination under paragraph (3) of a  
12 percentage for a teaching hospital described in para-  
13 graph (1) shall be made for the most recent fiscal  
14 year for which the Secretary has sufficient data to  
15 make the determination (referred to in this sub-  
16 section as the ‘designated fiscal year’).

17 “(3) DETERMINATION OF PERCENTAGE.—For  
18 purposes of paragraph (1), the percentage deter-  
19 mined under this paragraph for the teaching hos-  
20 pital involved is the percentage constituted by the  
21 ratio of the amount determined under subparagraph  
22 (A) to the amount determined under subparagraph  
23 (B), as follows:

24 “(A) The amount determined under this  
25 subparagraph is an amount equal to an esti-

1           mate by the Secretary of the total amount of  
2           payments that would have been paid to the hos-  
3           pital under section 1886(h) for the designated  
4           fiscal year if such section, as in effect for the  
5           first fiscal year for which payments pursuant to  
6           this subsection are to be made to the hospital,  
7           had applied to the hospital for cost reporting  
8           periods beginning in the designated fiscal year.

9           “(B) The Secretary shall make an estimate  
10          in accordance with subparagraph (A) for all  
11          teaching hospitals. The amount determined  
12          under this subparagraph is the sum of the esti-  
13          mates made by the Secretary under the preced-  
14          ing sentence.

15          “(c) CONSOLIDATIONS AND MERGERS.—In the case  
16          of two or more teaching hospitals that have each received  
17          payments pursuant to section 2231 for one or more fiscal  
18          years and that undergo a consolidation or merger, the per-  
19          centage applicable to the resulting teaching hospital for  
20          purposes of section 2231(b) is the sum of the respective  
21          percentages that would have applied pursuant to such sec-  
22          tion if the hospitals had not undergone the consolidation  
23          or merger.

1 **“SEC. 2233. DIRECT COSTS; AUTHORITY FOR PAYMENTS TO**  
2 **CONSORTIA OF PROVIDERS.**

3 “(a) IN GENERAL.—In lieu of making payments to  
4 teaching hospitals pursuant to section 2231, the Secretary  
5 may make payments under this section to consortia that  
6 meet the requirements of subsection (b).

7 “(b) QUALIFYING CONSORTIUM.—For purposes of  
8 subsection (a), a consortium meets the requirements of  
9 this subsection if the consortium is in compliance with the  
10 following:

11 “(1) The consortium consists of an approved  
12 medical residency training program of a teaching  
13 hospital and one or more of the following entities:

14 “(A) Schools of medicine or osteopathic  
15 medicine.

16 “(B) Other teaching hospitals (or the ap-  
17 proved medical residency training programs of  
18 the hospitals).

19 “(C) Community health centers (under sec-  
20 tion 330 of the Public Health Service Act).

21 “(D) Medical group practices.

22 “(E) Managed care entities.

23 “(F) Entities furnishing outpatient serv-  
24 ices.

25 “(G) Such other entities as the Secretary  
26 determines to be appropriate.

1           “(2) The members of the consortium have  
2 agreed to participate in the programs of graduate  
3 medical education that are operated by the teaching  
4 hospitals of the consortium.

5           “(3) With respect to the receipt by the consor-  
6 tium of payments made pursuant to this section, the  
7 members of the consortium have agreed on a method  
8 for allocating the payments among the members.

9           “(4) The consortium meets such additional re-  
10 quirements as the Secretary may establish.

11       “(c) PAYMENTS FROM ACCOUNTS.—

12           “(1) IN GENERAL.—Subject to subsection (d),  
13 the total of payments to a qualifying consortium for  
14 a fiscal year pursuant to subsection (a) shall be the  
15 sum of—

16           “(1) the aggregate amount determined for the  
17 teaching hospitals of the consortium pursuant to  
18 paragraph (1) of section 2231(a); and

19           “(2) an amount determined in accordance with  
20 the methodology that applies pursuant to paragraph  
21 (2) of such section, except that the estimate used for  
22 purposes of subsection (c)(2)(A) of such section shall  
23 be the estimate made for the consortium under sec-  
24 tion 1886(j)(2)(C)(ii).

1       “(d) LIMITATION ON AGGREGATE TOTAL OF PAY-  
2 MENTS TO CONSORTIA.—The aggregate total of the  
3 amounts paid under subsection (c)(2) to qualifying consor-  
4 tia for a fiscal year may not exceed the sum of—

5           “(1) the aggregate total of the amounts that  
6 would have been paid under section 2231(c) for the  
7 fiscal year to the teaching hospitals of the consortia  
8 if the hospitals had not been participants in the con-  
9 sortia; and

10          “(2) an amount equal to 1 percent of the  
11 amount that applies under paragraph (1)(A) of such  
12 section for the fiscal year (relating to the Medicare  
13 Direct-Costs Medical Education Account).

14       “(e) DEFINITION.—For purposes of this title, the  
15 term ‘qualifying consortium’ means a consortium that  
16 meets the requirements of subsection (b).

17 **“SEC. 2234. DIRECT COSTS; ALTERNATIVE PAYMENTS RE-**  
18 **GARDING TEACHING HOSPITALS IN CERTAIN**  
19 **STATES.**

20       “(a) IN GENERAL.—In the case of a teaching hospital  
21 in a State for which a demonstration project under section  
22 1814(b)(3) is in effect, this section applies in lieu of sec-  
23 tion 2231. For purposes of section 2211(a)(2), the amount  
24 determined for a teaching hospital for a fiscal year is the  
25 product of—

1           “(1) the amount in the General Direct-Costs  
2           Medical Education Account on the applicable date  
3           under section 2201(d) (once the appropriation under  
4           such section is made); and

5           “(2) the percentage determined under sub-  
6           section (b) for the hospital.

7           “(b) DETERMINATION OF PERCENTAGE.—For pur-  
8           poses of subsection (a)(2):

9           “(1) The Secretary shall make an estimate of  
10           the total amount of payments that would have been  
11           received under section 1886(h) by the hospital in-  
12           volved with respect to each of the fiscal years of the  
13           applicable period if such section (as in effect for  
14           such fiscal years) had applied to the hospital for  
15           such years.

16           “(2) The percentage determined under this sub-  
17           section for the hospital for a fiscal year is a mean  
18           average percentage determined for the hospital in  
19           accordance with the methodology of section  
20           2231(b)(2)(A), except that the estimate made by the  
21           Secretary under paragraph (1) of this subsection for  
22           a fiscal year of the applicable period is deemed to be  
23           the amount that applies for purposes of section  
24           2231(b)(2)(B)(i) for such year.

1       “(c) RULE REGARDING PAYMENTS FROM CERTAIN  
2 AMOUNTS.—In the case of a teaching hospital in a State  
3 for which a demonstration project under section  
4 1814(b)(3) is in effect, this section does not provide any  
5 payment to the hospital from amounts transferred to the  
6 Fund under section 1886(j).

7               “Subpart 4—General Provisions

8       **“SEC. 2241. ADJUSTMENTS IN PAYMENT AMOUNTS.**

9       “(a) COLLECTION OF DATA ON ACCURACY OF ESTI-  
10 MATES.—The Secretary shall collect data on whether the  
11 estimates made by the Secretary under section 1886(j) for  
12 a fiscal year were substantially accurate.

13       “(b) ADJUSTMENTS.—If the Secretary determines  
14 under subsection (a) that an estimate for a fiscal year was  
15 not substantially accurate, the Secretary shall, for the first  
16 fiscal year beginning after the Secretary makes the deter-  
17 mination—

18               “(1) make adjustments accordingly in transfers  
19 to the Fund under section 1886(j); and

20               “(2) make adjustments accordingly in the  
21 amount of payments to teaching hospitals pursuant  
22 to 2231(c) (or, as applicable, to qualifying consortia  
23 pursuant to section 2232(c)(2)).”.

1 **PART 2—AMENDMENTS TO MEDICARE PROGRAM**

2 **SEC. 15411. TRANSFERS TO TEACHING HOSPITAL AND**  
3 **GRADUATE MEDICAL EDUCATION TRUST**  
4 **FUND.**

5 Section 1886 (42 U.S.C. 1395ww) is amended—

6 (1) in subsection (d)(5)(B), in the matter pre-  
7 ceding clause (i), by striking “The Secretary shall  
8 provide” and inserting the following: “For dis-  
9 charges occurring on or before September 30, 1996,  
10 the Secretary shall provide”;

11 (2) in subsection (h)—

12 (A) in paragraph (1), in the first sentence,  
13 by striking “the Secretary shall provide” and  
14 inserting “the Secretary shall, subject to para-  
15 graph (6), provide”; and

16 (B) by adding at the end the following  
17 paragraph:

18 “(6) LIMITATION.—

19 “(A) IN GENERAL.—The authority to  
20 make payments under this subsection applies  
21 only with respect to cost reporting periods end-  
22 ing on or before September 30, 1996, except as  
23 provided in subparagraph (B).

24 “(B) RULE REGARDING PORTION OF LAST  
25 COST REPORTING PERIOD.—In the case of a  
26 cost reporting period that extends beyond Sep-

1           tember 30, 1996, payments under this sub-  
2           section shall be made with respect to such por-  
3           tion of the period as has lapsed as of such date.

4           “(C) RULE OF CONSTRUCTION.—This  
5           paragraph may not be construed as authorizing  
6           any payment under section 1861(v) with re-  
7           spect to graduate medical education.”; and

8           (3) by adding at the end the following sub-  
9           section:

10          “(j) TRANSFERS TO TEACHING HOSPITAL AND  
11          GRADUATE MEDICAL EDUCATION TRUST FUND.—

12                 “(1) INDIRECT COSTS OF MEDICAL EDU-  
13          CATION.—

14                         “(A) IN GENERAL.—From the Federal  
15                         Hospital Insurance Trust Fund, the Secretary  
16                         shall, for fiscal year 1997 and each subsequent  
17                         fiscal year, transfer to the Indirect-Costs Medi-  
18                         cal Education Account (under section 2201) an  
19                         amount determined by the Secretary in accord-  
20                         ance with subparagraph (B).

21                         “(B) DETERMINATION OF AMOUNTS.—The  
22                         Secretary shall make an estimate for the fiscal  
23                         year involved of the nationwide total of the  
24                         amounts that would have been paid under sub-  
25                         section (d)(5)(B) to hospitals during the fiscal

1 year if such payments had not been terminated  
2 for discharges occurring after September 30,  
3 1996. For purposes of subparagraph (A), the  
4 amount determined under this subparagraph  
5 for the fiscal year is the estimate made by the  
6 Secretary under the preceding sentence.

7 “(2) DIRECT COSTS OF MEDICAL EDUCATION.—

8 “(A) IN GENERAL.—From the Federal  
9 Hospital Insurance Trust Fund and the Fed-  
10 eral Supplementary Medical Insurance Trust  
11 Fund, the Secretary shall, for fiscal year 1997  
12 and each subsequent fiscal year, transfer to the  
13 Medicare Direct-Costs Medical Education Ac-  
14 count (under section 2201) the sum of—

15 “(i) an amount determined by the  
16 Secretary in accordance with subparagraph  
17 (B); and

18 “(ii) as applicable, an amount deter-  
19 mined by the Secretary in accordance with  
20 subparagraph (C)(ii).

21 “(B) DETERMINATION OF AMOUNTS.—For  
22 each hospital (other than a hospital that is a  
23 member of a qualifying consortium referred to  
24 in subparagraph (C)), the Secretary shall make  
25 an estimate for the fiscal year involved of the

1 amount that would have been paid under sub-  
2 section (h) to the hospital during the fiscal year  
3 if such payments had not been terminated for  
4 cost reporting periods ending on or before Sep-  
5 tember 30, 1996. For purposes of subparagraph  
6 (A)(i), the amount determined under this sub-  
7 paragraph for the fiscal year is the sum of all  
8 estimates made by the Secretary under the pre-  
9 ceding sentence.

10 “(C) ESTIMATES REGARDING QUALIFYING  
11 CONSORTIA.—If the Secretary elects to author-  
12 ize one or more qualifying consortia for pur-  
13 poses of section 2233(a), the Secretary shall  
14 carry out the following:

15 “(i) The Secretary shall establish a  
16 methodology for making payments to quali-  
17 fying consortia with respect to the reason-  
18 able direct costs of such consortia in carry-  
19 ing out programs of graduate medical edu-  
20 cation. The methodology shall be the meth-  
21 odology established in subsection (h),  
22 modified to the extent necessary to take  
23 into account the participation in such pro-  
24 grams of entities other than hospitals.

1           “(ii) For each qualifying consortium,  
2           the Secretary shall make an estimate for  
3           the fiscal year involved of the amount that  
4           would have been paid to the consortium  
5           during the fiscal year if, using the meth-  
6           odology under clause (i), payments had  
7           been made to the consortium for the fiscal  
8           year as reimbursements with respect to  
9           cost reporting periods. For purposes of  
10          subparagraph (A)(ii), the amount deter-  
11          mined under this clause for the fiscal year  
12          is the sum of all estimates made by the  
13          Secretary under the preceding sentence.

14          “(D) ALLOCATION BETWEEN FUNDS.—In  
15          providing for a transfer under subparagraph  
16          (A) for a fiscal year, the Secretary shall provide  
17          for an allocation of the amounts involved be-  
18          tween part A and part B (and the trust funds  
19          established under the respective parts) as rea-  
20          sonably reflects the proportion of direct grad-  
21          uate medical education costs of hospitals associ-  
22          ated with the provision of services under each  
23          respective part.

24          “(3) APPLICABILITY OF CERTAIN AMEND-  
25          MENTS.—Amendments made to subsection (d)(5)(B)

1 and subsection (h) that are effective on or after Oc-  
 2 tober 1, 1996, apply only for purposes of estimates  
 3 under paragraphs (1) and (2) and for purposes of  
 4 determining the amount of payments under 2211.  
 5 Such amendments do not require any adjustment to  
 6 amounts paid under subsection (d)(5)(B) or (h) with  
 7 respect to fiscal year 1996 or any prior fiscal year.

8 “(4) RELATIONSHIP TO CERTAIN DEMONSTRA-  
 9 TION PROJECTS.—In the case of a State for which  
 10 a demonstration project under section 1814(b)(3) is  
 11 in effect, the Secretary, in making determinations of  
 12 the rates of increase under such section, shall in-  
 13 clude all amounts transferred under this subsection.  
 14 Such amounts shall be so included to the same ex-  
 15 tent and in the same manner as amounts determined  
 16 under subsections (d)(5)(B) and (h) were included in  
 17 such determination under the provisions of this title  
 18 in effect on September 30, 1996.”

19 **SEC. 15412. MODIFICATION IN PAYMENT POLICIES REGARD-**  
 20 **ING GRADUATE MEDICAL EDUCATION.**

21 (a) **INDIRECT COSTS OF MEDICAL EDUCATION; AP-**  
 22 **PLICABLE PERCENTAGE.—**

23 (1) **MODIFICATION REGARDING 5.6 PERCENT.—**

24 Section 1886(d)(5)(B)(ii) (42 U.S.C.  
 25 1395ww(d)(5)(B)(ii)) is amended—

1 (A) by striking “on or after October 1,  
2 1988,” and inserting “on or after October 1,  
3 1999,”; and

4 (B) by striking “1.89” and inserting  
5 “1.38”.

6 (2) SPECIAL RULE REGARDING FISCAL YEARS  
7 1996 THROUGH 1998; MODIFICATION REGARDING 6  
8 PERCENT.—Section 1886(d)(5)(B)(ii), as amended  
9 by paragraph (1), is amended by adding at the end  
10 the following: “In the case of discharges occurring  
11 on or after October 1, 1995, and before October 1,  
12 1999, the preceding sentence applies to the same ex-  
13 tent and in the same manner as the sentence applies  
14 to discharges occurring on or after October 1, 1999,  
15 except that the term ‘1.38’ is deemed to be ‘1.48’.”.

16 (b) DIRECT COSTS OF MEDICAL EDUCATION.—

17 (1) LIMITATION ON NUMBER OF FULL-TIME-  
18 EQUIVALENT RESIDENTS.—Section 1886(h)(4) (42  
19 U.S.C. 1395ww(h)(4)) is amended by adding at the  
20 end the following new subparagraph:

21 “(F) LIMITATION ON NUMBER OF RESI-  
22 DENTS FOR CERTAIN FISCAL YEARS.—Such  
23 rules shall provide that for purposes of a cost  
24 reporting period beginning on or after October  
25 1, 1995, and on or before September 30, 2002,

1 the number of full-time-equivalent residents de-  
2 termined under this paragraph with respect to  
3 an approved medical residency training program  
4 may not exceed the number of full-time-equiva-  
5 lent residents with respect to the program as of  
6 August 1, 1995 (except that this subparagraph  
7 does not apply to any nonphysician post-  
8 graduate training program that, under para-  
9 graph (5)(A), is an approved medical residency  
10 training program).”.

11 (2) EXCLUSION OF RESIDENTS AFTER INITIAL  
12 RESIDENCY PERIOD.—Section 1886(h)(4)(C) (42  
13 U.S.C. 1395ww(h)(4)(C)) is amended to read as fol-  
14 lows:

15 “(C) WEIGHTING FACTORS FOR RESI-  
16 DENTS.—Effective for cost reporting periods  
17 beginning on or after October 1, 1997, such  
18 rules shall provide that, in the calculation of the  
19 number of full-time-equivalent residents in an  
20 approved residency program, the weighting fac-  
21 tor for a resident who is in the initial residency  
22 period (as defined in paragraph (5)(F)) is 1.0  
23 and the weighting factor for a resident who has  
24 completed such period is 0.0. (In the case of  
25 cost reporting periods beginning before October

1           1, 1997, the weighting factors that apply in  
2           such calculation are the weighting factors that  
3           were applicable under this subparagraph on the  
4           day before the date of the enactment of the  
5           Medicare Preservation Act of 1995.)”.

6           (3) REDUCTIONS IN PAYMENTS FOR ALIEN  
7           RESIDENTS.—Section 1886(h)(4) (42 U.S.C.  
8           1395ww(h)(4)), as amended by paragraph (1), is  
9           amended by adding at the end the following new  
10          subparagraph:

11                 “(G) SPECIAL RULES FOR ALIEN RESI-  
12                 DENTS.—In the case of individuals who are not  
13                 citizens or nationals of the United States, in  
14                 the calculation of the number of full-time-equiv-  
15                 alent residents in an approved medical resi-  
16                 dency program, the following rules shall apply  
17                 with respect to such individuals who are resi-  
18                 dents in the program:

19                         “(i) For a cost reporting period begin-  
20                         ning during fiscal year 1996, for each such  
21                         individual the Secretary shall apply a  
22                         weighting factor of .75.

23                         “(ii) For a cost reporting period be-  
24                         ginning during fiscal year 1997, for each

1           such individual the Secretary shall apply a  
2           weighting factor of .50.

3           “(iii) For a cost reporting period be-  
4           ginning during fiscal year 1998, for each  
5           such individual the Secretary shall apply a  
6           weighting factor of .25.

7           “(iv) For a cost reporting period be-  
8           ginning during fiscal year 1999 or any  
9           subsequent fiscal year, such individuals  
10          shall be excluded from the calculation of  
11          the number of full-time-equivalent resi-  
12          dents in an approved medical residency  
13          program under this paragraph.”.

14          (c) EFFECTIVE DATE.—Except as provided otherwise  
15          in this section (or in the amendments made by this sec-  
16          tion), the amendments made by this section apply to hos-  
17          pital cost reporting periods beginning on or after October  
18          1, 1995.

1 **PART 3—REFORM OF FEDERAL POLICIES RE-**  
2 **GARDING TEACHING HOSPITALS AND GRAD-**  
3 **UATE MEDICAL EDUCATION**

4 **SEC. 15421. ESTABLISHMENT OF ADVISORY PANEL FOR**  
5 **RECOMMENDING POLICIES.**

6 Title XXII of the Social Security Act, as added by  
7 section 15401, is amended by adding at the end the follow-  
8 ing part:

9 “PART C—OTHER MATTERS  
10 **“SEC. 2251. ADVISORY PANEL ON REFORM IN FINANCING**  
11 **OF TEACHING HOSPITALS AND GRADUATE**  
12 **MEDICAL EDUCATION.**

13 “(a) ESTABLISHMENT.—The Chair of the Medicare  
14 Payment Review Commission under section 1806 shall es-  
15 tablish a temporary advisory panel to be known as the Ad-  
16 visory Panel on Financing for Teaching Hospitals and  
17 Graduate Medical Education (in this section referred to  
18 as the ‘Panel’).

19 “(b) DUTIES.—The Panel shall develop recommenda-  
20 tions on whether and to what extent Federal policies re-  
21 garding teaching hospitals and graduate medical edu-  
22 cation should be reformed, including recommendations re-  
23 garding the following:

24 “(1) The financing of graduate medical edu-  
25 cation, including consideration of alternative broad-  
26 based sources of funding for such education.

1           “(2) The financing of teaching hospitals, in-  
2           cluding consideration of the difficulties encountered  
3           by such hospitals as competition among health care  
4           entities increases. Matters considered under this  
5           paragraph shall include consideration of the effects  
6           on teaching hospitals of the method of financing  
7           used for the program under part C of title XVIII  
8           (relating to MedicarePlus).

9           “(3) The methodology for making payments for  
10          graduate medical education, and the selection of en-  
11          tities to receive the payments. Matters considered  
12          under this paragraph shall include the following:

13                 “(A) The methodology under part B for  
14                 making payments from the Fund, including the  
15                 use of data from the fiscal years 1992 through  
16                 1994, and including the methodology that ap-  
17                 plies with respect to consolidations and mergers  
18                 of participants in the program under such part  
19                 and with respect to the inclusion of additional  
20                 participants in the program.

21                 “(B) Issues regarding children’s hospitals,  
22                 and approved medical residency training pro-  
23                 grams in pediatrics.

24                 “(C) Whether and to what extent pay-  
25                 ments are being made (or should be made) for

1 graduate training in the various nonphysician  
2 health professions.

3 “(4) Federal policies regarding international  
4 medical graduates.

5 “(5) The dependence of schools of medicine on  
6 service-generated income.

7 “(6) The effects of the amendments made by  
8 section 15412 of the Medicare Preservation Act of  
9 1995, including adverse effects on teaching hospitals  
10 that result from modifications in policies regarding  
11 international medical graduates.

12 “(7) The feasibility and desirability of reducing  
13 payments for graduate medical education for high-  
14 cost residency programs under section  
15 1886(h)(2)(D)(iii).

16 “(c) COMPOSITION.—Not later than three months  
17 after being designated as the initial chairman of the Medi-  
18 care Payment Review Commission, the chairman of the  
19 Commission shall appoint to the Panel 19 individuals who  
20 are not members of the Commission, who are not officers  
21 or employees of the United States, and who possess exper-  
22 tise on matters on which the Panel is to make rec-  
23 ommendations under subsection (b). Such individuals shall  
24 include the following:

1           “(1) Deans from allopathic and osteopathic  
2 schools of medicine.

3           “(2) Chief executive officers (or equivalent ad-  
4 ministrative heads) from academic health centers,  
5 integrated health care systems, and approved medi-  
6 cal residency training programs.

7           “(3) Chairs of departments or divisions from  
8 allopathic and osteopathic schools of medicine,  
9 schools of dentistry, and approved medical residency  
10 training programs in oral surgery.

11           “(4) Individuals with leadership experience  
12 from each of the fields of advanced practice nursing,  
13 physician assistants, and podiatric medicine.

14           “(5) Individuals with substantial experience in  
15 the study of issues regarding the composition of the  
16 health care workforce of the United States.

17           “(6) Individuals with expertise on the financing  
18 of health care.

19           “(7) Representatives from health insurance or-  
20 ganizations and health plan organizations.

21           “(d) RELATIONSHIP OF PANEL TO MEDICARE PAY-  
22 MENT REVIEW COMMISSION.—From amounts appro-  
23 priated under subsection (n), the Medicare Review Pay-  
24 ment Commission shall provide for the Panel such staff  
25 and administrative support (including quarters for the

1 Panel) as may be necessary for the Panel to carry out  
2 the duties under subsection (b).

3 “(e) CHAIR.—The Panel shall designate a member of  
4 the Panel to serve as the Chair of the Panel.

5 “(f) MEETINGS.—The Panel shall meet at the call of  
6 the Chair or a majority of the members, except that the  
7 first meeting of the Panel shall be held not later than  
8 three months after the date on which appointments under  
9 subsection (c) are completed.

10 “(g) TERMS.—The term of a member of the Panel  
11 is the duration of the Panel.

12 “(h) VACANCIES.—

13 “(1) IN GENERAL.—A vacancy in the member-  
14 ship of the Panel does not affect the power of the  
15 remaining members to carry out the duties under  
16 subsection (b). A vacancy in the membership of the  
17 Panel shall be filled in the manner in which the  
18 original appointment was made.

19 “(2) INCOMPLETE TERM.—If a member of the  
20 Panel does not serve the full term applicable to the  
21 member, the individual appointed to fill the resulting  
22 vacancy shall be appointed for the remainder of the  
23 term of the predecessor of the individual.

24 “(i) COMPENSATION; REIMBURSEMENT OF EX-  
25 PENSES.—

1           “(1) COMPENSATION.—Members of the Panel  
2 shall receive compensation for each day (including  
3 traveltime) engaged in carrying out the duties of the  
4 Committee. Such compensation may not be in an  
5 amount in excess of the daily equivalent of the an-  
6 nual maximum rate of basic pay payable under the  
7 General Schedule (under title 5, United States  
8 Code) for positions above GS-15.

9           “(2) REIMBURSEMENT.—Members of the Panel  
10 may, in accordance with chapter 57 of title 5, Unit-  
11 ed States Code, be reimbursed for travel, subsist-  
12 ence, and other necessary expenses incurred in car-  
13 rying out the duties of the Panel.

14           “(j) CONSULTANTS.—The Panel may procure such  
15 temporary and intermittent services of consultants under  
16 section 3109(b) of title 5, United States Code, as the  
17 Panel may determine to be useful in carrying out the du-  
18 ties under section 3. The Panel may not procure services  
19 under this subsection at any rate in excess of the daily  
20 equivalent of the maximum annual rate of basic pay pay-  
21 able under the General Schedule for positions above GS-  
22 15. Consultants under this subsection may, in accordance  
23 with chapter 57 of title 5, United States Code, be reim-  
24 bursed for travel, subsistence, and other necessary ex-

1 penses incurred for activities carried out on behalf of the  
2 Panel pursuant to section 3.

3 “(k) POWERS.—

4 “(1) IN GENERAL.—For the purpose of carry-  
5 ing out the duties of the Panel under subsection (b),  
6 the Panel may hold such hearings, sit and act at  
7 such times and places, take such testimony, and re-  
8 ceive such evidence as the Panel considers appro-  
9 priate.

10 “(2) OBTAINING OFFICIAL INFORMATION.—

11 Upon the request of the Panel, the heads of Federal  
12 agencies shall furnish directly to the Panel informa-  
13 tion necessary for the Panel to carry out the duties  
14 under subsection (b).

15 “(3) USE OF MAILS.—The Panel may use the  
16 United States mails in the same manner and under  
17 the same conditions as Federal agencies.

18 “(l) REPORTS.—

19 “(1) FIRST INTERIM REPORT.—Not later than  
20 one year after the date of the enactment of the Med-  
21 icare Preservation Act of 1995, the Panel shall sub-  
22 mit to the Congress a report providing the rec-  
23 ommendations of the Panel regarding the matters  
24 specified in paragraphs (1) through (4) of subsection  
25 (b).

1           “(2) SECOND INTERIM REPORT.—Not later  
2 than 2 years after the date of enactment specified  
3 in paragraph (1), the Panel shall submit to the Con-  
4 gress a report providing the recommendations of the  
5 Panel regarding the matters specified in paragraphs  
6 (5) and (6) of subsection (b).

7           “(3) FINAL REPORT.—Not later than 3 years  
8 after the date of enactment specified in paragraph  
9 (1), the Panel shall submit to the Congress a final  
10 report providing the recommendations of the Panel  
11 under subsection (b).

12          “(m) DURATION.—The Panel terminates upon the  
13 expiration of the 180-day period beginning on the date on  
14 which the final report under subsection (l)(3) is submitted  
15 to the Congress.

16          “(n) AUTHORIZATION OF APPROPRIATIONS.—

17           “(1) IN GENERAL.—Subject to paragraph (2),  
18 for the purpose of carrying out this section, there  
19 are authorized to be appropriated such sums as may  
20 be necessary for each of the fiscal years 1996  
21 through 2000.

22           “(2) LIMITATION.—The authorization of appro-  
23 priations established in paragraph (1) is effective  
24 only with respect to appropriations made from allo-

1 cations under section 302(b) of the Congressional  
2 Budget Act of 1974—

3 “(A) for the Subcommittee on Labor,  
4 Health and Human Services, and Education,  
5 Committee on Appropriations of the House of  
6 Representatives, in the case of any bill, resolu-  
7 tion, or amendment considered in the House;  
8 and

9 “(B) for the Subcommittee on Labor,  
10 Health and Human Services, and Education,  
11 Committee on Appropriations of the Senate, in  
12 the case of any bill, resolution, or amendment  
13 considered in the Senate.”.

14 **Subtitle F—Provisions Relating to**  
15 **Medicare Part A**

16 **PART 1—HOSPITALS**

17 **Subpart A—General Provisions Relating to Hospitals**

18 **SEC. 15501. REDUCTIONS IN INFLATION UPDATES FOR PPS**

19 **HOSPITALS.**

20 Section 1886(b)(3)(B)(i) (42 U.S.C.  
21 1395ww(b)(3)(B)(i)) is amended by striking subclauses  
22 (XI), (XII), and (XIII) and inserting the following:

23 “(XI) for fiscal year 1996, the market basket  
24 percentage increase minus 2.5 percentage points for  
25 hospitals in all areas,

1           “(XII) for each of the fiscal years 1997 through  
2           2002, the market basket percentage increase minus  
3           2.0 percentage points for hospitals in all areas, and

4           “(XIII) for fiscal year 2003 and each subse-  
5           quent fiscal year, the market basket percentage in-  
6           crease for hospitals in all areas.”.

7   **SEC. 15502. REDUCTIONS IN DISPROPORTIONATE SHARE**  
8                           **PAYMENT ADJUSTMENTS.**

9           Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F))  
10 is amended—

11           (1) in clause (ii), by striking “The amount”  
12           and inserting “Subject to clause (ix), the amount”;  
13           and

14           (2) by adding at the end the following new  
15           clause:

16           “(ix) In the case of discharges occurring on or after  
17           October 1, 1995, the additional payment amount other-  
18           wise determined under clause (ii) shall be reduced as fol-  
19           lows:

20                   “(I) For discharges occurring on or after Octo-  
21                   ber 1, 1995, and on or before September 30, 1996,  
22                   by 17 percent.

23                   “(II) For discharges occurring on or after Octo-  
24                   ber 1, 1996, and on or before September 30, 1997,  
25                   by 15 percent.

1           “(III) For discharges occurring on or after Oc-  
2           tober 1, 1997, and on or before September 30, 1998,  
3           by 20 percent.

4           “(IV) For discharges occurring on or after Oc-  
5           tober 1, 1998, and on or before September 30, 1999,  
6           by 20 percent.

7           “(V) For discharges occurring on or after Octo-  
8           ber 1, 1999, and on or before September 30, 2000,  
9           by 25 percent.

10           “(VI) For discharges occurring on or after Oc-  
11           tober 1, 2000, and on or before September 30, 2001,  
12           by 30 percent.

13           “(VII) For discharges occurring on or after Oc-  
14           tober 1, 2001, by 30 percent.”.

15 **SEC. 15503. PAYMENTS FOR CAPITAL-RELATED COSTS FOR**  
16 **INPATIENT HOSPITAL SERVICES.**

17           (a) REDUCTION IN PAYMENTS FOR PPS Hos-  
18           PITALS.—

19                   (1) CONTINUATION OF CURRENT REDUC-  
20           TIONS.—Section 1886(g)(1)(A) (42 U.S.C.  
21           1395ww(g)(1)(A)) is amended in the second sen-  
22           tence—

23                           (A) by striking “through 1995” and insert-  
24                           ing “through 2002”; and

1 (B) by inserting after “reduction” the fol-  
2 lowing: “(or a 15 percent reduction in the case  
3 of payments during fiscal years 1996 through  
4 2002)”.

5 (2) REDUCTION IN BASE PAYMENT RATES.—  
6 Section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A))  
7 is amended by adding at the end the following new  
8 sentence: “In addition to the reduction described in  
9 the preceding sentence, for discharges occurring  
10 after September 30, 1995, the Secretary shall reduce  
11 by 7.47 percent the unadjusted standard Federal  
12 capital payment rate (as described in 42 CFR  
13 412.308(c), as in effect on the date of the enactment  
14 of the Medicare Preservation Act of 1995) and shall  
15 reduce by 8.27 percent the unadjusted hospital-spe-  
16 cific rate (as described in 42 CFR 412.328(e)(1), as  
17 in effect on such date of enactment).”.

18 (b) REDUCTION IN PAYMENTS FOR PPS-EXEMPT  
19 HOSPITALS.—Section 1886(g) (42 U.S.C. 1395ww(g)) is  
20 amended by adding at the end the following new para-  
21 graph:

22 “(4)(A) Except as provided in subparagraph (B), in  
23 determining the amount of the payments that may be  
24 made under this title with respect to all the capital-related  
25 costs of inpatient hospital services furnished during fiscal

1 years 1996 through 2002 of a hospital which is not a sub-  
2 section (d) hospital or a subsection (d) Puerto Rico hos-  
3 pital, the Secretary shall reduce the amounts of such pay-  
4 ments otherwise determined under this title by 15 percent.

5 “(B) Subparagraph (A) shall not apply to payments  
6 with respect to the capital-related costs of any hospital  
7 that is a sole community hospital (as defined in subsection  
8 (d)(5)(D)(iii)) or a rural primary care hospital (as defined  
9 in section 1861(mm)(1)).”.

10 (c) HOSPITAL-SPECIFIC ADJUSTMENT FOR CAPITAL-  
11 RELATED TAX COSTS.—Section 1886(g)(1) (42 U.S.C.  
12 1395ww(g)(1)) is amended—

13 (1) by redesignating subparagraph (C) as sub-  
14 paragraph (D), and

15 (2) by inserting after subparagraph (B) the fol-  
16 lowing:

17 “(C)(i) For discharges occurring after Sep-  
18 tember 30, 1995, such system shall provide for  
19 an adjustment in an amount equal to the  
20 amount determined under clause (iv) for cap-  
21 ital-related tax costs for each hospital that is el-  
22 igible for such adjustment.

23 “(ii) Subject to clause (iii), a hospital is el-  
24 igible for an adjustment under this subpara-

1 graph, with respect to discharges occurring in a  
2 fiscal year, if the hospital—

3 “(I) is a hospital that may otherwise  
4 receive payments under this subsection,

5 “(II) is not a public hospital, and

6 “(III) incurs capital-related tax costs  
7 for the fiscal year.

8 “(iii)(I) In the case of a hospital that first  
9 incurs capital-related tax costs in a fiscal year  
10 after fiscal year 1992 because of a change from  
11 nonproprietary to proprietary status or because  
12 the hospital commenced operation after such  
13 fiscal year, the first fiscal year for which the  
14 hospital shall be eligible for such adjustment is  
15 the second full fiscal year following the fiscal  
16 year in which the hospital first incurs such  
17 costs.

18 “(II) In the case of a hospital that first in-  
19 curs capital-related tax costs in a fiscal year  
20 after fiscal year 1992 because of a change in  
21 State or local tax laws, the first fiscal year for  
22 which the hospital shall be eligible for such ad-  
23 justment is the fourth full fiscal year following  
24 the fiscal year in which the hospital first incurs  
25 such costs.

1           “(iv) The per discharge adjustment under  
2 this clause shall be equal to the hospital-specific  
3 capital-related tax costs per discharge of a hos-  
4 pital for fiscal year 1992 (or, in the case of a  
5 hospital that first incurs capital-related tax  
6 costs for a fiscal year after fiscal year 1992, for  
7 the first full fiscal year for which such costs are  
8 incurred), updated to the fiscal year to which  
9 the adjustment applies. Such per discharge ad-  
10 justment shall be added to the Federal capital  
11 rate, after such rate has been adjusted as de-  
12 scribed in 42 CFR 412.312 (as in effect on the  
13 date of the enactment of the Medicare Preser-  
14 vation Act of 1995), and before such rate is  
15 multiplied by the applicable Federal rate per-  
16 centage.

17           “(v) For purposes of this subparagraph,  
18 capital-related tax costs include—

19                   “(I) the costs of taxes on land and de-  
20 preciable assets owned by a hospital (or re-  
21 lated organization) and used for patient  
22 care,

23                   “(II) payments in lieu of such taxes  
24 (made by hospitals that are exempt from  
25 taxation), and

1           “(III) the costs of taxes paid by a  
2           hospital (or related organization) as lessee  
3           of land, buildings, or fixed equipment from  
4           a lessor that is unrelated to the hospital  
5           (or related organization) under the terms  
6           of a lease that requires the lessee to pay  
7           all expenses (including mortgage, interest,  
8           and amortization) and leaves the lessor  
9           with an amount free of all claims (some-  
10          times referred to as a ‘net net net’ or ‘tri-  
11          ple net’ lease).

12           In determining the adjustment required under  
13          clause (i), the Secretary shall not take into ac-  
14          count any capital-related tax costs of a hospital  
15          to the extent that such costs are based on tax  
16          rates and assessments that exceed those for  
17          similar commercial properties.

18           “(vi) The system shall provide that the  
19          Federal capital rate for any fiscal year after  
20          September 30, 1995, shall be reduced by a per-  
21          centage sufficient to ensure that the adjust-  
22          ments required to be paid under clause (i) for  
23          a fiscal year neither increase nor decrease the  
24          total amount that would have been paid under

1           this system but for the payment of such adjust-  
2           ments for such fiscal year.”.

3           (d) REVISION OF EXCEPTIONS PROCESS UNDER  
4 PROSPECTIVE PAYMENT SYSTEM FOR CERTAIN  
5 PROJECTS.—

6           (1) IN GENERAL.—Section 1886(g)(1) (42  
7 U.S.C. 1395ww(g)(1)), as amended by subsection  
8 (c), is amended—

9                   (A) by redesignating subparagraph (D) as  
10                   subparagraph (E), and

11                   (B) by inserting after subparagraph (C)  
12                   the following:

13           “(D) The exceptions under the system provided by  
14 the Secretary under subparagraph (B)(iii) shall include  
15 the provision of exception payments under the special ex-  
16 ceptions process provided under 42 CFR 412.348(g) (as  
17 in effect on September 1, 1995), except that the Secretary  
18 shall revise such process as follows:

19                   “(i) A hospital with at least 100 beds which is  
20                   located in an urban area shall be eligible under such  
21                   process without regard to its disproportionate pa-  
22                   tient percentage under subsection (d)(5)(F) or  
23                   whether it qualifies for additional payment amounts  
24                   under such subsection.

1           “(ii) The minimum payment level for qualifying  
2 hospitals shall be 85 percent.

3           “(iii) A hospital shall be considered to meet the  
4 requirement that it completes the project involved no  
5 later than the end of the hospital’s last cost report-  
6 ing period beginning after October 1, 2001, if—

7                   “(I) the hospital has obtained a certificate  
8 of need for the project approved by the State or  
9 a local planning authority, and

10                   “(II) by September 1, 1995, the hospital  
11 has expended on the project at least \$750,000  
12 or 10 percent of the estimated cost of the  
13 project.

14           “(iv) The amount of the exception payment  
15 made shall not be reduced by any offsetting  
16 amounts.”.

17           (2) CONFORMING AMENDMENT.—Section  
18 1886(g)(1)(B) (42 U.S.C. 1395ww(g)(1)(B)) is  
19 amended by striking “may provide” and inserting  
20 “shall provide (in accordance with subparagraph  
21 (D))”.

1 **SEC. 15504. REDUCTION IN ADJUSTMENT FOR INDIRECT**  
2 **MEDICAL EDUCATION.**

3 For provisions modifying medicare payment policies  
4 regarding graduate medical education, see part 2 of sub-  
5 title E.

6 **SEC. 15505. TREATMENT OF PPS-EXEMPT HOSPITALS.**

7 (a) **UPDATES.**—Section 1886(b)(3)(B)(ii)(V) (42  
8 U.S.C. 1395ww(b)(3)(B)(ii)(V)) is amended by striking  
9 “thorough 1997” and inserting “through 2002”.

10 (b) **REBASING FOR CERTAIN LONG-TERM CARE HOS-**  
11 **PITALS.**—

12 (1) **IN GENERAL.**—Section 1886(b)(3) (42  
13 U.S.C. 1395ww(b)(3)) is amended—

14 (A) in subparagraph (A), by striking “and  
15 (E)” and inserting “(E), and (F)”;

16 (B) in subparagraph (B)(ii), by striking  
17 “(A) and (E)” and inserting “(A), (E), and  
18 (F)”;

19 (C) by adding at the end the following new  
20 subparagraph:

21 “(F)(i) In the case of a qualified long-term care hos-  
22 pital (as defined in clause (ii)), the term ‘target amount’  
23 means—

24 “(I) with respect to the first 12-month cost re-  
25 porting period in which this subparagraph is applied  
26 to the hospital, the allowable operating costs of inpa-

1       tient hospital services (as defined in subsection  
2       (a)(4)) recognized under this title for the hospital  
3       for the 12-month cost reporting period beginning  
4       during fiscal year 1991; or

5               “(II) with respect to a later cost reporting pe-  
6       riod, the target amount for the preceding cost re-  
7       porting period, increase by the applicable percentage  
8       increase under subparagraph (B)(ii) for that later  
9       cost reporting period.

10       “(ii) In clause (i), a ‘qualified long-term care hospital’  
11       means, with respect to a cost reporting period, a hospital  
12       described in clause (iv) of subsection (d)(1)(B) during fis-  
13       cal year 1995 for which the hospital’s allowable operating  
14       costs of inpatient hospital services recognized under this  
15       title for each of the two most recent previous 12-month  
16       cost reporting periods exceeded the hospital’s target  
17       amount determined under this paragraph for such cost re-  
18       porting periods, if the hospital—

19               “(I) has a disproportionate patient percentage  
20       during such cost reporting period (as determined by  
21       the Secretary under subsection (d)(5)(F)(vi) as if  
22       the hospital were a subsection (d) hospital) of at  
23       least 25 percent, or

24               “(II) is located in a State for which no payment  
25       is made under the State plan under title XIX for

1 days of inpatient hospital services furnished to any  
2 individual in excess of the limit on the number of  
3 days of such services furnished to the individual for  
4 which payment may be made under this title.”.

5 (2) EFFECTIVE DATE.—The amendment made  
6 by paragraph (1) shall apply to discharges occurring  
7 during cost reporting periods beginning on or after  
8 October 1, 1995.

9 (c) TREATMENT OF CERTAIN UNITS LOCATED  
10 WITHIN OTHER HOSPITALS.—

11 (1) IN GENERAL.—Section 1886(d)(1)(B) (42  
12 U.S.C. 1395ww(d)(1)(B)) is amended in the matter  
13 following clause (v) by striking the period and in-  
14 sserting the following: “, or a long-term care unit of  
15 the hospital if such unit was not treated as a sub-  
16 section (d) hospital with respect to discharges occur-  
17 ring on or before September 30, 1995.”.

18 (2) STUDY BY REVIEW COMMISSION.—Not later  
19 than 12 months after the date a majority of the  
20 members of the Medicare Payment Review Commis-  
21 sion are first appointed, the Commission shall sub-  
22 mit a report to Congress containing recommenda-  
23 tions for appropriate revisions in the treatment of  
24 distinct units of hospitals for purposes of section  
25 1886 of the Social Security Act.

1 **SEC. 15506. REDUCTION IN PAYMENTS TO HOSPITALS FOR**  
2 **ENROLLEES' BAD DEBTS.**

3 (a) IN GENERAL.—Section 1861(v)(1) (42 U.S.C.  
4 1395x(v)(1)) is amended by adding at the end the follow-  
5 ing new subparagraph:

6 “(T) In determining such reasonable costs for hos-  
7 pitals, the amount of bad debts otherwise treated as allow-  
8 able costs which are attributable to the deductibles and  
9 coinsurance amounts under this title shall be reduced by—

10 “(i) 75 percent for cost reporting periods begin-  
11 ning during fiscal year 1996,

12 “(ii) 60 percent for cost reporting periods be-  
13 ginning during fiscal year 1997, and

14 “(iii) 50 percent for subsequent cost reporting  
15 periods.”.

16 (b) EFFECTIVE DATE.—The amendment made by  
17 subsection (a) shall apply to hospital cost reporting peri-  
18 ods beginning on or after October 1, 1995.

19 **SEC. 15507. PERMANENT EXTENSION OF HEMOPHILIA PASS-**  
20 **THROUGH.**

21 Effective as if included in the enactment of OBRA-  
22 1989, section 6011(d) of such Act (as amended by section  
23 13505 of OBRA-1993) is amended by striking “and shall  
24 expire September 30, 1994”.

1 **SEC. 15508. CONFORMING AMENDMENT TO CERTIFICATION**  
2 **OF CHRISTIAN SCIENCE PROVIDERS.**

3 (a) HOSPITALS.—Section 1861(e) (42 U.S.C.  
4 1395x(e)) is amended in the sixth sentence by inserting  
5 after “Massachusetts,” the following: “or by the Commis-  
6 sion for Accreditation of Christian Science Nursing Orga-  
7 nizations/Facilities, Inc.,”.

8 (b) SKILLED NURSING FACILITIES.—Section  
9 1861(y)(1) is amended by inserting after “Massachu-  
10 setts,” the following: “or by the Commission for Accredita-  
11 tion of Christian Science Nursing Organizations/Facilities,  
12 Inc.,”.

13 **Subpart B—Provisions Relating to Rural Hospitals**

14 **SEC. 15511. SOLE COMMUNITY HOSPITALS.**

15 (a) UPDATE.—Section 1886(b)(3)(B)(iv) (42 U.S.C.  
16 1395ww(b)(3)(B)(iv)) is amended—

17 (A) in subclause (III), by striking “and” at  
18 the end; and

19 (B) by striking subclause (IV) and insert-  
20 ing the following:

21 “(IV) for each of the fiscal years 1996 through  
22 2000, the market basket percentage increase minus  
23 1 percentage points, and

24 “(V) for fiscal year 2001 and each subsequent  
25 fiscal year, the applicable percentage increase under  
26 clause (i).”.

1 (b) STUDY OF IMPACT OF SOLE COMMUNITY HOS-  
2 PITAL DESIGNATIONS.—

3 (1) STUDY.—The Medicare Payment Review  
4 Commission shall conduct a study of the impact of  
5 the designation of hospitals as sole community hos-  
6 pitals under the medicare program on the delivery of  
7 health care services to individuals in rural areas, and  
8 shall include in the study an analysis of the charac-  
9 teristics of the hospitals designated as such sole  
10 community hospitals under the program.

11 (2) REPORT.—Not later than 12 months after  
12 the date a majority of the members of the Commis-  
13 sion are first appointed, the Commission shall sub-  
14 mit to Congress a report on the study conducted  
15 under paragraph (1).

16 **SEC. 15512. CLARIFICATION OF TREATMENT OF EAC AND**  
17 **RPC HOSPITALS.**

18 Paragraphs (1)(A) and (2)(A) of section 1820(i) (42  
19 U.S.C. 1395i-4(i)) are each amended by striking the semi-  
20 colon at the end and inserting the following: “, or in a  
21 State which the Secretary finds would receive a grant  
22 under such subsection during a fiscal year if funds were  
23 appropriated for grants under such subsection for the fis-  
24 cal year;”.

1 **SEC. 15513. RURAL EMERGENCY ACCESS CARE HOSPITALS.**

2 (a) ESTABLISHMENT OF PROGRAM.—

3 (1) IN GENERAL.—Section 1861 (42 U.S.C.  
4 1395x) is amended by adding at the end the follow-  
5 ing new subsection:

6 “Rural Emergency Access Care Hospital; Rural  
7 Emergency Access Care Hospital Services

8 “(oo)(1) The term ‘rural emergency access care hos-  
9 pital’ means, for a fiscal year, a facility with respect to  
10 which the Secretary finds the following:

11 “(A) The facility is located in a rural area (as  
12 defined in section 1886(d)(2)(D)).

13 “(B) The facility was a hospital under this title  
14 at any time during the 5-year period that ends on  
15 the date of the enactment of this subsection.

16 “(C) The facility is in danger of closing due to  
17 low inpatient utilization rates and negative operating  
18 losses, and the closure of the facility would limit the  
19 access of individuals residing in the facility’s service  
20 area to emergency services.

21 “(D) The facility has entered into (or plans to  
22 enter into) an agreement with a hospital with a par-  
23 ticipation agreement in effect under section 1866(a),  
24 and under such agreement the hospital shall accept  
25 patients transferred to the hospital from the facility

1 and receive data from and transmit data to the facil-  
2 ity.

3 “(E) There is a practitioner who is qualified to  
4 provide advanced cardiac life support services (as de-  
5 termined by the State in which the facility is lo-  
6 cated) on-site at the facility on a 24-hour basis.

7 “(F) A physician is available on-call to provide  
8 emergency medical services on a 24-hour basis.

9 “(G) The facility is a member of a community  
10 rural health network under section 104 of the Rural  
11 Health Development Act.

12 “(H) The facility meets such staffing require-  
13 ments as would apply under section 1861(e) to a  
14 hospital located in a rural area, except that—

15 “(i) the facility need not meet hospital  
16 standards relating to the number of hours dur-  
17 ing a day, or days during a week, in which the  
18 facility must be open, except insofar as the fa-  
19 cility is required to provide emergency care on  
20 a 24-hour basis under subparagraphs (E) and  
21 (F); and

22 “(ii) the facility may provide any services  
23 otherwise required to be provided by a full-time,  
24 on-site dietician, pharmacist, laboratory techni-

1           cian, medical technologist, or radiological tech-  
2           nologist on a part-time, off-site basis.

3           “(I) The facility meets the requirements appli-  
4           cable to clinics and facilities under subparagraphs  
5           (C) through (J) of paragraph (2) of section  
6           1861(aa) and of clauses (ii) and (iv) of the second  
7           sentence of such paragraph (or, in the case of the  
8           requirements of subparagraph (E), (F), or (J) of  
9           such paragraph, would meet the requirements if any  
10          reference in such subparagraph to a ‘nurse practi-  
11          tioner’ or to ‘nurse practitioners’ was deemed to be  
12          a reference to a ‘nurse practitioner or nurse’ or to  
13          ‘nurse practitioners or nurses’); except that in deter-  
14          mining whether a facility meets the requirements of  
15          this subparagraph, subparagraphs (E) and (F) of  
16          that paragraph shall be applied as if any reference  
17          to a ‘physician’ is a reference to a physician as de-  
18          fined in section 1861(r)(1).

19          “(2) The term ‘rural emergency access care hospital  
20          services’ means the following services provided by a rural  
21          emergency access care hospital:

22                  “(A) An appropriate medical screening exam-  
23                  ination (as described in section 1867(a)).

1           “(B) Necessary stabilizing examination and  
2           treatment services for an emergency medical condi-  
3           tion and labor (as described in section 1867(b)).

4           “(3) The term ‘inpatient rural emergency access care  
5           hospital services’ means services described in paragraph  
6           (2), furnished to an individual over a continuous period  
7           not to exceed 24 hours (except that such services may be  
8           furnished over a longer period in the case of an individual  
9           who is unable to leave the hospital because of inclement  
10          weather) that would be inpatient hospital services if fur-  
11          nished to an inpatient of a hospital by a hospital.”.

12           (2) REQUIRING RURAL EMERGENCY ACCESS  
13          CARE HOSPITALS TO MEET HOSPITAL ANTI-DUMPING  
14          REQUIREMENTS.—Section 1867(e)(5) (42 U.S.C.  
15          1395dd(e)(5)) is amended by striking  
16          “1861(mm)(1))” and inserting “1861(mm)(1)) and  
17          a rural emergency access care hospital (as defined in  
18          section 1861(oo)(1))”.

19           (b) COVERAGE OF AND PAYMENT FOR SERVICES  
20          UNDER PART A.—

21           (1) COVERAGE.—Section 1812(a)(1) (42 U.S.C.  
22          1395d(a)(1)) is amended by striking “or inpatient  
23          rural primary care hospital services” and inserting  
24          “inpatient rural primary care hospital services, or

1 inpatient rural emergency access care hospital serv-  
2 ices”.

3 (2) APPLICATION OF DEDUCTIBLE AND COIN-  
4 SURANCE.—(A) Sections 1813(a) and 1813(b)(3)(A)  
5 (42 U.S.C. 1395e(a), 1395e(b)(3)(A)) are each  
6 amended by striking “services or inpatient rural pri-  
7 mary care hospital services” each place it appears  
8 and inserting “services, inpatient rural primary care  
9 hospital services, or inpatient rural emergency access  
10 care hospital services”.

11 (B) Section 1813(b)(3)(B) (42 U.S.C.  
12 1395e(b)(3)(B)) is amended by inserting “, inpatient  
13 rural emergency access care hospital services,” after  
14 “inpatient rural primary care hospital services”.

15 (3) PAYMENT BASED ON REASONABLE COSTS.—  
16 Section 1814 (42 U.S.C. 1395f) is amended by add-  
17 ing at the end the following new subsection:

18 “Payment for Inpatient Rural Emergency Access Care  
19 Hospital Services

20 “(m) The amount of payment under this part for in-  
21 patient rural primary care hospital services shall be equal  
22 to the reasonable cost of such services (as determined  
23 under section 1861(v)), less the amount the hospital may  
24 charge as described in clause (ii) of section 1866(a)(2)(A),

1 but in no case may the payment for such services exceed  
2 80 percent of such reasonable cost.”.

3 (4) APPLICATION OF SPELL OF ILLNESS.—Sec-  
4 tion 1861(a) (42 U.S.C. 1395x(a)) is amended—

5 (A) in paragraph (1), by inserting “, inpa-  
6 tient rural emergency access care hospital serv-  
7 ices,” after “inpatient rural primary care hos-  
8 pital services”; and

9 (B) in paragraph (2), by striking “hospital  
10 or rural primary care hospital” and inserting  
11 “hospital, rural primary care hospital, or rural  
12 emergency access care hospital”.

13 (c) REFERENCE TO PAYMENT PROVISIONS UNDER  
14 PART B.—For provisions relating to payment for inpa-  
15 tient rural emergency access care hospital services under  
16 part B, see section 15607.

17 (d) EFFECTIVE DATE.—The amendments made by  
18 this section shall apply to fiscal years beginning on or  
19 after October 1, 1995.

20 **SEC. 15514. CLASSIFICATION OF RURAL REFERRAL CEN-**  
21 **TERS.**

22 (a) PROHIBITING DENIAL OF REQUEST FOR RECLAS-  
23 SIFICATION ON BASIS OF COMPARABILITY OF WAGES.—

24 (1) IN GENERAL.—Section 1886(d)(10)(D) (42  
25 U.S.C. 1395ww(d)(10)(D)) is amended—

1 (A) by redesignating clause (iii) as clause  
2 (iv); and

3 (B) by inserting after clause (ii) the follow-  
4 ing new clause:

5 “(iii) Under the guidelines published by the Secretary  
6 under clause (i), in the case of a hospital which is classi-  
7 fied by the Secretary as a rural referral center under para-  
8 graph (5)(C), the Board may not reject the application  
9 of the hospital under this paragraph on the basis of any  
10 comparison between the average hourly wage of the hos-  
11 pital and the average hourly wage of hospitals in the area  
12 in which it is located.”.

13 (2) EFFECTIVE DATE.—Notwithstanding sec-  
14 tion 1886(d)(10)(C)(ii) of the Social Security Act, a  
15 hospital may submit an application to the Medicare  
16 Geographic Classification Review Board during the  
17 30-day period beginning on the date of the enact-  
18 ment of this Act requesting a change in its classi-  
19 fication for purposes of determining the area wage  
20 index applicable to the hospital under section  
21 1886(d)(3)(D) of such Act for fiscal year 1997, if  
22 the hospital would be eligible for such a change in  
23 its classification under the standards described in  
24 section 1886(d)(10)(D) (as amended by paragraph

1 (1)) but for its failure to meet the deadline for appli-  
2 cations under section 1886(d)(10)(C)(ii).

3 (b) CONTINUING TREATMENT OF PREVIOUSLY DES-  
4 IGNATED CENTERS.—Any hospital classified as a rural re-  
5 ferral center by the Secretary of Health and Human Serv-  
6 ices under section 1886(d)(5)(C) of the Social Security  
7 Act for fiscal year 1994 shall be classified as such a rural  
8 referral center for fiscal year 1996 and each subsequent  
9 fiscal year.

10 **SEC. 15515. FLOOR ON AREA WAGE INDEX.**

11 (a) IN GENERAL.—For purposes of section  
12 1886(d)(3)(E) of the Social Security Act for discharges  
13 occurring on or after October 1, 1995, the area wage index  
14 applicable under such section to any hospital which is not  
15 located in a rural area (as defined in section  
16 1886(d)(2)(D) of such Act) may not be less than the aver-  
17 age of the area wage indices applicable under such section  
18 to hospitals located in rural areas in the State in which  
19 the hospital is located.

20 (b) BUDGET-NEUTRALITY IN IMPLEMENTATION.—  
21 The Secretary of Health and Human Services shall make  
22 any adjustments required under subsection (a) in a man-  
23 ner which assures that the aggregate payments made  
24 under section 1886(d) of the Social Security Act in a fiscal  
25 year for the operating costs of inpatient hospital services



1 “INCENTIVES FOR COST-EFFECTIVE MANAGEMENT OF  
2 COVERED NON-ROUTINE SERVICES OF SKILLED  
3 NURSING FACILITIES

4 “SEC. 1888A. (a) DEFINITIONS.—For purposes of  
5 this section:

6 “(1) COVERED NON-ROUTINE SERVICES.—The  
7 term ‘covered non-routine services’ means post-hos-  
8 pital extended care services consisting of any of the  
9 following:

10 “(A) Physical or occupational therapy or  
11 speech-language pathology services, or res-  
12 piratory therapy.

13 “(B) Prescription drugs.

14 “(C) Complex medical equipment.

15 “(D) Intravenous therapy and solutions  
16 (including enteral and parenteral nutrients,  
17 supplies, and equipment).

18 “(E) Radiation therapy.

19 “(F) Diagnostic services, including labora-  
20 tory, radiology (including computerized tomog-  
21 raphy services and imaging services), and pul-  
22 monary services.

23 “(2) SNF MARKET BASKET PERCENTAGE IN-  
24 CREASE.—The term ‘SNF market basket percentage  
25 increase’ for a fiscal year means a percentage equal

1 to the percentage increase in routine service cost  
2 limits for the year under section 1888(a).

3 “(3) STAY.—The term ‘stay’ means, with re-  
4 spect to an individual who is a resident of a skilled  
5 nursing facility, a period of continuous days during  
6 which the facility provides extended care services for  
7 which payment may be made under this title to the  
8 individual during the individual’s spell of illness.

9 “(b) NEW PAYMENT METHOD FOR COVERED NON-  
10 ROUTINE SERVICES.—

11 “(1) IN GENERAL.—Subject to subsection (c), a  
12 skilled nursing facility shall receive interim pay-  
13 ments under this title for covered non-routine serv-  
14 ices furnished to an individual during a cost report-  
15 ing period beginning during a fiscal year (after fiscal  
16 year 1996) in an amount equal to the reasonable  
17 cost of providing such services in accordance with  
18 section 1861(v). The Secretary may adjust such pay-  
19 ments if the Secretary determines (on the basis of  
20 such estimated information as the Secretary consid-  
21 ers appropriate) that payments to the facility under  
22 this paragraph for a cost reporting period would  
23 substantially exceed the cost reporting period limit  
24 determined under subsection (c)(1)(B).

1           “(2) RESPONSIBILITY OF SKILLED NURSING  
2 FACILITY TO MANAGE BILLINGS.—

3           “(A) CLARIFICATION RELATING TO PART A  
4 BILLING.—In the case of a covered non-routine  
5 service furnished to an individual who (at the  
6 time the service is furnished) is a resident of a  
7 skilled nursing facility who is entitled to cov-  
8 erage under section 1812(a)(2) for such service,  
9 the skilled nursing facility shall submit a claim  
10 for payment under this title for such service  
11 under part A (without regard to whether or not  
12 the item or service was furnished by the facility,  
13 by others under arrangement with them made  
14 by the facility, under any other contracting or  
15 consulting arrangement, or otherwise).

16           “(B) PART B BILLING.—In the case of a  
17 covered non-routine service furnished to an in-  
18 dividual who (at the time the service is fur-  
19 nished) is a resident of a skilled nursing facility  
20 who is not entitled to coverage under section  
21 1812(a)(2) for such service but is entitled to  
22 coverage under part B for such service, the  
23 skilled nursing facility shall submit a claim for  
24 payment under this title for such service under  
25 part B (without regard to whether or not the

1 item or service was furnished by the facility, by  
2 others under arrangement with them made by  
3 the facility, under any other contracting or con-  
4 sulting arrangement, or otherwise).

5 “(C) MAINTAINING RECORDS ON SERVICES  
6 FURNISHED TO RESIDENTS.—Each skilled nurs-  
7 ing facility receiving payments for extended  
8 care services under this title shall document on  
9 the facility’s cost report all covered non-routine  
10 services furnished to all residents of the facility  
11 to whom the facility provided extended care  
12 services for which payment was made under  
13 part A during a fiscal year (beginning with fis-  
14 cal year 1996) (without regard to whether or  
15 not the services were furnished by the facility,  
16 by others under arrangement with them made  
17 by the facility, under any other contracting or  
18 consulting arrangement, or otherwise).

19 “(c) RECONCILIATION OF AMOUNTS.—

20 “(1) LIMIT BASED ON PER STAY LIMIT AND  
21 NUMBER OF STAYS.—

22 “(A) IN GENERAL.—If a skilled nursing fa-  
23 cility has received aggregate payments under  
24 subsection (b) for covered non-routine services  
25 during a cost reporting period beginning during

1 a fiscal year in excess of an amount equal to  
2 the cost reporting period limit determined  
3 under subparagraph (B), the Secretary shall re-  
4 duce the payments made to the facility with re-  
5 spect to such services for cost reporting periods  
6 beginning during the following fiscal year in an  
7 amount equal to such excess. The Secretary  
8 shall reduce payments under this subparagraph  
9 at such times and in such manner during a fis-  
10 cal year as the Secretary finds necessary to  
11 meet the requirement of this subparagraph.

12 “(B) COST REPORTING PERIOD LIMIT.—  
13 The cost reporting period limit determined  
14 under this subparagraph is an amount equal to  
15 the product of—

16 “(i) the per stay limit applicable to  
17 the facility under subsection (d) for the pe-  
18 riod; and

19 “(ii) the number of stays beginning  
20 during the period for which payment was  
21 made to the facility for such services.

22 “(C) PROSPECTIVE REDUCTION IN PAY-  
23 MENTS.—In addition to the process for reduc-  
24 ing payments described in subparagraph (A),  
25 the Secretary may reduce payments made to a

1 facility under this section during a cost report-  
2 ing period if the Secretary determines (on the  
3 basis of such estimated information as the Sec-  
4 retary considers appropriate) that payments to  
5 the facility under this section for the period will  
6 substantially exceed the cost reporting period  
7 limit for the period determined under this para-  
8 graph.

9 “(2) INCENTIVE PAYMENTS.—

10 “(A) IN GENERAL.—If a skilled nursing fa-  
11 cility has received aggregate payments under  
12 subsection (b) for covered non-routine services  
13 during a cost reporting period beginning during  
14 a fiscal year in an amount that is less than the  
15 amount determined under paragraph (1)(B),  
16 the Secretary shall pay the skilled nursing facil-  
17 ity in the following fiscal year an incentive pay-  
18 ment equal to 50 percent of the difference be-  
19 tween such amounts, except that the incentive  
20 payment may not exceed 5 percent of the aggre-  
21 gate payments made to the facility under sub-  
22 section (b) for the previous fiscal year (without  
23 regard to subparagraph (B)).

24 “(B) INSTALLMENT INCENTIVE PAY-  
25 MENTS.—The Secretary may make installment

1 payments during a fiscal year to a skilled nurs-  
2 ing facility based on the estimated incentive  
3 payment that the facility would be eligible to  
4 receive with respect to such fiscal year.

5 “(d) DETERMINATION OF FACILITY PER STAY  
6 LIMIT.—

7 “(1) LIMIT FOR FISCAL YEAR 1997.—

8 “(A) IN GENERAL.—Except as provided in  
9 subparagraph (B), the Secretary shall establish  
10 separate per stay limits for hospital-based and  
11 freestanding skilled nursing facilities for the 12-  
12 month cost reporting period beginning during  
13 fiscal year 1997 that are equal to the sum of—

14 “(i) 50 percent of the facility-specific  
15 stay amount for the facility (as determined  
16 under subsection (e)) for the last 12-month  
17 cost reporting period ending on or before  
18 September 30, 1994, increased (in a  
19 compounded manner) by the SNF market  
20 basket percentage increase for fiscal years  
21 1995 through 1997; and

22 “(ii) 50 percent of the average of all  
23 facility-specific stay amounts for all hos-  
24 pital-based facilities or all freestanding fa-  
25 cilities (whichever is applicable) during the

1 cost reporting period described in clause  
2 (i), increased (in a compounded manner)  
3 by the SNF market basket percentage in-  
4 crease for fiscal years 1995 through 1997.

5 “(B) FACILITIES NOT HAVING 1994 COST  
6 REPORTING PERIOD.—In the case of a skilled  
7 nursing facility for which payments were not  
8 made under this title for covered non-routine  
9 services for the last 12-month cost reporting pe-  
10 riod ending on or before September 30, 1994,  
11 the per stay limit for the 12-month cost report-  
12 ing period beginning during fiscal year 1997  
13 shall be twice the amount determined under  
14 subparagraph (A)(ii).

15 “(2) LIMIT FOR SUBSEQUENT FISCAL YEARS.—  
16 The per stay limit for a skilled nursing facility for  
17 a 12-month cost reporting period beginning during  
18 a fiscal year after fiscal year 1997 is equal to the  
19 per stay limit established under this subsection for  
20 the 12-month cost reporting period beginning during  
21 the previous fiscal year, increased by the SNF mar-  
22 ket basket percentage increase for such subsequent  
23 fiscal year minus 2 percentage points.

24 “(3) REBASING OF AMOUNTS.—

1           “(A) IN GENERAL.—The Secretary shall  
2 provide for an update to the facility-specific  
3 amounts used to determine the per stay limits  
4 under this subsection for cost reporting periods  
5 beginning on or after October 1, 1999, and  
6 every 2 years thereafter.

7           “(B) TREATMENT OF FACILITIES NOT  
8 HAVING REBASED COST REPORTING PERIODS.—  
9 Paragraph (1)(B) shall apply with respect to a  
10 skilled nursing facility for which payments were  
11 not made under this title for covered non-rou-  
12 tine services for the 12-month cost reporting  
13 period used by the Secretary to update facility-  
14 specific amounts under subparagraph (A) in the  
15 same manner as such paragraph applies with  
16 respect to a facility for which payments were  
17 not made under this title for covered non-rou-  
18 tine services for the last 12-month cost report-  
19 ing period ending on or before September 30,  
20 1994.

21           “(e) DETERMINATION OF FACILITY-SPECIFIC STAY  
22 AMOUNTS.—The ‘facility-specific stay amount’ for a  
23 skilled nursing facility for a cost reporting period is the  
24 sum of—

1           “(1) the average amount of payments made to  
2           the facility under part A during the period which are  
3           attributable to covered non-routine services fur-  
4           nished during a stay (as determined on a per diem  
5           basis); and

6           “(2) the Secretary’s best estimate of the aver-  
7           age amount of payments made under part B during  
8           the period for covered non-routine services furnished  
9           to all residents of the facility to whom the facility  
10          provided extended care services for which payment  
11          was made under part A during the period (without  
12          regard to whether or not the services were furnished  
13          by the facility, by others under arrangement with  
14          them made by the facility, under any other contract-  
15          ing or consulting arrangement, or otherwise), as es-  
16          timated by the Secretary.

17          “(f) INTENSIVE NURSING OR THERAPY NEEDS.—

18                 “(1) IN GENERAL.—In applying subsection (b)  
19                 to covered non-routine services furnished during a  
20                 stay beginning during a cost reporting period begin-  
21                 ning during a fiscal year (beginning with fiscal years  
22                 after fiscal year 1997) to a resident of a skilled  
23                 nursing facility who requires intensive nursing or  
24                 therapy services, the per stay limit for such resident  
25                 shall be the per stay limit developed under para-

1 graph (2) instead of the per stay limit determined  
2 under subsection (d)(1)(A).

3 “(2) PER STAY LIMIT FOR INTENSIVE NEED  
4 RESIDENTS.—Not later than June 30, 1997, the  
5 Secretary, after consultation with the Medicare Pay-  
6 ment Review Commission and skilled nursing facility  
7 experts, shall develop and publish a per stay limit  
8 for residents of a skilled nursing facility who require  
9 intensive nursing or therapy services.

10 “(3) BUDGET NEUTRALITY.—The Secretary  
11 shall adjust payments under subsection (b) in a  
12 manner that ensures that total payments for covered  
13 non-routine services under this section are not great-  
14 er or less than total payments for such services  
15 would have been but for the application of para-  
16 graph (1).

17 “(g) SPECIAL TREATMENT FOR SMALL SKILLED  
18 NURSING FACILITIES.—This section shall not apply with  
19 respect to a skilled nursing facility for which payment is  
20 made for routine service costs during a cost reporting pe-  
21 riod on the basis of prospective payments under section  
22 1888(d).

23 “(h) EXCEPTIONS AND ADJUSTMENTS TO LIMITS.—

24 “(1) IN GENERAL.—The Secretary may make  
25 exceptions and adjustments to the cost reporting

1 limits applicable to a skilled nursing facility under  
2 subsection (c)(1)(B) for a cost reporting period, ex-  
3 cept that the total amount of any additional pay-  
4 ments made under this section for covered non-rou-  
5 tine services during the cost reporting period as a  
6 result of such exceptions and adjustments may not  
7 exceed 5 percent of the aggregate payments made  
8 to all skilled nursing facilities for covered non-rou-  
9 tine services during the cost reporting period (deter-  
10 mined without regard to this paragraph).

11 “(2) BUDGET NEUTRALITY.—The Secretary  
12 shall adjust payments under subsection (b) in a  
13 manner that ensures that total payments for covered  
14 non-routine services under this section are not great-  
15 er or less than total payments for such services  
16 would have been but for the application of para-  
17 graph (1).

18 “(i) SPECIAL RULE FOR X-RAY SERVICES.—Before  
19 furnishing a covered non-routine service consisting of an  
20 X-ray service for which payment may be made under part  
21 A or part B to a resident, a skilled nursing facility shall  
22 consider whether furnishing the service through a provider  
23 of portable X-ray service services would be appropriate,  
24 taking into account the cost effectiveness of the service  
25 and the convenience to the resident.”.

1 (b) CONFORMING AMENDMENT.—Section 1814(b)  
2 (42 U.S.C. 1395f(b)) is amended in the matter preceding  
3 paragraph (1) by striking “1813 and 1886” and inserting  
4 “1813, 1886, 1888, and 1888A”.

5 **SEC. 15523. PAYMENTS FOR ROUTINE SERVICE COSTS.**

6 (a) MAINTAINING SAVINGS RESULTING FROM TEM-  
7 PORARY FREEZE ON PAYMENT INCREASES.—

8 (1) BASING UPDATES TO PER DIEM COST LIM-  
9 ITS ON LIMITS FOR FISCAL YEAR 1993.—

10 (A) IN GENERAL.—The last sentence of  
11 section 1888(a) (42 U.S.C. 1395yy(a)) is  
12 amended by adding at the end the following:  
13 “(except that such updates may not take into  
14 account any changes in the routine service costs  
15 of skilled nursing facilities occurring during  
16 cost reporting periods which began during fiscal  
17 year 1994 or fiscal year 1995).”.

18 (B) NO EXCEPTIONS PERMITTED BASED  
19 ON AMENDMENT.—The Secretary of Health and  
20 Human Services shall not consider the amend-  
21 ment made by subparagraph (A) in making any  
22 adjustments pursuant to section 1888(c) of the  
23 Social Security Act.

24 (2) PAYMENTS DETERMINED ON PROSPECTIVE  
25 BASIS.—Any change made by the Secretary of

1 Health and Human Services in the amount of any  
2 prospective payment paid to a skilled nursing facility  
3 under section 1888(d) of the Social Security Act for  
4 cost reporting periods beginning on or after October  
5 1, 1995, may not take into account any changes in  
6 the costs of services occurring during cost reporting  
7 periods which began during fiscal year 1994 or fiscal  
8 year 1995.

9 (b) ESTABLISHMENT OF SCHEDULE FOR MAKING  
10 ADJUSTMENTS TO LIMITS.—Section 1888(c) (42 U.S.C.  
11 1395yy(c)) is amended by striking the period at the end  
12 of the second sentence and inserting “, and may only make  
13 adjustments under this subsection with respect to a facil-  
14 ity which applies for an adjustment during an annual ap-  
15 plication period established by the Secretary.”.

16 (c) LIMITATION ON AGGREGATE INCREASE IN PAY-  
17 MENTS RESULTING FROM ADJUSTMENTS TO LIMITS.—  
18 Section 1888(c) (42 U.S.C. 1395yy(c)) is amended—

19 (1) by striking “(c) The Secretary” and insert-  
20 ing “(c)(1) Subject to paragraph (2), the Sec-  
21 retary”; and

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

24 “(2) The Secretary may not make any adjustments  
25 under this subsection in the limits set forth in subsection

1 (a) for a cost reporting period beginning during a fiscal  
2 year to the extent that the total amount of the additional  
3 payments made under this title as a result of such adjust-  
4 ments is greater than an amount equal to—

5           “(A) for cost reporting periods beginning dur-  
6           ing fiscal year 1997, the total amount of the addi-  
7           tional payments made under this title as a result of  
8           adjustments under this subsection for cost reporting  
9           periods beginning during fiscal year 1996 increased  
10          by the SNF market basket percentage increase (as  
11          defined in section 1888A(e)(3)) for fiscal year 1997;  
12          and

13           “(B) for cost reporting periods beginning dur-  
14          ing a subsequent fiscal year, the amount determined  
15          under this paragraph for the previous fiscal year in-  
16          creased by the SNF market basket percentage in-  
17          crease for such subsequent fiscal year.”.

18          (d) IMPOSITION OF LIMITS FOR ALL COST REPORT-  
19          ING PERIODS.—Section 1888(a) (42 U.S.C. 1395yy(a)) is  
20          amended in the matter preceding paragraph (1) by insert-  
21          ing after “extended care services” the following: “(for any  
22          cost reporting period for which payment is made under  
23          this title to the skilled nursing facility for such services)”.

1 **SEC. 15524. REDUCTIONS IN PAYMENT FOR CAPITAL-RE-**  
2 **LATED COSTS.**

3 Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)), as  
4 amended by section 15506, is amended by adding at the  
5 end the following new subparagraph:

6 “(U) Such regulations shall provide that, in deter-  
7 mining the amount of the payments that may be made  
8 under this title with respect to all the capital-related costs  
9 of skilled nursing facilities, the Secretary shall reduce the  
10 amounts of such payments otherwise established under  
11 this title by 15 percent for payments attributable to por-  
12 tions of cost reporting periods occurring during fiscal  
13 years 1996 through 2002.”.

14 **SEC. 15525. TREATMENT OF ITEMS AND SERVICES PAID**  
15 **FOR UNDER PART B.**

16 (a) **REQUIRING PAYMENT FOR ALL ITEMS AND**  
17 **SERVICES TO BE MADE TO FACILITY.—**

18 (1) **IN GENERAL.—**The first sentence of section  
19 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended—

20 (A) by striking “and (D)” and inserting  
21 “(D)”; and

22 (B) by striking the period at the end and  
23 inserting the following: “, and (E) in the case  
24 of an item or service furnished to an individual  
25 who (at the time the item or service is fur-  
26 nished) is a resident of a skilled nursing facil-

1           ity, payment shall be made to the facility (with-  
2           out regard to whether or not the item or service  
3           was furnished by the facility, by others under  
4           arrangement with them made by the facility, or  
5           otherwise).”.

6           (2) EXCLUSION FOR ITEMS AND SERVICES NOT  
7           BILLED BY FACILITY.—Section 1862(a) (42 U.S.C.  
8           1395y(a)) is amended—

9                   (A) by striking “or” at the end of para-  
10                  graph (14);

11                  (B) by striking the period at the end of  
12                  paragraph (15) and inserting “; or”; and

13                  (C) by inserting after paragraph (15) the  
14                  following new paragraph:

15                  “(16) where such expenses are for covered non-  
16                  routine services (as defined in section 1888A(a)(1))  
17                  furnished to an individual who is a resident of a  
18                  skilled nursing facility and for which the claim for  
19                  payment under this title is not submitted by the fa-  
20                  cility.”.

21           (3) CONFORMING AMENDMENT.—Section  
22           1832(a)(1) (42 U.S.C. 1395k(a)(1)) is amended by  
23           striking “(2);” and inserting “(2) and section  
24           1842(b)(6)(E);”.

1 (b) REDUCTION IN PAYMENTS FOR ITEMS AND SERV-  
 2 ICES FURNISHED BY OR UNDER ARRANGEMENTS WITH  
 3 FACILITIES.—Section 1861(v)(1) (42 U.S.C.  
 4 1395x(v)(1)), as amended by sections 15506 and 15524,  
 5 is amended by adding at the end the following new sub-  
 6 paragraph:

7 “(V) In the case of an item or service furnished by  
 8 a skilled nursing facility (or by others under arrangement  
 9 with them made by a skilled nursing facility) for which  
 10 payment is made under part B in an amount determined  
 11 in accordance with section 1833(a)(2)(B), the Secretary  
 12 shall reduce the reasonable cost for such item or service  
 13 otherwise determined under clause (i)(I) of such section  
 14 by 5.8 percent for payments attributable to portions of  
 15 cost reporting periods occurring during fiscal years 1996  
 16 through 2002.”.

17 **SEC. 15526. CERTIFICATION OF FACILITIES MEETING RE-**  
 18 **QUIRED NURSING HOME REFORM STANDARDS.**

19 (a) IN GENERAL.—Section 1819(a)(3) (42 U.S.C.  
 20 1395i-3(a)(3)) is amended to read as follows:

21 “(3)(A) is certified by the Secretary as meeting  
 22 the standards established under subsection (b), or  
 23 (B) is a State-certified facility (as defined in sub-  
 24 section (c)).”.

1           (b) REQUIREMENTS DESCRIBED.—Section 1819 (42  
2 U.S.C. 1395i-3) is amended by striking subsections (b)  
3 through (i) and inserting the following:

4           “(b) STANDARDS FOR AND CERTIFICATION OF FA-  
5 CILITIES.—

6           “(1) STANDARDS FOR FACILITIES.—

7                   “(A) IN GENERAL.—The Secretary shall  
8 provide for the establishment and maintenance  
9 of standards consistent with the contents de-  
10 scribed in subparagraph (B) for skilled nursing  
11 facilities which furnish services for which pay-  
12 ment may be made under this title.

13                   “(B) CONTENTS OF STANDARDS.—The  
14 standards established for facilities under this  
15 paragraph shall contain provisions relating to  
16 the following items:

17                           “(i) The treatment of resident medical  
18 records.

19                           “(ii) Policies, procedures, and bylaws  
20 for operation.

21                           “(iii) Quality assurance systems.

22                           “(iv) Resident assessment procedures,  
23 including care planning and outcome eval-  
24 uation.

1           “(vi) The assurance of a safe and ade-  
2           quate physical plant for the facility.

3           “(vii) Qualifications for staff suffi-  
4           cient to provide adequate care.

5           “(viii) Utilization review.

6           “(ix) The protection and enforcement  
7           of resident rights described in subpara-  
8           graph (C).

9           “(C) RESIDENT RIGHTS DESCRIBED.—The  
10          resident rights described in this subparagraph  
11          are the rights of residents to the following:

12           “(i) To exercise the individual’s rights  
13           as a resident of the facility and as a citizen  
14           or resident of the United States.

15           “(ii) To receive notice of rights and  
16           services.

17           “(iii) To be protected against the mis-  
18           use of resident funds.

19           “(iv) To be provided privacy and con-  
20           fidentiality.

21           “(v) To voice grievances.

22           “(vi) To examine the results of inspec-  
23           tions under the certification program.

24           “(vii) To refuse to perform services  
25           for the facility.

1           “(viii) To be provided privacy in com-  
2           munications and to receive mail.

3           “(ix) To have the facility provide im-  
4           mediate access to any resident by any rep-  
5           resentative of the certification program,  
6           the resident’s individual physician, the  
7           State long term care ombudsman, and any  
8           person the resident has designated as a  
9           visitor.

10           “(x) To retain and use personal prop-  
11           erty.

12           “(xi) To be free from abuse, including  
13           verbal, sexual, physical and mental abuse,  
14           corporal punishment, and involuntary se-  
15           clusion.

16           “(xii) To be provided with prior writ-  
17           ten notice of a pending transfer or dis-  
18           charge.

19           “(D) REQUIRING NOTICE AND COM-  
20           MENT.—The standards established for facilities  
21           under this paragraph may only take effect after  
22           the Secretary has provided the public with no-  
23           tice and an opportunity for comment.

24           “(2) CERTIFICATION PROGRAM.—

1           “(A) IN GENERAL.—The Secretary shall  
2 provide for the establishment and operation of  
3 a program consistent with the requirements of  
4 subparagraph (B) for the certification of skilled  
5 nursing facilities which meet the standards es-  
6 tablished under paragraph (1) and the decerti-  
7 fication of facilities which fail to meet such  
8 standards.

9           “(B) REQUIREMENTS FOR PROGRAM.—In  
10 addition to any other requirements the Sec-  
11 retary may impose, in establishing and operat-  
12 ing the certification program under subpara-  
13 graph (A), the Secretary shall ensure the fol-  
14 lowing:

15           “(i) The Secretary shall ensure public  
16 access (as defined by the Secretary) to the  
17 certification program’s evaluations of par-  
18 ticipating facilities, including compliance  
19 records and enforcement actions and other  
20 reports by the Secretary regarding the  
21 ownership, compliance histories, and serv-  
22 ices provided by certified facilities.

23           “(ii) Not less often than every 4  
24 years, the Secretary shall audit its expendi-  
25 tures under the program, through an en-

1           tity designated by the Secretary which is  
2           not affiliated with the program, as des-  
3           ignated by the Secretary.

4           “(c) INTERMEDIATE SANCTION AUTHORITY.—

5           “(1) AUTHORITY.—In addition to any other au-  
6           thority, where the Secretary determines that a nurs-  
7           ing facility which is certified for participation under  
8           this title plan no longer substantially meets the re-  
9           quirements for such a facility under this title and  
10          further determines that the facility’s deficiencies—

11           “(A) immediately jeopardize the health and  
12          safety of its residents, the Secretary shall at  
13          least provide for the termination of the facility’s  
14          certification for participation under this title, or

15           “(B) do not immediately jeopardize the  
16          health and safety of its residents, the Secretary  
17          may, in lieu of providing for terminating the fa-  
18          cility’s certification for participation under the  
19          plan, provide lesser sanctions including one that  
20          provides that no payment will be made under  
21          this title with respect to any individual admit-  
22          ted to such facility after a date specified by the  
23          Secretary.

24           “(2) NOTICE.—The Secretary shall not make  
25          such a decision with respect to a facility until the fa-

1 cility has had a reasonable opportunity, following the  
2 initial determination that it no longer substantially  
3 meets the requirements for such a facility under the  
4 plan, to correct its deficiencies, and, following this  
5 period, has been given reasonable notice and oppor-  
6 tunity for a hearing.

7 “(3) EFFECTIVENESS.—The Secretary’s deci-  
8 sion to deny payment may be made effective only  
9 after such notice to the public and to the facility as  
10 may be provided for by the Secretary, and its effec-  
11 tiveness shall terminate (A) when the Secretary  
12 finds that the facility is in substantial compliance  
13 (or is making good faith efforts to achieve substan-  
14 tial compliance) with the requirements for such a fa-  
15 cility under this title, or (B) in the case described  
16 in paragraph (1)(B), with the end of the eleventh  
17 month following the month such decision is made ef-  
18 fective, whichever occurs first. If a facility to which  
19 clause (B) of the previous sentence applies still fails  
20 to substantially meet the provisions of the respective  
21 section on the date specified in such clause, the Sec-  
22 retary shall terminate such facility’s certification for  
23 participation under this title effective with the first  
24 day of the first month following the month specified  
25 in such clause.

1       “(c) STATE-CERTIFIED FACILITY DEFINED.—In  
2 subsection (a), a ‘State-certified facility’ means a facility  
3 licensed or certified as a skilled nursing facility by the  
4 State in which it is located, or a facility which otherwise  
5 meets the requirements applicable to providers of nursing  
6 facility services under the State plan under title XIX or  
7 the MediGrant program under title XXI.”.

8       (c) CONFORMING AMENDMENTS.—(1) Section  
9 1861(v)(1)(E) (42 U.S.C. 1395x(v)(1)(E)) is amended by  
10 striking the second sentence.

11       (2) Section 1864 (42 U.S.C. 1395aa) is amended by  
12 striking subsection (d).

13       (3) Section 1866(f)(1) (42 U.S.C. 1395cc(f)(1)) is  
14 amended by striking “1819(c)(2)(E),”.

15       (4) Section 1883(f) (42 U.S.C. 1395tt(f)) is amend-  
16 ed—

17               (A) in the second sentence, by striking “such a  
18 hospital” and inserting “a hospital which enters into  
19 an agreement with the Secretary under this section”;  
20 and

21               (B) by striking the first sentence.

22       (d) EFFECTIVE DATE.—The amendments made by  
23 this section shall apply with respect to cost reporting peri-  
24 ods beginning on or after October 1, 1995.

1 **SEC. 15527. MEDICAL REVIEW PROCESS.**

2 In order to ensure that medicare beneficiaries are  
3 furnished appropriate extended care services, the Sec-  
4 retary of Health and Human Services shall establish and  
5 implement a thorough medical review process to examine  
6 the effects of the amendments made by this part on the  
7 quality of extended care services furnished to medicare  
8 beneficiaries. In developing such a medical review process,  
9 the Secretary shall place a particular emphasis on the  
10 quality of non-routine covered services for which payment  
11 is made under section 1888A of the Social Security Act.

12 **SEC. 15528. REPORT BY MEDICARE PAYMENT REVIEW COM-**  
13 **MISSION.**

14 Not later than October 1, 1997, the Medicare Pay-  
15 ment Review Commission shall submit to Congress a re-  
16 port on the system under which payment is made under  
17 the medicare program for extended care services furnished  
18 by skilled nursing facilities, and shall include in the report  
19 the following:

20 (1) An analysis of the effect of the methodology  
21 established under section 1888A of the Social Secu-  
22 rity Act (as added by section 15522) on the pay-  
23 ments for, and the quality of, extended care services  
24 under the medicare program.

25 (2) An analysis of the advisability of determin-  
26 ing the amount of payment for covered non-routine

1 services of facilities (as described in such section) on  
2 the basis of the amounts paid for such services when  
3 furnished by suppliers under part B of the medicare  
4 program.

5 (3) An analysis of the desirability of maintain-  
6 ing separate limits for hospital-based and freestand-  
7 ing facilities in the costs of extended care services  
8 recognized as reasonable under the medicare pro-  
9 gram.

10 (4) An analysis of the quality of services fur-  
11 nished by skilled nursing facilities.

12 (5) An analysis of the adequacy of the process  
13 and standards used to provide exceptions to the lim-  
14 its described in paragraph (3).

15 **SEC. 15529. EFFECTIVE DATE.**

16 Except as otherwise provided in this subchapter, the  
17 amendments made by this subchapter shall apply to serv-  
18 ices furnished during cost reporting periods (or portions  
19 of cost reporting periods) beginning on or after October  
20 1, 1996.

1    **Subtitle G—Provisions Relating to**  
2                    **Medicare Part B**

3                    **PART 1—PAYMENT REFORMS**

4    **SEC. 15601. PAYMENTS FOR PHYSICIANS' SERVICES.**

5           (a) REPLACEMENT OF VOLUME PERFORMANCE  
6 STANDARD WITH SUSTAINABLE GROWTH RATE.—Section  
7 1848(f)(2) (42 U.S.C. 1395w-4(f)(2)) is amended to read  
8 as follows:

9           “(f) SUSTAINABLE GROWTH RATE.—

10                   “(1) SPECIFICATION OF GROWTH RATE.—

11                           “(A) FISCAL YEAR 1996.—The sustainable  
12 growth rate for all physicians' services for fiscal  
13 year 1996 shall be equal to the product of—

14                                   “(i) 1 plus the Secretary's estimate of  
15 the percentage change in the medicare eco-  
16 nomic index for 1996 (described in the  
17 fourth sentence of section 1842(b)(3)) (di-  
18 vided by 100),

19                                   “(ii) 1 plus the Secretary's estimate of  
20 the percentage change (divided by 100) in  
21 the average number of individuals enrolled  
22 under this part (other than private plan  
23 enrollees) from fiscal year 1995 to fiscal  
24 year 1996,

1           “(iii) 1 plus the Secretary’s estimate  
2           of the projected percentage growth in real  
3           gross domestic product per capita (divided  
4           by 100) from fiscal year 1995 to fiscal  
5           year 1996, plus 2 percentage points, and

6           “(iv) 1 plus the Secretary’s estimate  
7           of the percentage change (divided by 100)  
8           in expenditures for all physicians’ services  
9           in fiscal year 1996 (compared with fiscal  
10          year 1995) which will result from changes  
11          in law, determined without taking into ac-  
12          count estimated changes in expenditures  
13          due to changes in the volume and intensity  
14          of physicians’ services or changes in ex-  
15          penditures resulting from changes in the  
16          update to the conversion factor under sub-  
17          section (d),

18          minus 1 and multiplied by 100.

19          “(B) SUBSEQUENT FISCAL YEARS.—The  
20          sustainable growth rate for all physicians’ serv-  
21          ices for fiscal year 1997 and each subsequent  
22          fiscal year shall be equal to the sustainable  
23          growth rate determined under this paragraph  
24          for the previous fiscal year, increased by the  
25          product of—

1           “(i) 1 plus the Secretary’s estimate of  
2           the percentage change in the medicare eco-  
3           nomic index for the fiscal year involved  
4           (described in the fourth sentence of section  
5           1842(b)(3)) (divided by 100),

6           “(ii) 1 plus the Secretary’s estimate of  
7           the percentage change (divided by 100) in  
8           the average number of individuals enrolled  
9           under this part (other than private plan  
10          enrollees) from the previous fiscal year to  
11          the fiscal year involved,

12          “(iii) 1 plus the Secretary’s estimate  
13          of the projected percentage growth in real  
14          gross domestic product per capita (divided  
15          by 100) from the previous fiscal year to  
16          the fiscal year involved, plus 2 percentage  
17          points, and

18          “(iv) 1 plus the Secretary’s estimate  
19          of the percentage change (divided by 100)  
20          in expenditures for all physicians’ services  
21          in the fiscal year (compared with the pre-  
22          vious fiscal year) which will result from  
23          changes in law, determined without taking  
24          into account estimated changes in expendi-  
25          tures due to changes in the volume and in-

1           tensity of physicians' services or changes in  
2           expenditures resulting from changes in the  
3           update to the conversion factor under sub-  
4           section (d)(3),  
5           minus 1 and multiplied by 100.”.

6           “(2) EXCLUSION OF SERVICES FURNISHED TO  
7           PRIVATE PLAN ENROLLEES.—In this subsection, the  
8           term ‘physicians’ services’ with respect to a fiscal  
9           year does not include services furnished to an indi-  
10          vidual enrolled under this part who has elected to re-  
11          ceive benefits under this title for the fiscal year  
12          through a MedicarePlus product offered under part  
13          C or through enrollment with an eligible organiza-  
14          tion with a risk-sharing contract under section  
15          1876.”.

16          (b) ESTABLISHING UPDATE TO CONVERSION FAC-  
17          TOR TO MATCH SPENDING UNDER SUSTAINABLE  
18          GROWTH RATE.—

19                 (1) IN GENERAL.—Section 1848(d) (42 U.S.C.  
20                 1395w-4(d)(3)) is amended—

21                         (A) by striking paragraph (2);

22                         (B) by amending paragraph (3) to read as  
23                 follows:

24                 “(3) UPDATE.—

1           “(A) IN GENERAL.—Subject to subpara-  
2 graph (E), for purposes of this section the up-  
3 date for a year (beginning with 1997) is equal  
4 to the product of—

5                   “(i) 1 plus the Secretary’s estimate of  
6 the percentage increase in the medicare  
7 economic index (described in the fourth  
8 sentence of section 1842(b)(3)) for the  
9 year (divided by 100), and

10                   “(ii) 1 plus the Secretary’s estimate of  
11 the update adjustment factor for the year  
12 (divided by 100),

13 minus 1 and multiplied by 100.

14           “(B) UPDATE ADJUSTMENT FACTOR.—The  
15 ‘update adjustment factor’ for a year is equal to  
16 the quotient of—

17                   “(i) the difference between (I) the  
18 sum of the allowed expenditures for physi-  
19 cians’ services furnished during each of the  
20 years 1995 through the year involved and  
21 (II) the sum of the amount of actual ex-  
22 penditures for physicians’ services fur-  
23 nished during each of the years 1995  
24 through the previous year; divided by

1           “(ii) the Secretary’s estimate of al-  
2           lowed expenditures for physicians’ services  
3           furnished during the year.

4           “(C) DETERMINATION OF ALLOWED EX-  
5           PENDITURES.—For purposes of subparagraph  
6           (B), allowed expenditures for physicians’ serv-  
7           ices shall be determined as follows (as esti-  
8           mated by the Secretary):

9           “(i) In the case of allowed expendi-  
10          tures for 1995, such expenditures shall be  
11          equal to actual expenditures for services  
12          furnished during the 12-month period end-  
13          ing with June of 1995.

14          “(ii) In the case of allowed expendi-  
15          tures for 1996 and each subsequent year,  
16          such expenditures shall be equal to allowed  
17          expenditures for the previous year, in-  
18          creased by the sustainable growth rate  
19          under subsection (f) for the fiscal year  
20          which begins during the year.

21          “(D) DETERMINATION OF ACTUAL EX-  
22          PENDITURES.—For purposes of subparagraph  
23          (B), the amount of actual expenditures for phy-  
24          sicians’ services furnished during a year shall  
25          be equal to the amount of expenditures for such

1 services during the 12-month period ending  
2 with June of the previous year.

3 “(E) RESTRICTION ON VARIATION FROM  
4 MEDICARE ECONOMIC INDEX.—Notwithstanding  
5 the amount of the update adjustment factor de-  
6 termined under subparagraph (B) for a year,  
7 the update in the conversion factor under this  
8 paragraph for the year may not be—

9 “(i) greater than 103 percent of the  
10 Secretary’s estimate of the percentage in-  
11 crease in the medicare economic index (de-  
12 scribed in the fourth sentence of section  
13 1842(b)(3)) for the year; or

14 “(ii) less than 93 percent of the Sec-  
15 retary’s estimate of the percentage in-  
16 crease in the medicare economic index (de-  
17 scribed in the fourth sentence of section  
18 1842(b)(3)) for the year.”; and

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

21 “(4) REPORTING REQUIREMENTS.—

22 “(A) IN GENERAL.—Not later than No-  
23 vember 1 of each year (beginning with 1996),  
24 the Secretary shall transmit to the Congress a  
25 report that describes the update in the conver-

1           sion factor for physicians' services (as defined  
2           in subsection (f)(3)(A)) in the following year.

3           “(B) COMMISSION REVIEW.—The Medicare  
4           Payment Review Commission shall review the  
5           report submitted under subparagraph (A) for a  
6           year and shall submit to the Congress, by not  
7           later than December 1 of the year, a report  
8           containing its analysis of the conversion factor  
9           for the following year.”.

10          (2) EFFECTIVE DATE.—The amendments made  
11          by this subsection shall apply to physicians' services  
12          furnished on or after January 1, 1997.

13          (c) ESTABLISHMENT OF SINGLE CONVERSION FAC-  
14          TOR FOR 1996.—

15               (1) IN GENERAL.—Section 1848(d)(1) (42  
16               U.S.C. 1395w-4(d)(1)) is amended—

17                       (A) by redesignating subparagraph (C) as  
18                       subparagraph (D); and

19                       (B) by inserting after subparagraph (B)  
20                       the following new subparagraph:

21                               “(C) SPECIAL RULE FOR 1996.—For 1996,  
22                               the conversion factor under this subsection shall  
23                               be \$34.60 for all physicians' services.”.

1 (2) CONFORMING AMENDMENTS.—Section 1848  
2 (42 U.S.C. 1395w-4) is amended—

3 (A) by striking “(or factors)” each place it  
4 appears in subsection (d)(1)(A) and  
5 (d)(1)(C)(ii);

6 (B) in subsection (d)(1)(A), by striking “or  
7 updates”;

8 (C) in subsection (d)(1)(C)(ii), by striking  
9 “(or updates)”;

10 (D) in subsection (i)(1)(C), by striking  
11 “conversion factors” and inserting “the conver-  
12 sion factor”.

13 **SEC. 15602. ELIMINATION OF FORMULA-DRIVEN OVERPAY-**  
14 **MENTS FOR CERTAIN OUTPATIENT HOSPITAL**  
15 **SERVICES.**

16 (a) AMBULATORY SURGICAL CENTER PROCE-  
17 DURES.—Section 1833(i)(3)(B)(i)(II) (42 U.S.C.  
18 1395l(i)(3)(B)(i)(II)) is amended—

19 (1) by striking “of 80 percent”; and

20 (2) by striking the period at the end and insert-  
21 ing the following: “, less the amount a provider may  
22 charge as described in clause (ii) of section  
23 1866(a)(2)(A).”.

1 (b) RADIOLOGY SERVICES AND DIAGNOSTIC PROCE-  
2 DURES.—Section 1833(n)(1)(B)(i)(II) (42 U.S.C.  
3 1395l(n)(1)(B)(i)(II)) is amended—

4 (1) by striking “of 80 percent”; and

5 (2) by striking the period at the end and insert-  
6 ing the following: “, less the amount a provider may  
7 charge as described in clause (ii) of section  
8 1866(a)(2)(A).”.

9 (c) EFFECTIVE DATE.—The amendments made by  
10 this section shall apply to services furnished during por-  
11 tions of cost reporting periods occurring on or after Octo-  
12 ber 1, 1995.

13 **SEC. 15603. REDUCTION IN UPDATES TO PAYMENT**  
14 **AMOUNTS FOR DURABLE MEDICAL EQUIP-**  
15 **MENT.**

16 (a) IN GENERAL.—

17 (1) FREEZE IN UPDATE FOR COVERED  
18 ITEMS.—Section 1834(a)(14) (42 U.S.C.  
19 1395m(a)(14)) is amended—

20 (A) by striking “and” at the end of sub-  
21 paragraph (A);

22 (B) in subparagraph (B)—

23 (i) by striking “a subsequent year”  
24 and inserting “1993, 1994, and 1995”,  
25 and

1 (ii) by striking the period at the end  
2 and inserting “; and”; and

3 (C) by adding at the end the following:

4 “(C) for each of the years 1996 through  
5 2002, 0 percentage points; and

6 “(D) for a subsequent year, the percentage  
7 increase in the consumer price index for all  
8 urban consumers (U.S. urban average) for the  
9 12-month period ending with June of the pre-  
10 vious year.”.

11 (2) UPDATE FOR ORTHOTICS AND PROSTHET-  
12 ICS.—Section 1834(h)(4)(A) (42 U.S.C.  
13 1395m(h)(4)(A)) is amended—

14 (A) by striking “and” at the end of clause  
15 (iii);

16 (B) by redesignating clause (iv) as clause  
17 (v); and

18 (C) by inserting after clause (iii) the fol-  
19 lowing new clause:

20 “(iv) for each of the years 1996  
21 through 2002, 1 percent, and”.

22 (b) OXYGEN AND OXYGEN EQUIPMENT.—Section  
23 1834(a)(9)(C) (42 U.S.C. 1395m(a)(9)(C)) is amended—

24 (1) by striking “and” at the end of clause (iii);

25 (2) in clause (iv)—

1 (A) by striking “a subsequent year” and  
2 inserting “1993, 1994, and 1995”, and

3 (B) by striking the period at the end and  
4 inserting a semicolon; and

5 (3) by adding at the end the following new  
6 clauses:

7 “(v) in 1996, is 80 percent of the na-  
8 tional limited monthly payment rate com-  
9 puted under subparagraph (B) for the item  
10 for the year; and

11 “(vi) in a subsequent year, is the na-  
12 tional limited monthly payment rate com-  
13 puted under subparagraph (B) for the item  
14 for the year.”.

15 **SEC. 15604. REDUCTION IN UPDATES TO PAYMENT**  
16 **AMOUNTS FOR CLINICAL DIAGNOSTIC LAB-**  
17 **ORATORY TESTS.**

18 (a) CHANGE IN UPDATE.—Section  
19 1833(h)(2)(A)(ii)(IV) (42 U.S.C. 1395l(h)(2)(A)(ii)(IV))  
20 is amended striking “1994 and 1995” and inserting  
21 “1994 through 2002”.

22 (b) LOWERING CAP ON PAYMENT AMOUNTS.—Sec-  
23 tion 1833(h)(4)(B) (42 U.S.C. 1395l(h)(4)(B)) is amend-  
24 ed—

25 (1) in clause (vi), by striking “and” at the end;

1 (2) in clause (vii)—

2 (A) by inserting “and before January 1,  
3 1997,” after “1995,” and

4 (B) by striking the period at the end and  
5 inserting “, and”; and

6 (3) by adding at the end the following new  
7 clause:

8 “(viii) after December 31, 1996, is equal to 65  
9 percent of such median.”.

10 **SEC. 15605. EXTENSION OF REDUCTIONS IN PAYMENTS FOR**  
11 **COSTS OF HOSPITAL OUTPATIENT SERVICES.**

12 (a) REDUCTION IN PAYMENTS FOR CAPITAL-RELAT-  
13 ED COSTS.—Section 1861(v)(1)(S)(ii)(I) (42 U.S.C.  
14 1395x(v)(1)(S)(ii)(I)) is amended by striking “through  
15 1998” and inserting “through 2002”.

16 (b) REDUCTION IN PAYMENTS FOR OTHER COSTS.—  
17 Section 1861(v)(1)(S)(ii)(II) (42 U.S.C.  
18 1395x(v)(1)(S)(ii)(II)) is amended by striking “through  
19 1998” and inserting “through 2002”.

20 **SEC. 15606. FREEZE IN PAYMENTS FOR AMBULATORY SUR-**  
21 **GICAL CENTER SERVICES.**

22 The Secretary of Health and Human Services shall  
23 not provide for any inflation update in the payment  
24 amounts under subparagraphs (A) and (B) of section

1 1833(i)(2) of the Social Security Act for any of the fiscal  
2 years 1996 through 2002.

3 **SEC. 15607. RURAL EMERGENCY ACCESS CARE HOSPITALS.**

4 (a) COVERAGE UNDER PART B.—Section 1832(a)(2)  
5 (42 U.S.C. 1395k(a)(2)) is amended—

6 (1) by striking “and” at the end of subpara-  
7 graph (I);

8 (2) by striking the period at the end of sub-  
9 paragraph (J) and inserting “; and”; and

10 (3) by adding at the end the following new sub-  
11 paragraph:

12 “(K) rural emergency access care hospital  
13 services (as defined in section 1861(oo)(2)).”.

14 (b) PAYMENT BASED ON REASONABLE COSTS.—Sec-  
15 tion 1833(a)(2) (42 U.S.C. 1395l(a)(2)), as amended by  
16 section 15607(c), is amended—

17 (1) by striking “and” at the end of subpara-  
18 graph (F);

19 (2) by adding “and” at the end of subpara-  
20 graph (G); and

21 (3) by adding at the end the following new sub-  
22 paragraph:

23 “(H) with respect to rural emergency ac-  
24 cess care hospital services, the reasonable cost  
25 of such services (as determined under section

1           1861(v)), less the amount the hospital may  
2           charge as described in clause (ii) of section  
3           1866(a)(2)(A), but in no case may the payment  
4           for such services exceed 80 percent of such rea-  
5           sonable cost;”.

6           (c) EFFECTIVE DATE.—The amendments made by  
7           this section shall apply to services furnished on or after  
8           October 1, 1995.

9                           **PART 2—PART B PREMIUM**

10           **SEC. 15611. EXTENSION OF PART B PREMIUM.**

11           (a) IN GENERAL.—Section 1839(e)(1) (42 U.S.C.  
12           1395r(e)(1)) is amended—

13                   (1) in subparagraph (A)—

14                           (A) by striking “and prior to January  
15                           1999”, and

16                           (B) by inserting “(or, if higher, the per-  
17                           cent described in subparagraph (C))” after “50  
18                           percent”; and

19                   (2) by adding at the end the following new sub-  
20           paragraph:

21                   “(C) For purposes of subparagraph (A), the percent  
22           described in this subparagraph is the ratio (expressed as  
23           a percentage) of the monthly premium established under  
24           this section for months in 1995 to the monthly actuarial  
25           rate for enrollees age 65 and over applicable to such

1 months (as specified in the most recent report of the  
2 Board of Trustees of the Federal Supplementary Medical  
3 Insurance Trust Fund published prior to the date of the  
4 enactment of the Medicare Preservation Act of 1995).”.

5 (b) EFFECTIVE DATE.—The amendments made by  
6 subsection (a) apply to premiums for months beginning  
7 with January 1996.

8 **SEC. 15612. INCOME-RELATED REDUCTION IN MEDICARE**  
9 **SUBSIDY.**

10 (a) IN GENERAL.—Section 1839 (42 U.S.C. 1395r)  
11 is amended by adding at the end the following:

12 “(h)(1) Notwithstanding the previous subsections of  
13 this section, in the case of an individual whose modified  
14 adjusted gross income for a taxable year ending with or  
15 within a calendar year (as initially determined by the Sec-  
16 retary in accordance with paragraph (3)) exceeds the  
17 threshold amount described in paragraph (4), the Sec-  
18 retary shall increase the amount of the monthly premium  
19 for months in the calendar year by an amount equal to  
20 the difference between—

21 “(A) 200 percent of the monthly actuarial rate  
22 for enrollees age 65 and over as determined under  
23 subsection (a)(1) for that calendar year; and

1           “(B) the total of the monthly premiums paid by  
2           the individual under this section (determined without  
3           regard to subsection (b)) during such calendar year.

4           “(2) In the case of an individual described in para-  
5           graph (1) whose modified adjusted gross exceeds the  
6           threshold amount by less than \$25,000, the amount of the  
7           increase in the monthly premium applicable under para-  
8           graph (1) shall be an amount which bears the same ratio  
9           to the amount of the increase described in paragraph (1)  
10          (determined without regard to this paragraph) as such ex-  
11          cess bears to \$25,000. In the case of a joint return filed  
12          under section 6013 of the Internal Revenue Code of 1986  
13          by spouses both of whom are enrolled under this part, the  
14          previous sentence shall be applied by substituting  
15          ‘\$50,000’ for ‘\$25,000’. The preceding provisions of this  
16          paragraph shall not apply to any individual whose thresh-  
17          old amount is zero.

18          “(3) The Secretary shall make an initial determina-  
19          tion of the amount of an individual’s adjusted gross in-  
20          come for a taxable year ending with or within a calendar  
21          year for purposes of this subsection as follows:

22                 “(A) Not later than October 1 of the year pre-  
23                 ceding the year, the Secretary shall provide notice to  
24                 each individual whom the Secretary finds (on the  
25                 basis of the individual’s actual adjusted gross in-

1       come for the most recent taxable year for which such  
2       information is available or other information pro-  
3       vided to the Secretary by the Secretary of the Treas-  
4       ury) will be subject to an increase under this sub-  
5       section that the individual will be subject to such an  
6       increase, and shall include in such notice the Sec-  
7       retary's estimate of the individual's adjusted gross  
8       income for the year.

9               “(B) If, during the 30-day period beginning on  
10       the date notice is provided to an individual under  
11       subparagraph (A), the individual provides the Sec-  
12       retary with information on the individual's antici-  
13       pated adjusted gross income for the year, the  
14       amount initially determined by the Secretary under  
15       this paragraph with respect to the individual shall be  
16       based on the information provided by the individual.

17               “(C) If an individual does not provide the Sec-  
18       retary with information under subparagraph (B), the  
19       amount initially determined by the Secretary under  
20       this paragraph with respect to the individual shall be  
21       the amount included in the notice provided to the in-  
22       dividual under subparagraph (A).

23               “(4)(A) If the Secretary determines (on the basis of  
24       final information provided by the Secretary of the Treas-  
25       ury) that the amount of an individual's actual adjusted

1 gross income for a taxable year ending with or within a  
2 calendar year is less than or greater than the amount ini-  
3 tially determined by the Secretary under paragraph (3),  
4 the Secretary shall increase or decrease the amount of the  
5 individual's monthly premium under this section (as the  
6 case may be) for months during the following calendar  
7 year by an amount equal to  $\frac{1}{12}$  of the difference be-  
8 tween—

9           “(i) the total amount of all monthly premiums  
10       paid by the individual under this section during the  
11       previous calendar year; and

12           “(ii) the total amount of all such premiums  
13       which would have been paid by the individual during  
14       the previous calendar year if the amount of the indi-  
15       vidual's adjusted gross income initially determined  
16       under paragraph (3) were equal to the actual  
17       amount of the individual's adjusted gross income de-  
18       termined under this paragraph.

19       “(B) In the case of an individual who is not enrolled  
20       under this part for any calendar year for which the indi-  
21       vidual's monthly premium under this section for months  
22       during the year would be increased pursuant to subpara-  
23       graph (A) if the individual were enrolled under this part  
24       for the year, the Secretary may take such steps as the  
25       Secretary considers appropriate to recover from the indi-

1 vidual the total amount by which the individual’s monthly  
2 premium for months during the year would have been in-  
3 creased under subparagraph (A) if the individual were en-  
4 rolled under this part for the year.

5 “(5) In this subsection, the following definitions  
6 apply:

7 “(A) The term ‘modified adjusted gross income’  
8 means, with respect to an individual for a taxable  
9 year, the individual’s adjusted gross income under  
10 the Internal Revenue Code of 1986—

11 “(i) determined without regard to sections  
12 135, 911, 931, and 933 of such Code, and

13 “(ii) increased by the amount of interest  
14 received or accrued by the individual during the  
15 taxable year which is exempt from tax under  
16 such Code.

17 “(B) The term ‘threshold amount’ means—

18 “(i) except as otherwise provided in this  
19 paragraph, \$75,000,

20 “(ii) \$125,000, in the case of a joint re-  
21 turn, and

22 “(iii) zero in the case of a taxpayer who—

23 “(I) is married at the close of the tax-  
24 able year but does not file a joint return  
25 for such year, and

1                   “(II) does not live apart from his  
2                   spouse at all times during the taxable  
3                   year.”.

4           (b) CONFORMING AMENDMENT.—Section 1839(f)  
5 (42 U.S.C. 1395r(f)) is amended by striking “if an indi-  
6 vidual” and inserting the following: “if an individual  
7 (other than an individual subject to an increase in the  
8 monthly premium under this section pursuant to sub-  
9 section (h))”.

10          (c) REPORTING REQUIREMENTS FOR SECRETARY OF  
11 THE TREASURY.—Notwithstanding section 6103 of the  
12 Internal Revenue Code of 1986, the Secretary of the  
13 Treasury shall provide, at the request of the Secretary of  
14 Health and Human Services, such information (at such  
15 times and in such form as the Secretary of Health and  
16 Human Services may require) as is necessary for the Sec-  
17 retary of Health and Human Services to carry out section  
18 1839(h) of the Social Security Act (as added by subsection  
19 (a)).

20          (d) EFFECTIVE DATE.—The amendments made by  
21 subsections (a) and (b) shall apply to the monthly pre-  
22 mium under section 1839 of the Social Security Act for  
23 months beginning with January 1997.

1 **Subtitle H—Provisions Relating to**  
2 **Medicare Parts A and B**

3 **PART 1—PAYMENTS FOR HOME HEALTH**  
4 **SERVICES**

5 **SEC. 15701. PAYMENT FOR HOME HEALTH SERVICES.**

6 (a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et  
7 seq.), as amended by section 15106, is amended by adding  
8 at the end the following new section:

9 “PAYMENT FOR HOME HEALTH SERVICES

10 “SEC. 1894. (a) IN GENERAL.—

11 “(1) PER VISIT PAYMENTS.—Subject to sub-  
12 section (c), the Secretary shall make per visit pay-  
13 ments beginning with fiscal year 1997 to a home  
14 health agency in accordance with this section for  
15 each type of home health service described in para-  
16 graph (2) furnished to an individual who at the time  
17 the service is furnished is under a plan of care by  
18 the home health agency under this title (without re-  
19 gard to whether or not the item or service was fur-  
20 nished by the agency or by others under arrange-  
21 ment with them made by the agency, or otherwise).

22 “(2) TYPES OF SERVICES.—The types of home  
23 health services described in this paragraph are the  
24 following:

1           “(A) Part-time or intermittent nursing  
2           care provided by or under the supervision of a  
3           registered professional nurse.

4           “(B) Physical therapy.

5           “(C) Occupational therapy.

6           “(D) Speech-language pathology services.

7           “(E) Medical social services under the di-  
8           rection of a physician.

9           “(F) To the extent permitted in regula-  
10          tions, part-time or intermittent services of a  
11          home health aide who has successfully com-  
12          pleted a training program approved by the Sec-  
13          retary.

14          “(b) ESTABLISHMENT OF PER VISIT RATE FOR  
15          EACH TYPE OF SERVICES.—

16               “(1) IN GENERAL.—The Secretary shall, sub-  
17          ject to paragraph (3), establish a per visit payment  
18          rate for a home health agency in an area for each  
19          type of home health service described in subsection  
20          (a)(2). Such rate shall be equal to the national per  
21          visit payment rate determined under paragraph (2)  
22          for each such type, except that the labor-related por-  
23          tion of such rate shall be adjusted by the area wage  
24          index applicable under section 1886(d)(3)(E) for the  
25          area in which the agency is located (as determined

1 without regard to any reclassification of the area  
2 under section 1886(d)(8)(B) or a decision of the  
3 Medicare Geographic Classification Review Board or  
4 the Secretary under section 1886(d)(10) for cost re-  
5 porting periods beginning after October 1, 1995).

6 “(2) NATIONAL PER VISIT PAYMENT RATE.—  
7 The national per visit payment rate for each type of  
8 service described in subsection (a)(2)—

9 “(A) for fiscal year 1997, is an amount  
10 equal to the national average amount paid per  
11 visit under this title to home health agencies for  
12 such type of service during the most recent 12-  
13 month cost reporting period ending on or before  
14 June 30, 1994, increased (in a compounded  
15 manner) by the home health market basket per-  
16 centage increase for fiscal years 1995, 1996,  
17 and 1997; and

18 “(B) for each subsequent fiscal year, is an  
19 amount equal to the national per visit payment  
20 rate in effect for the preceding fiscal year, in-  
21 creased by the home health market basket per-  
22 centage increase for such subsequent fiscal year  
23 minus 2 percentage points.

24 “(3) REBASING OF RATES.—The Secretary  
25 shall provide for an update to the national per visit

1 payment rates under this subsection for cost report-  
2 ing periods beginning not later than the first day of  
3 the fifth fiscal year which begins after fiscal year  
4 1997, and not later than every 5 years thereafter, to  
5 reflect the most recent available data.

6 “(4) HOME HEALTH MARKET BASKET PER-  
7 CENTAGE INCREASE.—For purposes of this sub-  
8 section, the term ‘home health market basket per-  
9 centage increase’ means, with respect to a fiscal  
10 year, a percentage (estimated by the Secretary be-  
11 fore the beginning of the fiscal year) determined and  
12 applied with respect to the types of home health  
13 services described in subsection (a)(2) in the same  
14 manner as the market basket percentage increase  
15 under section 1886(b)(3)(B)(iii) is determined and  
16 applied to inpatient hospital services for the fiscal  
17 year.

18 “(c) PER EPISODE LIMIT.—

19 “(1) AGGREGATE LIMIT.—

20 “(A) IN GENERAL.—Except as provided in  
21 paragraph (2), a home health agency may not  
22 receive aggregate per visit payments under sub-  
23 section (a) for a fiscal year in excess of an  
24 amount equal to the sum of the following prod-

1           ucts determined for each case-mix category for  
2           which the agency receives payments:

3                   “(i) The number of episodes of each  
4                   case-mix category during the fiscal year;  
5                   multiplied by

6                   “(ii) the per episode limit determined  
7                   for such case-mix category for such fiscal  
8                   year.

9                   “(B) ESTABLISHMENT OF PER EPISODE  
10           LIMITS.—

11                   “(i) IN GENERAL.—The per episode  
12                   limit for a fiscal year for any case-mix cat-  
13                   egory for the area in which a home health  
14                   agency is located is equal to—

15                           “(I) the mean number of visits  
16                           for each type of home health service  
17                           described in subsection (a)(2) fur-  
18                           nished during an episode of such case-  
19                           mix category in such area during fis-  
20                           cal year 1994, adjusted by the case-  
21                           mix adjustment factor determined in  
22                           clause (ii) for the fiscal year involved;  
23                           multiplied by

24                           “(II) the per visit payment rate  
25                           established under subsection (b) for

1           such type of home health service for  
2           the fiscal year for which the deter-  
3           mination is being made.

4           “(ii) CASE MIX ADJUSTMENT FAC-  
5           TOR.—For purposes of clause (i), the case-  
6           mix adjustment factor for a year is the  
7           factor determined by the Secretary to as-  
8           sure that aggregate payments for home  
9           health services under this section during  
10          the year will not exceed the payment for  
11          such services during the previous year as a  
12          result of changes in the number and type  
13          of home health visits within case-mix cat-  
14          egories over the previous year.

15          “(iii) REBASING OF PER EPISODE  
16          AMOUNTS.—Beginning with fiscal year  
17          1999 and every 2 years thereafter, the Sec-  
18          retary shall revise the mean number of  
19          home health visits determined under clause  
20          (i)(I) for each type of home health service  
21          visit described in subsection (a)(2) fur-  
22          nished during an episode in a case-mix cat-  
23          egory to reflect the most recently available  
24          data on the number of visits.

1           “(iv) DETERMINATION OF APPLICA-  
2           BLE AREA.—For purposes of determining  
3           per episode limits under this subpara-  
4           graph, the area in which a home health  
5           agency is considered to be located shall be  
6           such area as the Secretary finds appro-  
7           priate for purposes of this subparagraph.

8           “(C) CASE-MIX CATEGORY.—For purposes  
9           of this paragraph, the term ‘case-mix category’  
10          means each of the 18 case-mix categories estab-  
11          lished under the Phase II Home Health Agency  
12          Prospective Payment Demonstration Project  
13          conducted by the Health Care Financing Ad-  
14          ministration. The Secretary may develop an al-  
15          ternate methodology for determining case-mix  
16          categories.

17          “(D) EPISODE.—

18                 “(i) IN GENERAL.—For purposes of  
19                 this paragraph, the term ‘episode’ means  
20                 the continuous 120-day period that—

21                         “(I) begins on the date of an in-  
22                         dividual’s first visit for a type of home  
23                         health service described in subsection  
24                         (a)(2) for a case-mix category, and

1           “(II) is immediately preceded by  
2           a 60-day period in which the individ-  
3           ual did not receive visits for a type of  
4           home health service described in sub-  
5           section (a)(2).

6           “(ii) TREATMENT OF EPISODES SPAN-  
7           NING COST REPORTING PERIODS.—The  
8           Secretary shall provide for such rules as  
9           the Secretary considers appropriate regard-  
10          ing the treatment of episodes under this  
11          paragraph which begin during a cost re-  
12          porting period and end in a subsequent  
13          cost reporting period.

14          “(E) EXEMPTIONS AND EXCEPTIONS.—  
15          The Secretary may provide for exemptions and  
16          exceptions to the limits established under this  
17          paragraph for a fiscal year as the Secretary  
18          deems appropriate, to the extent such exemp-  
19          tions and exceptions do not result in greater  
20          payments under this section than the exemp-  
21          tions and exceptions provided under section  
22          1861(v)(1)(L)(ii) in fiscal year 1994, increased  
23          by the home health market basket percentage  
24          increase for the fiscal year involved (as defined  
25          in subsection (b)(4)).

1           “(2) RECONCILIATION OF AMOUNTS.—

2                   “(A) OVERPAYMENTS TO HOME HEALTH  
3 AGENCIES.—Subject to subparagraph (B), if a  
4 home health agency has received aggregate per  
5 visit payments under subsection (a) for a fiscal  
6 year in excess of the amount determined under  
7 paragraph (1) with respect to such home health  
8 agency for such fiscal year, the Secretary shall  
9 reduce payments under this section to the home  
10 health agency in the following fiscal year in  
11 such manner as the Secretary considers appro-  
12 priate (including on an installment basis) to re-  
13 capture the amount of such excess.

14                   “(B) EXCEPTION FOR HOME HEALTH  
15 SERVICES FURNISHED OVER A PERIOD GREAT-  
16 ER THAN 165 DAYS.—

17                           “(i) IN GENERAL.—For purposes of  
18 subparagraph (A), the amount of aggre-  
19 gate per visit payments determined under  
20 subsection (a) shall not include payments  
21 for home health visits furnished to an indi-  
22 vidual on or after a continuous period of  
23 more than 165 days after an individual be-  
24 gins an episode described in subsection

1 (c)(1)(D) (if such period is not interrupted  
2 by the beginning of a new episode).

3 “(ii) REQUIREMENT OF CERTIFI-  
4 CATION.—Clause (i) shall not apply if the  
5 agency has not obtained a physician’s cer-  
6 tification with respect to the individual re-  
7 quiring such visits that includes a state-  
8 ment that the individual requires such con-  
9 tinued visits, the reason for the need for  
10 such visits, and a description of such serv-  
11 ices furnished during such visits.

12 “(C) SHARE OF SAVINGS.—

13 “(i) BONUS PAYMENTS.—If a home  
14 health agency has received aggregate per  
15 visit payments under subsection (a) for a  
16 fiscal year in an amount less than the  
17 amount determined under paragraph (1)  
18 with respect to such home health agency  
19 for such fiscal year, the Secretary shall pay  
20 such home health agency a bonus payment  
21 equal to 50 percent of the difference be-  
22 tween such amounts in the following fiscal  
23 year, except that the bonus payment may  
24 not exceed 5 percent of the aggregate per

1 visit payments made to the agency for the  
2 year.

3 “(ii) INSTALLMENT BONUS PAY-  
4 MENTS.—The Secretary may make install-  
5 ment payments during a fiscal year to a  
6 home health agency based on the estimated  
7 bonus payment that the agency would be  
8 eligible to receive with respect to such fis-  
9 cal year.

10 “(d) MEDICAL REVIEW PROCESS.—The Secretary  
11 shall implement a medical review process (with a particu-  
12 lar emphasis on fiscal years 1997 and 1998) for the sys-  
13 tem of payments described in this section that shall pro-  
14 vide an assessment of the pattern of care furnished to in-  
15 dividuals receiving home health services for which pay-  
16 ments are made under this section to ensure that such  
17 individuals receive appropriate home health services. Such  
18 review process shall focus on low-cost cases described in  
19 subsection (e)(3) and cases described in subsection  
20 (c)(2)(B) and shall require recertification by  
21 intermediaries at 30, 60, 90, 120, and 165 days into an  
22 episode described in subsection (c)(1)(D).

23 “(e) ADJUSTMENT OF PAYMENTS TO AVOID CIR-  
24 CUMVENTION OF LIMITS.—

1           “(1) IN GENERAL.—The Secretary shall provide  
2 for appropriate adjustments to payments to home  
3 health agencies under this section to ensure that  
4 agencies do not circumvent the purpose of this sec-  
5 tion by—

6           “(A) discharging patients to another home  
7 health agency or similar provider;

8           “(B) altering corporate structure or name  
9 to avoid being subject to this section or for the  
10 purpose of increasing payments under this title;  
11 or

12           “(C) undertaking other actions considered  
13 unnecessary for effective patient care and in-  
14 tended to achieve maximum payments under  
15 this title.

16           “(2) TRACKING OF PATIENTS THAT SWITCH  
17 HOME HEALTH AGENCIES DURING EPISODE.—

18           “(A) DEVELOPMENT OF SYSTEM.—The  
19 Secretary shall develop a system that tracks  
20 home health patients that receive home health  
21 services described in subsection (a)(2) from  
22 more than 1 home health agency during an epi-  
23 sode described in subsection (c)(1)(D).

24           “(B) ADJUSTMENT OF PAYMENTS.—The  
25 Secretary shall adjust payments under this sec-

1           tion to each home health agency that furnishes  
2           an individual with a type of home health service  
3           described in subsection (a)(2) to ensure that  
4           aggregate payments on behalf of such individual  
5           during such episode do not exceed the amount  
6           that would be paid under this section if the in-  
7           dividual received such services from a single  
8           home health agency.

9           “(3) LOW-COST CASES.—The Secretary shall  
10          develop a system designed to adjust payments to a  
11          home health agency for a fiscal year to eliminate any  
12          increase in growth of the percentage of low-cost epi-  
13          sodes for which home health services are furnished  
14          by the agency over such percentage determined for  
15          the agency for the 12-month cost reporting period  
16          ending on June 30, 1994. The Secretary shall define  
17          a low-cost episode in a manner that provides that a  
18          home health agency has an incentive to be cost effi-  
19          cient in delivering home health services and that the  
20          volume of such services does not increase as a result  
21          of factors other than patient needs.

22          “(f) REPORT BY MEDICARE PAYMENT REVIEW COM-  
23          MISSION.—During the first 3 years in which payments are  
24          made under this section, the Medicare Payment Review  
25          Commission shall annually submit a report to Congress

1 on the effectiveness of the payment methodology estab-  
2 lished under this section that shall include recommenda-  
3 tions regarding the following:

4 “(1) Case-mix and volume increases.

5 “(2) Quality monitoring of home health agency  
6 practices.

7 “(3) Whether a capitated payment for home  
8 care patients receiving care during a continuous pe-  
9 riod exceeding 165 days is warranted.

10 “(4) Whether public providers of service are  
11 adequately reimbursed.

12 “(5) The adequacy of the exemptions and ex-  
13 ceptions to the limits provided under subsection  
14 (c)(1)(E).

15 “(6) The appropriateness of the methods pro-  
16 vided under this section to adjust the per episode  
17 limits and annual payment updates to reflect  
18 changes in the mix of services, number of visits, and  
19 assignment to case categories to reflect changing  
20 patterns of home health care.

21 “(7) The geographic areas used to determine  
22 the per episode limits.”.

23 (b) PAYMENT FOR PROSTHETICS AND ORTHOTICS  
24 UNDER PART A.—Section 1814(k) (42 U.S.C. 1395f(k))  
25 is amended—

1 (1) by inserting “and prosthetics and orthotics”  
2 after “durable medical equipment”; and

3 (2) by inserting “and 1834(h), respectively”  
4 after “1834(a)(1)”.

5 (c) CONFORMING AMENDMENTS.—

6 (1) PAYMENTS UNDER PART A.—Section  
7 1814(b) (42 U.S.C. 1395f(b)), as amended by sec-  
8 tion 15522(b), is amended in the matter preceding  
9 paragraph (1) by striking “1888 and 1888A” and  
10 inserting “1888, 1888A, and 1894”.

11 (2) TREATMENT OF ITEMS AND SERVICES PAID  
12 UNDER PART B.—

13 (A) PAYMENTS UNDER PART B.—Section  
14 1833(a)(2) (42 U.S.C. 1395l(a)(2)) is amend-  
15 ed—

16 (i) by amending subparagraph (A) to  
17 read as follows:

18 “(A) with respect to home health serv-  
19 ices—

20 “(i) that are a type of home health  
21 service described in section 1894(a)(2),  
22 and which are furnished to an individual  
23 who (at the time the item or service is fur-  
24 nished) is under a plan of care of a home

1 health agency, the amount determined  
2 under section 1894;

3 “(ii) that are not described in clause  
4 (i) (other than a covered osteoporosis  
5 drug) (as defined in section 1861(kk)), the  
6 lesser of—

7 “(I) the reasonable cost of such  
8 services, as determined under section  
9 1861(v), or

10 “(II) the customary charges with  
11 respect to such services;”.

12 (ii) by striking “and” at the end of  
13 subparagraph (E);

14 (iii) by adding “and” at the end of  
15 subparagraph (F); and

16 (iv) by adding at the end the following  
17 new subparagraph:

18 “(G) with respect to items and services de-  
19 scribed in section 1861(s)(10)(A), the lesser  
20 of—

21 “(i) the reasonable cost of such serv-  
22 ices, as determined under section 1861(v),  
23 or

24 “(ii) the customary charges with re-  
25 spect to such services,

1 or, if such services are furnished by a public  
 2 provider of services, or by another provider  
 3 which demonstrates to the satisfaction of the  
 4 Secretary that a significant portion of its pa-  
 5 tients are low-income (and requests that pay-  
 6 ment be made under this provision), free of  
 7 charge or at nominal charges to the public, the  
 8 amount determined in accordance with section  
 9 1814(b)(2);”.

10 (B) REQUIRING PAYMENT FOR ALL ITEMS  
 11 AND SERVICES TO BE MADE TO AGENCY.—

12 (i) IN GENERAL.—The first sentence  
 13 of section 1842(b)(6) (42 U.S.C.  
 14 1395u(b)(6)) is amended—

15 (I) by striking “and (D)” and in-  
 16 sserting “(D)”; and

17 (II) by striking the period at the  
 18 end and inserting the following: “,  
 19 and (E) in the case of types of home  
 20 health services described in section  
 21 1894(a)(2) furnished to an individual  
 22 who (at the time the item or service is  
 23 furnished) is under a plan of care of  
 24 a home health agency, payment shall  
 25 be made to the agency (without re-

1           gard to whether or not the item or  
 2           service was furnished by the agency,  
 3           by others under arrangement with  
 4           them made by the agency, or other-  
 5           wise).”.

6           (ii) CONFORMING AMENDMENT.—Sec-  
 7           tion 1832(a)(1) (42 U.S.C. 1395k(a)(1)) is  
 8           amended by striking “(2);” and inserting  
 9           “(2) and section 1842(b)(6)(E);”.

10          (C) EXCLUSIONS FROM COVERAGE.—Sec-  
 11          tion 1862(a) (42 U.S.C. 1395y(a)), as amended  
 12          by section 15525(a)(2), is amended—

13               (i) by striking “or” at the end of  
 14               paragraph (15);

15               (ii) by striking the period at the end  
 16               of paragraph (16) and inserting “or”; and

17               (iii) by adding at the end the follow-  
 18               ing new paragraph:

19               “(17) where such expenses are for home health  
 20               services furnished to an individual who is under a  
 21               plan of care of the home health agency if the claim  
 22               for payment for such services is not submitted by  
 23               the agency.”.

24          (3) SUNSET OF REASONABLE COST LIMITA-  
 25          TIONS.—Section 1861(v)(1)(L) (42 U.S.C.

1 1395x(v)(1)(L)) is amended by adding at the end  
2 the following new clause:

3 “(iv) This subparagraph shall apply only to services  
4 furnished by home health agencies during cost reporting  
5 periods ending on or before September 30, 1996.”.

6 (c) EFFECTIVE DATE.—The amendments made by  
7 subsections (a) and (b) shall apply to cost reporting peri-  
8 ods beginning on or after October 1, 1996.

9 **SEC. 15702. MAINTAINING SAVINGS RESULTING FROM TEM-**  
10 **PORARY FREEZE ON PAYMENT INCREASES**  
11 **FOR HOME HEALTH SERVICES.**

12 (a) BASING UPDATES TO PER VISIT COST LIMITS ON  
13 LIMITS FOR FISCAL YEAR 1993.—Section  
14 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is  
15 amended by adding at the end the following sentence: “In  
16 establishing limits under this subparagraph, the Secretary  
17 may not take into account any changes in the costs of  
18 the provision of services furnished by home health agencies  
19 with respect to cost reporting periods which began on or  
20 after July 1, 1994, and before July 1, 1996.”.

21 (b) NO EXCEPTIONS PERMITTED BASED ON AMEND-  
22 MENT.—The Secretary of Health and Human Services  
23 shall not consider the amendment made by subsection (a)  
24 in making any exemptions and exceptions pursuant to sec-  
25 tion 1861(v)(1)(L)(ii) of the Social Security Act.

1 **SEC. 15703. EXTENSION OF WAIVER OF PRESUMPTION OF**  
2 **LACK OF KNOWLEDGE OF EXCLUSION FROM**  
3 **COVERAGE FOR HOME HEALTH AGENCIES.**

4 Section 9305(g)(3) of OBRA–1986, as amended by  
5 section 426(d) of the Medicare Catastrophic Coverage Act  
6 of 1988 and section 4207(b)(3) of OBRA–1990 (as re-  
7 numbered by section 160(d)(4) of the Social Security Act  
8 Amendments of 1994), is amended by striking “December  
9 31, 1995” and inserting “September 30, 1996”.

10 **PART 2—MEDICARE SECONDARY PAYER**  
11 **IMPROVEMENTS**

12 **SEC. 15711. EXTENSION AND EXPANSION OF EXISTING RE-**  
13 **QUIREMENTS.**

14 (a) DATA MATCH.—

15 (1) Section 1862(b)(5)(C) (42 U.S.C.  
16 1395y(b)(5)(C)) is amended by striking clause (iii).

17 (2) Section 6103(l)(12) of the Internal Revenue  
18 Code of 1986 is amended by striking subparagraph  
19 (F).

20 (b) APPLICATION TO DISABLED INDIVIDUALS IN  
21 LARGE GROUP HEALTH PLANS.—

22 (1) IN GENERAL.—Section 1862(b)(1)(B) (42  
23 U.S.C. 1395y(b)(1)(B)) is amended—

24 (A) in clause (i), by striking “clause (iv)”  
25 and inserting “clause (iii)”,

26 (B) by striking clause (iii), and

1 (C) by redesignating clause (iv) as clause  
 2 (iii).

3 (2) CONFORMING AMENDMENTS.—Paragraphs  
 4 (1) through (3) of section 1837(i) (42 U.S.C.  
 5 1395p(i)) and the second sentence of section  
 6 1839(b) (42 U.S.C. 1395r(b)) are each amended by  
 7 striking “1862(b)(1)(B)(iv)” each place it appears  
 8 and inserting “1862(b)(1)(B)(iii)”.

9 (c) EXPANSION OF PERIOD OF APPLICATION TO IN-  
 10 DIVIDUALS WITH END STAGE RENAL DISEASE.—Section  
 11 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended—

12 (1) in the first sentence, by striking “12-  
 13 month” each place it appears and inserting “24-  
 14 month”, and

15 (2) by striking the second sentence.

16 **SEC. 15712. IMPROVEMENTS IN RECOVERY OF PAYMENTS.**

17 (a) PERMITTING RECOVERY AGAINST THIRD PARTY  
 18 ADMINISTRATORS OF PRIMARY PLANS.—Section  
 19 1862(b)(2)(B)(ii) (42 U.S.C. 1395y(b)(2)(B)(ii)) is  
 20 amended—

21 (1) by striking “under this subsection to pay”  
 22 and inserting “(directly, as a third-party adminis-  
 23 trator, or otherwise) to make payment”, and

24 (2) by adding at the end the following: “The  
 25 United States may not recover from a third-party

1 administrator under this clause in cases where the  
2 third-party administrator would not be able to re-  
3 cover the amount at issue from the employer or  
4 group health plan for whom it provides administra-  
5 tive services due to the insolvency or bankruptcy of  
6 the employer or plan.”.

7 (b) EXTENSION OF CLAIMS FILING PERIOD.—Sec-  
8 tion 1862(b)(2)(B) (42 U.S.C. 1395y(b)(2)(B)) is amend-  
9 ed by adding at the end the following new clause:

10 “(vi) CLAIMS-FILING PERIOD.—Not-  
11 withstanding any other time limits that  
12 may exist for filing a claim under an em-  
13 ployer group health plan, the United  
14 States may seek to recover conditional pay-  
15 ments in accordance with this subpara-  
16 graph where the request for payment is  
17 submitted to the entity required or respon-  
18 sible under this subsection to pay with re-  
19 spect to the item or service (or any portion  
20 thereof) under a primary plan within the  
21 3-year period beginning on the date on  
22 which the item or service was furnished.”.

23 (c) EFFECTIVE DATE.—The amendments made by  
24 this section shall apply to items and services furnished on  
25 or after the date of the enactment of this Act.

1 **SEC. 15713. PROHIBITING RETROACTIVE APPLICATION OF**  
 2 **POLICY REGARDING ESRD BENEFICIARIES**  
 3 **ENROLLED IN PRIMARY PLANS.**

4 For purposes of carrying out section 1862(b)(1)(C)  
 5 of the Social Security Act, the Secretary of Health and  
 6 Human Services shall apply the policy directive issued by  
 7 the Administrator of the Health Care Financing Adminis-  
 8 tration on April 24, 1995, only with respect to items and  
 9 services furnished on or after such date.

10 **PART 3—FAILSAFE**

11 **SEC. 15721. FAILSAFE BUDGET MECHANISM.**

12 (a) IN GENERAL.—Title XVIII, as amended by sec-  
 13 tions 15106(a) and 15701(a), is amended by adding at  
 14 the end the following new section:

15 “FAILSAFE BUDGET MECHANISM

16 “SEC. 1895. (a) REQUIREMENT OF PAYMENT AD-  
 17 JUSTMENTS TO ACHIEVE MEDICARE BUDGET TAR-  
 18 GETS.—

19 “(1) IN GENERAL.—If the Secretary determines  
 20 under subsection (e)(3)(C) before a fiscal year (be-  
 21 ginning with fiscal year 1998) that—

22 “(A) the fee-for-service expenditures (as  
 23 defined in subsection (f)) for a sector of medi-  
 24 care services (as defined in subsection (b)) for  
 25 the fiscal year, will exceed

1           “(B) the allotment specified under sub-  
 2           section (c)(2) for such fiscal year (taking into  
 3           account any adjustment in the allotment under  
 4           subsection (h) for that fiscal year),  
 5           then, notwithstanding any other provision of this  
 6           title, there shall be an adjustment (consistent with  
 7           subsection (d)) in applicable payment rates or pay-  
 8           ments for items and services included in the sector  
 9           in the fiscal year so that such expenditures for the  
 10          sector for the year will be reduced by 133 $\frac{1}{3}$  percent  
 11          of the amount of such excess.

12          “(b) SECTORS OF MEDICARE SERVICES DE-  
 13          SCRIBED.—

14           “(1) IN GENERAL.—For purposes of this sec-  
 15          tion, items and services included under each of the  
 16          following subparagraphs shall be considered to be a  
 17          separate ‘sector’ of medicare services:

18                   “(A) Inpatient hospital services.

19                   “(B) Home health services.

20                   “(C) Extended care services (for inpatients  
 21                   of skilled nursing facilities).

22                   “(D) Hospice care.

23                   “(E) Physicians’ services (including serv-  
 24                   ices and supplies described in section  
 25                   1861(s)(2)(A)) and services of other health care

1 professionals (including certified registered  
 2 nurse anesthetists, nurse practitioners, physi-  
 3 cian assistants, and clinical psychologists) for  
 4 which separate payment is made under this  
 5 title.

6 “(F) Outpatient hospital services and am-  
 7 bulatory facility services.

8 “(G) Durable medical equipment and sup-  
 9 plies, including prosthetic devices and orthotics.

10 “(H) Diagnostic tests (including clinical  
 11 laboratory services and x-ray services).

12 “(I) Other items and services.

13 “(2) CLASSIFICATION OF ITEMS AND SERV-  
 14 ICES.—The Secretary shall classify each type of  
 15 items and services covered and paid for separately  
 16 under this title into one of the sectors specified in  
 17 paragraph (1). After publication of such classifica-  
 18 tion under subsection (e)(1), the Secretary is not au-  
 19 thorized to make substantive changes in such classi-  
 20 fication.

21 “(c) ALLOTMENT.—

22 “(1) ALLOTMENTS FOR EACH SECTOR.—For  
 23 purposes of this section, subject to subsection (h)(1),  
 24 the allotment for a sector of medicare services for a  
 25 fiscal year is equal to the product of—

1           “(A) the total allotment for the fiscal year  
2 established under paragraph (2), and

3           “(B) the allotment proportion (specified  
4 under paragraph (3)) for the sector and fiscal  
5 year involved.

6           “(2) TOTAL ALLOTMENT.—

7           “(A) IN GENERAL.—For purposes of this  
8 section, the total allotment for a fiscal year is  
9 equal to—

10           “(i) the medicare benefit budget for  
11 the fiscal year (as specified under subpara-  
12 graph (B)), reduced by

13           “(ii) the amount of payments the Sec-  
14 retary estimates will be made in the fiscal  
15 year under the MedicarePlus program  
16 under part C.

17           In making the estimate under clause (ii), the  
18 Secretary shall take into account estimated en-  
19 rollment and demographic profile of individuals  
20 electing MedicarePlus products.

21           “(B) MEDICARE BENEFIT BUDGET.—For  
22 purposes of this subsection, subject to subpara-  
23 graph (C), the ‘medicare benefit budget’—

24           “(i) for fiscal year 1997 is \$203.1 bil-  
25 lion;

1           “(ii) for fiscal year 1998 is \$214.3  
2 billion;

3           “(iii) for fiscal year 1999 is \$227.2  
4 billion;

5           “(iv) for fiscal year 2000 is \$241.0  
6 billion;

7           “(v) for fiscal year 2001 is \$259.1 bil-  
8 lion;

9           “(vi) for fiscal year 2002 is \$280.0  
10 billion; and

11           “(vi) for a subsequent fiscal year is  
12 equal to the medicare benefit budget under  
13 this subparagraph for the preceding fiscal  
14 year increased by the sum of (I) 5 percent-  
15 age points, and (II) the annual percentage  
16 increase in the average number of medi-  
17 care beneficiaries from the previous fiscal  
18 year to the fiscal year involved.

19           “(3) MEDICARE ALLOTMENT PROPORTION DE-  
20 FINED.—

21           “(A) IN GENERAL.—For purposes of this  
22 section and with respect to a sector of medicare  
23 services for a fiscal year, the term ‘medicare al-  
24 lotment proportion’ means the ratio of—

1           “(i) the baseline-projected medicare  
2           expenditures (as determined under sub-  
3           paragraph (B)) for the sector for the fiscal  
4           year, to

5           “(ii) the sum of such baseline expendi-  
6           tures for all such sectors for the fiscal  
7           year.

8           “(B)    BASELINE-PROJECTED    MEDICARE  
9           EXPENDITURES.—In this paragraph, the ‘base-  
10          line, projected medicare expenditures’ for a sec-  
11         tor of medicare services—

12           “(i) for fiscal year 1996 is equal to  
13           fee-for-service expenditures for such sector  
14           during fiscal year 1995, increased by the  
15           baseline annual growth rate for such sector  
16           of medicare services for fiscal year 1996  
17           (as specified in table in subparagraph (C));  
18           and

19           “(ii) for a subsequent fiscal year is  
20           equal to the baseline-projected medicare  
21           expenditures under this subparagraph for  
22           the sector for the previous fiscal year in-  
23           creased by the baseline annual growth rate  
24           for such sector for the fiscal year involved  
25           (as specified in such table).

1                   “(C) BASELINE ANNUAL GROWTH  
 2                   RATES.—The following table specifies the base-  
 3                   line annual growth rates for each of the sectors  
 4                   for different fiscal years:

“For the following sector—	Baseline annual growth rates for fiscal year—						
	1996	1997	1998	1999	2000	2001	2002 and thereafter
(A) Inpatient hospital services .....	5.7%	5.6%	6.0%	6.1%	5.7%	5.5%	5.2%
(B) Home health services .....	17.2%	15.1%	11.7%	9.1%	8.4%	8.1%	7.9%
(C) Extended care services .....	19.7%	12.3%	9.3%	8.7%	8.6%	8.4%	8.0%
(D) Hospice care .....	32.0%	24.0%	18.0%	15.0%	12.0%	10.0%	9.0%
(E) Physicians’ services .....	12.4%	9.7%	8.7%	9.0%	9.3%	9.6%	10.1%
(F) Outpatient hospital services .....	14.7%	13.9%	14.5%	15.0%	14.1%	13.9%	14.0%
(G) Durable medical equipment and supplies .....	16.1%	15.5%	13.7%	12.4%	13.2%	13.9%	14.5%
(H) Diagnostic tests .....	13.1%	11.3%	11.0%	11.4%	11.4%	11.5%	11.9%
(I) Other items and services .....	11.2%	10.2%	10.9%	12.0%	11.6%	11.6%	11.8%

5                   “(d) MANNER OF PAYMENT ADJUSTMENT.—

6                   “(1) IN GENERAL.—Subject to the succeeding  
 7                   provisions of this subsection, the Secretary shall  
 8                   apply a payment reduction for a sector for a fiscal  
 9                   year in such a manner as to—

10                   “(A) make a change in payment rates (to  
 11                   the maximum extent practicable) at the time  
 12                   payment rates are otherwise changed or subject  
 13                   to change for that fiscal year; and

14                   “(B) provide for the full appropriate ad-  
 15                   justment so that the fee-for-service expenditures  
 16                   for the sector for the fiscal year will approxi-  
 17                   mate (and not exceed) the allotment for the sec-  
 18                   tor for the fiscal year.

1           “(2) TAKING INTO ACCOUNT VOLUME AND  
2 CASH FLOW.—In providing for an adjustment in  
3 payments under this subsection for a sector for a  
4 fiscal year, the Secretary shall take into account (in  
5 a manner consistent with actuarial projections)—

6                   “(A) the impact of such an adjustment on  
7 the volume or type of services provided in such  
8 sector (and other sectors), and

9                   “(B) the fact that an adjustment may  
10 apply to items and services furnished in a fiscal  
11 year (payment for which may occur in a subse-  
12 quent fiscal year),

13 in a manner that is consistent with assuring that  
14 total fee-for-services expenditures for each sector for  
15 the fiscal year will not exceed the allotment under  
16 subsection (c)(1) for such sector for such year.

17           “(3) PROPORTIONALITY OF REDUCTIONS WITH-  
18 IN A SECTOR.—In making adjustments under this  
19 subsection in payment for items and services in-  
20 cluded within a sector of medicare services for a fis-  
21 cal year, the Secretary shall provide for such an ad-  
22 justment that results (to the maximum extent fea-  
23 sible) in the same percentage reductions in aggre-  
24 gate Federal payments under parts A and B for the

1 different classes of items and services included with-  
2 in the sector for the fiscal year.

3 “(4) APPLICATION TO PAYMENTS MADE BASED  
4 ON PROSPECTIVE PAYMENT RATES DETERMINED ON  
5 A FISCAL YEAR BASIS.—

6 “(A) IN GENERAL.—In applying subsection  
7 (a) with respect to items and services for which  
8 payment is made under part A or B on the  
9 basis of rates that are established on a prospec-  
10 tive basis for (and in advance of) a fiscal year,  
11 the Secretary shall provide for the payment ad-  
12 justment under such subsection through an ap-  
13 propriate reduction in such rates established for  
14 items and services furnished (or, in the case of  
15 payment for operating costs of inpatient hos-  
16 pital services of subsection (d) hospitals and  
17 subsection (d) Puerto Rico hospitals (as defined  
18 in paragraphs (1)(B) and (9)(A) of section  
19 1886(d)), discharges occurring) during such  
20 year.

21 “(B) DESCRIPTION OF APPLICATION TO  
22 SPECIFIC SERVICES.—The payment adjustment  
23 described in subparagraph (A) applies for a fis-  
24 cal year to at least the following:

1           “(i) UPDATE FACTOR FOR PAYMENT  
2           FOR OPERATING COSTS OF INPATIENT  
3           HOSPITAL SERVICES OF PPS HOSPITALS.—  
4           To the computation of the applicable per-  
5           centage increase specified in section  
6           1886(d)(3)(B)(i) for discharges occurring  
7           in the fiscal year.

8           “(ii) HOME HEALTH SERVICES.—To  
9           the extent payment amounts for home  
10          health services are based on per visit pay-  
11          ment rates under section 1894, to the com-  
12          putation of the increase in the national per  
13          visit payment rates established for the year  
14          under section 1894(b)(2)(B).

15          “(iii) HOSPICE CARE.—To the update  
16          of payment rates for hospice care under  
17          section 1814(i) for services furnished dur-  
18          ing the fiscal year.

19          “(iv) UPDATE FACTOR FOR PAYMENT  
20          OF OPERATING COSTS OF INPATIENT HOS-  
21          PITAL SERVICES OF PPS-EXEMPT HOS-  
22          PITALS.—To the computation of the target  
23          amount under section 1886(b)(3) for dis-  
24          charges occurring during the fiscal year.

1                   “(v) COVERED NON-ROUTINE SERV-  
2                   ICES OF SKILLED NURSING FACILITIES.—  
3                   To the computation of the facility per stay  
4                   limits for the year under section 1888A(d)  
5                   for covered non-routine services of a skilled  
6                   nursing facility (as described in such sec-  
7                   tion).

8                   “(5) APPLICATION TO PAYMENTS MADE BASED  
9                   ON PROSPECTIVE PAYMENT RATES DETERMINED ON  
10                  A CALENDAR YEAR BASIS.—

11                  “(A) IN GENERAL.—In applying subsection  
12                  (a) for a fiscal year with respect to items and  
13                  services for which payment is made under part  
14                  A or B on the basis of rates that are estab-  
15                  lished on a prospective basis for (and in ad-  
16                  vance of) a calendar year, the Secretary shall  
17                  provide for the payment adjustment under such  
18                  subsection through an appropriate reduction in  
19                  such rates established for items and services  
20                  furnished at any time during such calendar  
21                  year as follows:

22                  “(i) For fiscal year 1997, the reduc-  
23                  tion shall be made for payment rates dur-  
24                  ing calendar year 1997 in a manner so as  
25                  to achieve the necessary payment reduc-

1           tions for such fiscal year for items and  
2           services furnished during the first 3 quar-  
3           ters of calendar year 1997.

4           “(ii) For a subsequent fiscal year, the  
5           reduction shall be made for payment rates  
6           during the calendar year in which the fis-  
7           cal year ends in a manner so as to achieve  
8           the necessary payment reductions for such  
9           fiscal year for items and services furnished  
10          during the first 3 quarters of the calendar  
11          year, but also taking into account the pay-  
12          ment reductions made in the first quarter  
13          of the fiscal year resulting from payment  
14          reductions made under this paragraph for  
15          the previous calendar year.

16          “(iii) Payment rate reductions ef-  
17          fected under this subparagraph for a cal-  
18          endar year and applicable to the last 3  
19          quarters of the fiscal year in which the cal-  
20          endar year ends shall continue to apply  
21          during the first quarter of the succeeding  
22          fiscal year.

23          “(B) APPLICATION IN SPECIFIC CASES.—  
24          The payment adjustment described in subpara-

1 graph (A) applies for a fiscal year to at least  
2 the following:

3 “(i) UPDATE IN CONVERSION FACTOR  
4 FOR PHYSICIANS’ SERVICES.—To the com-  
5 putation of the conversion factor under  
6 subsection (d) of section 1848 used in the  
7 fee schedule established under subsection  
8 (b) of such section, for items and services  
9 furnished during the calendar year in  
10 which the fiscal year ends.

11 “(ii) PAYMENT RATES FOR OTHER  
12 HEALTH CARE PROFESSIONALS.—To the  
13 computation of payments for professional  
14 services of certified registered nurse anes-  
15 thetists under section 1833(l), nurse mid-  
16 wives, physician assistants, nurse practi-  
17 tioners and clinical nurse specialists under  
18 section 1833(r), clinical psychologists, clin-  
19 ical social workers, physical or occupational  
20 therapists, and any other health profes-  
21 sionals for which payment rates are based  
22 (in whole or in part) on payments for phy-  
23 sicians’ services, for services furnished dur-  
24 ing the calendar year in which the fiscal  
25 year ends.

1           “(iii) UPDATE IN LAB FEE SCHED-  
2           ULE.—To the computation of the fee  
3           schedule amount under section 1833(h)(2)  
4           for clinical diagnostic laboratory services  
5           furnished during the calendar year in  
6           which the fiscal year ends.

7           “(iv) UPDATE IN REASONABLE  
8           CHARGES FOR VACCINES.—To the com-  
9           putation of the reasonable charge for vac-  
10          cines described in section 1861(s)(10) for  
11          vaccines furnished during the calendar  
12          year in which the fiscal year ends.

13          “(v) DURABLE MEDICAL EQUIPMENT-  
14          RELATED ITEMS.—To the computation of  
15          the payment basis under section  
16          1834(a)(1)(B) for covered items described  
17          in section 1834(a)(13), for items furnished  
18          during the calendar year in which the fis-  
19          cal year ends.

20          “(vi) RADIOLOGIST SERVICES.—To  
21          the computation of conversion factors for  
22          radiologist services under section 1834(b),  
23          for services furnished during the calendar  
24          year in which the fiscal year ends.

1           “(vii) SCREENING MAMMOGRAPHY.—  
2           To the computation of payment rates for  
3           screening mammography under section  
4           1834(c)(1)(C)(ii), for screening mammog-  
5           raphy performed during the calendar year  
6           in which the fiscal year ends.

7           “(viii)        PROSTHETICS        AND  
8           ORTHOTICS.—To the computation of the  
9           amount to be recognized under section  
10          1834(h) for payment for prosthetic devices  
11          and orthotics and prosthetics, for items  
12          furnished during the calendar year in  
13          which the fiscal year ends.

14          “(ix) SURGICAL DRESSINGS.—To the  
15          computation of the payment amount re-  
16          ferred to in section 1834(i)(1)(B) for sur-  
17          gical dressings, for items furnished during  
18          the calendar year in which the fiscal year  
19          ends.

20          “(x) PARENTERAL AND ENTERAL NU-  
21          TRITION.—To the computation of reason-  
22          able charge screens for payment for paren-  
23          teral and enteral nutrition under section  
24          1834(h), for nutrients furnished during the  
25          calendar year in which the fiscal year ends.

1           “(xi) AMBULANCE SERVICES.—To the  
2           computation of limits on reasonable  
3           charges for ambulance services, for services  
4           furnished during the calendar year in  
5           which the fiscal year ends.

6           “(6) APPLICATION TO PAYMENTS MADE BASED  
7           ON COSTS DURING A COST REPORTING PERIOD.—

8           “(A) IN GENERAL.—In applying subsection  
9           (a) for a fiscal year with respect to items and  
10          services for which payment is made under part  
11          A or B on the basis of costs incurred for items  
12          and services in a cost reporting period, the Sec-  
13          retary shall provide for the payment adjustment  
14          under such subsection for a fiscal year through  
15          a appropriate proportional reduction in the pay-  
16          ment for costs for such items and services in-  
17          curred at any time during each cost reporting  
18          period any part of which occurs during the fis-  
19          cal year involved, but only (for each such cost  
20          reporting period) in the same proportion as the  
21          fraction of the cost reporting period that occurs  
22          during the fiscal year involved.

23          “(B) APPLICATION IN SPECIFIC CASES.—  
24          The payment adjustment described in subpara-

1 graph (A) applies for a fiscal year to at least  
2 the following:

3 “(i) CAPITAL-RELATED COSTS OF  
4 HOSPITAL SERVICES.—To the computation  
5 of payment amounts for inpatient and out-  
6 patient hospital services under sections  
7 1886(g) and 1861(v) for portions of cost  
8 reporting periods occurring during the fis-  
9 cal year.

10 “(ii) OPERATING COSTS FOR PPS-EX-  
11 EMPT HOSPITALS.—To the computation of  
12 payment amounts under section 1886(b)  
13 for operating costs of inpatient hospital  
14 services of pps-exempt hospitals for por-  
15 tions of cost reporting periods occurring  
16 during the fiscal year.

17 “(iii) DIRECT GRADUATE MEDICAL  
18 EDUCATION.—To the computation of pay-  
19 ment amounts under section 1886(h) for  
20 reasonable costs of direct graduate medical  
21 education costs for portions of cost report-  
22 ing periods occurring during the fiscal  
23 year.

24 “(iv) INPATIENT RURAL PRIMARY  
25 CARE HOSPITAL SERVICES.—To the com-

1           putation of payment amounts under sec-  
2           tion 1814(j) for inpatient rural primary  
3           care hospital services for portions of cost  
4           reporting periods occurring during the fis-  
5           cal year.

6           “(v) EXTENDED CARE SERVICES OF A  
7           SKILLED NURSING FACILITY.—To the com-  
8           putation of payment amounts under sec-  
9           tion 1861(v) for post-hospital extended  
10          care services of a skilled nursing facility  
11          (other than covered non-routine services  
12          subject to section 1888A) for portions of  
13          cost reporting periods occurring during the  
14          fiscal year.

15          “(vi) REASONABLE COST CON-  
16          TRACTS.—To the computation of payment  
17          amounts under section 1833(a)(1)(A) for  
18          organizations for portions of cost reporting  
19          periods occurring during the fiscal year.

20          “(vii) HOME HEALTH SERVICES.—  
21          Subject to paragraph (4)(B)(ii), for pay-  
22          ment amounts for home health services, for  
23          portions of cost reporting periods occurring  
24          during such fiscal year.

1           “(7) OTHER.—In applying subsection (a) for a  
2           fiscal year with respect to items and services for  
3           which payment is made under part A or B on a  
4           basis not described in a previous paragraph of this  
5           subsection, the Secretary shall provide for the pay-  
6           ment adjustment under such subsection through a  
7           appropriate proportional reduction in the payments  
8           (or payment bases for items and services furnished)  
9           during the fiscal year.

10           “(8) ADJUSTMENT OF PAYMENT LIMITS.—The  
11           Secretary shall provide for such proportional adjust-  
12           ment in any limits on payment established under  
13           part A or B for payment for items and services with-  
14           in a sector as may be appropriate based on (and in  
15           order to properly carry out) the adjustment on the  
16           amount of payment under this subsection in the sec-  
17           tor.

18           “(9) REFERENCES TO PAYMENT RATES.—Ex-  
19           cept as the Secretary may provide, any reference in  
20           this title (other than this section) to a payment rate  
21           is deemed a reference to such a rate as adjusted  
22           under this subsection.

23           “(e) PUBLICATION OF DETERMINATIONS; JUDICIAL  
24           REVIEW.—

1           “(1) ONE-TIME PUBLICATION OF SECTORS AND  
2           GENERAL PAYMENT ADJUSTMENT METHODOLOGY.—  
3           Not later than October 1, 1996, the Secretary shall  
4           publish in the Federal Register the classification of  
5           medicare items and services into the sectors of medi-  
6           care services under subsection (b) and the general  
7           methodology to be used in applying payment adjust-  
8           ments to the different classes of items and services  
9           within the sectors.

10           “(2) INCLUSION OF INFORMATION IN PRESI-  
11           DENT’S BUDGET.—

12           “(A) IN GENERAL.—With respect to fiscal  
13           years beginning with fiscal year 1999, the  
14           President shall include in the budget submitted  
15           under section 1105 of title 31, United States  
16           Code, information on—

17           “(i) the fee-for-service expenditures,  
18           within each sector, for the second previous  
19           fiscal year, and how such expenditures  
20           compare to the adjusted sector allotment  
21           for that sector for that fiscal year; and

22           “(ii) actual annual growth rates for  
23           fee-for-service expenditures in the different  
24           sectors in the second previous fiscal year.

1           “(B) RECOMMENDATIONS REGARDING  
2 GROWTH FACTORS.—The President may include  
3 in such budget for a fiscal year (beginning with  
4 fiscal year 1998) recommendations regarding  
5 percentages that should be applied (for one or  
6 more fiscal years beginning with that fiscal  
7 year) instead of the baseline annual growth  
8 rates under subsection (c)(3)(C). Such rec-  
9 ommendations shall take into account medically  
10 appropriate practice patterns.

11           “(3) DETERMINATIONS CONCERNING PAYMENT  
12 ADJUSTMENTS.—

13           “(A) RECOMMENDATIONS OF COMMIS-  
14 SION.—By not later than March 1 of each year  
15 (beginning with 1997), the Medicare Payment  
16 Review Commission shall submit to the Sec-  
17 retary and the Congress a report that analyzes  
18 the previous operation (if any) of this section  
19 and that includes recommendations concerning  
20 the manner in which this section should be ap-  
21 plied for the following fiscal year.

22           “(B) PRELIMINARY NOTICE BY SEC-  
23 RETARY.—Not later than May 15 preceding the  
24 beginning of each fiscal year (beginning with  
25 fiscal year 1998), the Secretary shall publish in

1 the Federal Register a notice containing the  
2 Secretary's preliminary determination, for each  
3 sector of medicare services, concerning the fol-  
4 lowing:

5 “(i) The projected allotment under  
6 subsection (c) for such sector for the fiscal  
7 year.

8 “(ii) Whether there will be a payment  
9 adjustment for items and services included  
10 in such sector for the fiscal year under  
11 subsection (a).

12 “(iii) If there will be such an adjust-  
13 ment, the size of such adjustment and the  
14 methodology to be used in making such a  
15 payment adjustment for classes of items  
16 and services included in such sector.

17 “(iv) Beginning with fiscal year 1999,  
18 the fee-for-service expenditures for such  
19 sector for the second preceding fiscal year.

20 Such notice shall include an explanation of the  
21 basis for such determination. Determinations  
22 under this subparagraph and subparagraph (C)  
23 shall be based on the best data available at the  
24 time of such determinations.

1           “(C) FINAL DETERMINATION.—Not later  
2 than September 1 preceding the beginning of  
3 each fiscal year (beginning with fiscal year  
4 1998), the Secretary shall publish in the Fed-  
5 eral Register a final determination, for each  
6 sector of medicare services, concerning the mat-  
7 ters described in subparagraph (B) and an ex-  
8 planation of the reasons for any differences be-  
9 tween such determination and the preliminary  
10 determination for such fiscal year published  
11 under subparagraph (B).

12           “(4) LIMITATION ON ADMINISTRATIVE OR JUDI-  
13 CIAL REVIEW.—There shall be no administrative or  
14 judicial review under section 1878 or otherwise of—

15           “(A) the classification of items and serv-  
16 ices among the sectors of medicare services  
17 under subsection (b),

18           “(B) the determination of the amounts of  
19 allotments for the different sectors of medicare  
20 services under subsection (c),

21           “(C) the determination of the amount (or  
22 method of application) of any payment adjust-  
23 ment under subsection (d), or

24           “(D) any adjustment in an allotment ef-  
25 fected under subsection (h).

1 “(f) FEE-FOR-SERVICE EXPENDITURES DEFINED.—

2 In this section, the term ‘fee-for-service expenditures’, for  
 3 items and services within a sector of medicare services in  
 4 a fiscal year, means amounts payable for such items and  
 5 services which are furnished during the fiscal year, and—

6 “(1) includes types of expenses otherwise reim-  
 7 bursable under parts A and B (including administra-  
 8 tive costs incurred by organizations described in sec-  
 9 tions 1816 and 1842) with respect to such items and  
 10 services, and

11 “(2) does not include amounts paid under part  
 12 C.

13 “(g) EXPEDITED PROCESS FOR ADJUSTMENT OF  
 14 SECTOR GROWTH RATES.—

15 “(1) OPTIONAL INCLUSION OF LEGISLATIVE  
 16 PROPOSAL.—The President may include in rec-  
 17 ommendations under subsection (e)(2)(B) submitted  
 18 with respect to a fiscal year a specific legislative pro-  
 19 posal that provides only for the substitution of per-  
 20 centages specified in the proposal for one or more of  
 21 the baseline annual growth rates (specified in the  
 22 table in subsection (c)(3)(C) or in a previous legisla-  
 23 tive proposal under this subsection) for that fiscal  
 24 year or any subsequent fiscal year.

25 “(2) CONGRESSIONAL CONSIDERATION.—

1           “(A) IN GENERAL.—The percentages con-  
2           tained in a legislative proposal submitted under  
3           paragraph (1) shall apply under this section if  
4           a joint resolution (described in subparagraph  
5           (B)) approving such proposal is enacted, in ac-  
6           cordance with the provisions of subparagraph  
7           (C), before the end of the 60-day period begin-  
8           ning on the date on which such proposal was  
9           submitted. For purposes of applying the preced-  
10          ing sentence and subparagraphs (B) and (C),  
11          the days on which either House of Congress is  
12          not in session because of an adjournment of  
13          more than three days to a day certain shall be  
14          excluded in the computation of a period.

15          “(B) JOINT RESOLUTION OF APPROVAL.—  
16          A joint resolution described in this subpara-  
17          graph means only a joint resolution which is in-  
18          troduced within the 10-day period beginning on  
19          the date on which the President submits a pro-  
20          posal under paragraph (1) and—

21                  “(i) which does not have a preamble;

22                  “(ii) the matter after the resolving  
23          clause of which is as follows: “That Con-  
24          gress approves the proposal of the Presi-  
25          dent providing for substitution of percent-

1           ages for certain baseline annual growth  
2           rates under section 1895 of the Social Se-  
3           curity Act, as submitted by the President  
4           on \_\_\_\_\_.’, the blank space  
5           being filled in with the appropriate date;  
6           and

7           “(iii) the title of which is as follows:  
8           ‘Joint resolution approving Presidential  
9           proposal to substitute certain specified per-  
10          centages for baseline annual growth rates  
11          under section 1895 of the Social Security  
12          Act, as submitted by the President on  
13          \_\_\_\_\_.’, the blank space being  
14          filled in with the appropriate date.

15          “(C) PROCEDURES FOR CONSIDERATION  
16          OF RESOLUTION OF APPROVAL.—Subject to  
17          subparagraph (D), the provisions of section  
18          2908 (other than subsection (a)) of the Defense  
19          Base Closure and Realignment Act of 1990  
20          shall apply to the consideration of a joint reso-  
21          lution described in subparagraph (B) in the  
22          same manner as such provisions apply to a joint  
23          resolution described in section 2908(a) of such  
24          Act.

1           “(D) SPECIAL RULES.—For purposes of  
2           applying subparagraph (C) with respect to such  
3           provisions—

4                   “(i) any reference to the Committee  
5                   on Armed Services of the House of Rep-  
6                   resentatives shall be deemed a reference to  
7                   an appropriate Committee of the House of  
8                   Representatives (specified by the Speaker  
9                   of the House of Representatives at the  
10                  time of submission of a legislative proposal  
11                  under paragraph (1)) and any reference to  
12                  the Committee on Armed Services of the  
13                  Senate shall be deemed a reference to the  
14                  Committee on Finance of the Senate; and

15                   “(ii) any reference to the date on  
16                   which the President transmits a report  
17                   shall be deemed a reference to the date on  
18                   which the President submits the legislative  
19                   proposal under paragraph (1).

20           “(h) LOOK-BACK ADJUSTMENT IN ALLOTMENTS TO  
21           REFLECT ACTUAL EXPENDITURES.—

22                   “(1) IN GENERAL.—If the Secretary determines  
23                   under subsection (e)(3)(B) with respect to a particu-  
24                   lar fiscal year (beginning with fiscal year 1999) that

1 the fee-for-service expenditures for a sector of medi-  
2 care services for the second preceding fiscal year—

3 “(A) exceeded the adjusted allotment for  
4 such sector for such year (as defined in para-  
5 graph (2)), then the allotment for the sector for  
6 the particular fiscal year shall be reduced by  
7 133 $\frac{1}{3}$  percent of the amount of such excess, or

8 “(B) was less than the adjusted allotment  
9 for such sector for such year, then the allot-  
10 ment for the sector for the particular fiscal year  
11 shall be increased by the amount of such defi-  
12 cit.

13 “(2) ADJUSTED ALLOTMENT.—The adjusted al-  
14 lotment under this paragraph for a sector for a fis-  
15 cal year is—

16 “(A) the amount that would be computed  
17 as the allotment under subsection (c) for the  
18 sector for the fiscal year if the actual amount  
19 of payments made in the fiscal year under the  
20 MedicarePlus program under part C in the fis-  
21 cal year were substituted for the amount de-  
22 scribed in subsection (c)(2)(A)(ii) for that fiscal  
23 year,

24 “(B) adjusted to take into account the  
25 amount of any adjustment under paragraph (1)

1           for that fiscal year (based on expenditures in  
2           the second previous fiscal year).

3           “(i) PROSPECTIVE APPLICATION OF CERTAIN NA-  
4 TIONAL COVERAGE DETERMINATIONS.—In the case of a  
5 national coverage determination that the Secretary  
6 projects will result in significant additional expenditures  
7 under this title (taking into account any substitution for  
8 existing procedures or technologies), such determination  
9 shall not become effective before the beginning of the fiscal  
10 year that begins after the date of such determination and  
11 shall apply to contracts under part C entered into (or re-  
12 newed) after the date of such determination.”.

13           (b) REPORT OF TRUSTEES ON GROWTH RATE IN  
14 PART A EXPENDITURES.—Section 1817 (42 U.S.C.  
15 1395i) is amended by adding at the end the following new  
16 subsection:

17           “(k) Each annual report provided in subsection (b)(2)  
18 shall include information regarding the annual rate of  
19 growth in program expenditures that would be required  
20 to maintain the financial solvency of the Trust Fund and  
21 the extent to which the provisions of section 1895 restrain  
22 the rate of growth of expenditures under this part in order  
23 to achieve such solvency.”.

1       **PART 4—ADMINISTRATIVE SIMPLIFICATION**

2       **SEC. 15731. STANDARDS FOR MEDICARE INFORMATION**  
3                               **TRANSACTIONS AND DATA ELEMENTS.**

4           Title XVIII, as amended by section 15031, is amend-  
5 ed by inserting after section 1806 the following new sec-  
6 tion:

7           “STANDARDS FOR MEDICARE INFORMATION  
8                               TRANSACTIONS AND DATA ELEMENTS

9           “SEC. 1807. (a) ADOPTION OF STANDARDS FOR  
10 DATA ELEMENTS.—

11           “(1) IN GENERAL.—Pursuant to subsection (b),  
12 the Secretary shall adopt standards for information  
13 transactions and data elements of medicare informa-  
14 tion and modifications to the standards under this  
15 section that are—

16           “(A) consistent with the objective of reduc-  
17 ing the administrative costs of providing and  
18 paying for health care; and

19           “(B) developed or modified by a standard  
20 setting organization (as defined in subsection  
21 (h)(8)).

22           “(2) SPECIAL RULE RELATING TO DATA ELE-  
23 MENTS.—The Secretary may adopt or modify a  
24 standard relating to data elements that is different  
25 from the standard developed by a standard setting  
26 organization, if—

1           “(A) the different standard or modification  
2 will substantially reduce administrative costs to  
3 health care providers and health plans com-  
4 pared to the alternative; and

5           “(B) the standard or modification is pro-  
6 mulgated in accordance with the rulemaking  
7 procedures of subchapter III of chapter 5 of  
8 title 5, United States Code.

9           “(3) SECURITY STANDARDS FOR HEALTH IN-  
10 FORMATION NETWORK.—

11           “(A) IN GENERAL.—Each person, who  
12 maintains or transmits medicare information or  
13 data elements of medicare information and is  
14 subject to this section, shall maintain reason-  
15 able and appropriate administrative, technical,  
16 and physical safeguards—

17           “(i) to ensure the integrity and con-  
18 fidentiality of the information;

19           “(ii) to protect against any reasonably  
20 anticipated—

21           “(I) threats or hazards to the se-  
22 curity or integrity of the information;  
23 and

24           “(II) unauthorized uses or disclo-  
25 sures of the information; and

1           “(iii) to otherwise ensure compliance  
2           with this section by the officers and em-  
3           ployees of such person.

4           “(B) SECURITY STANDARDS.—The Sec-  
5           retary shall establish security standards and  
6           modifications to such standards with respect to  
7           medicare information network services, health  
8           plans, and health care providers that—

9           “(i) take into account—

10           “(I) the technical capabilities of  
11           record systems used to maintain medi-  
12           care information;

13           “(II) the costs of security meas-  
14           ures;

15           “(III) the need for training per-  
16           sons who have access to medicare in-  
17           formation; and

18           “(IV) the value of audit trails in  
19           computerized record systems; and

20           “(ii) ensure that a medicare informa-  
21           tion network service, if it is part of a larg-  
22           er organization, has policies and security  
23           procedures which isolate the activities of  
24           such service with respect to processing in-  
25           formation in a manner that prevents unau-

1           thorized access to such information by  
2           such larger organization.

3           The security standards established by the Sec-  
4           retary shall be based on the standards devel-  
5           oped or modified by standard setting organiza-  
6           tions. If such standards do not exist, the Sec-  
7           retary shall rely on the recommendations of the  
8           Health Information Advisory Committee (estab-  
9           lished under subsection (g)) and shall consult  
10          with appropriate government agencies and pri-  
11          vate organizations in accordance with para-  
12          graph (5).

13          “(4) IMPLEMENTATION SPECIFICATIONS.—The  
14          Secretary shall establish specifications for imple-  
15          menting each of the standards and the modifications  
16          to the standards adopted pursuant to paragraph (1).

17          “(5) ASSISTANCE TO THE SECRETARY.—In  
18          complying with the requirements of this section, the  
19          Secretary shall rely on recommendations of the Med-  
20          icare Information Advisory Committee established  
21          under subsection (g) and shall consult with appro-  
22          priate Federal and State agencies and private orga-  
23          nizations. The Secretary shall publish in the Federal  
24          Register the recommendations of the Medicare Infor-

1 mation Advisory Committee regarding the adoption  
2 of a standard under this section.

3 “(b) STANDARDS FOR INFORMATION TRANSACTIONS  
4 AND DATA ELEMENTS.—

5 “(1) IN GENERAL.—The Secretary shall adopt  
6 standards for transactions and data elements to  
7 make medicare information uniformly available to be  
8 exchanged electronically, that is—

9 “(A) appropriate for the following financial  
10 and administrative transactions: claims (includ-  
11 ing coordination of benefits) or equivalent en-  
12 counter information, enrollment and  
13 disenrollment, eligibility, premium payments,  
14 and referral certification and authorization; and

15 “(B) related to other financial and admin-  
16 istrative transactions determined appropriate by  
17 the Secretary consistent with the goals of im-  
18 proving the operation of the health care system  
19 and reducing administrative costs.

20 “(2) UNIQUE HEALTH IDENTIFIERS.—

21 “(A) ADOPTION OF STANDARDS.—The  
22 Secretary shall adopt standards providing for a  
23 standard unique health identifier for each indi-  
24 vidual, employer, health plan, and health care  
25 provider for use in the medicare information

1 system. In developing unique health identifiers  
2 for each health plan and health care provider,  
3 the Secretary shall take into account multiple  
4 uses for identifiers and multiple locations and  
5 specialty classifications for health care provid-  
6 ers.

7 “(B) PENALTY FOR IMPROPER DISCLO-  
8 SURE.—A person who knowingly uses or causes  
9 to be used a unique health identifier under sub-  
10 paragraph (A) for a purpose that is not author-  
11 ized by the Secretary shall—

12 “(i) be fined not more than \$50,000,  
13 imprisoned not more than 1 year, or both;  
14 or

15 “(ii) if the offense is committed under  
16 false pretenses, be fined not more than  
17 \$100,000, imprisoned not more than 5  
18 years, or both.

19 “(3) CODE SETS.—

20 “(A) IN GENERAL.—The Secretary, in con-  
21 sultation with the Medicare Information Advi-  
22 sory Committee, experts from the private sec-  
23 tor, and Federal and State agencies, shall—

24 “(i) select code sets for appropriate  
25 data elements from among the code sets

1           that have been developed by private and  
2           public entities; or

3           “(ii) establish code sets for such data  
4           elements if no code sets for the data ele-  
5           ments have been developed.

6           “(B) DISTRIBUTION.—The Secretary shall  
7           establish efficient and low-cost procedures for  
8           distribution (including electronic distribution) of  
9           code sets and modifications made to such code  
10          sets under subsection (c)(2).

11          “(4) ELECTRONIC SIGNATURE.—

12           “(A) IN GENERAL.—The Secretary, after  
13           consultation with the Medicare Information Ad-  
14           visory Committee, shall promulgate regulations  
15           specifying procedures for the electronic trans-  
16           mission and authentication of signatures, com-  
17           pliance with which will be deemed to satisfy  
18           Federal and State statutory requirements for  
19           written signatures with respect to information  
20           transactions required by this section and writ-  
21           ten signatures on enrollment and disenrollment  
22           forms.

23           “(B) PAYMENTS FOR SERVICES AND PRE-  
24           MIUMS.—Nothing in this section shall be con-  
25           strued to prohibit the payment of health care

1 services or health plan premiums by debit, cred-  
2 it, payment card or numbers, or other electronic  
3 means.

4 “(5) TRANSFER OF INFORMATION BETWEEN  
5 HEALTH PLANS.—The Secretary shall develop rules  
6 and procedures—

7 “(A) for determining the financial liability  
8 of health plans when health care benefits are  
9 payable under two or more health plans; and

10 “(B) for transferring among health plans  
11 appropriate standard data elements needed for  
12 the coordination of benefits, the sequential  
13 processing of claims, and other data elements  
14 for individuals who have more than one health  
15 plan.

16 “(6) COORDINATION OF BENEFITS.—If, at the  
17 end of the 5-year period beginning on the date of the  
18 enactment of this section, the Secretary determines  
19 that additional transaction standards for coordinat-  
20 ing benefits are necessary to reduce administrative  
21 costs or duplicative (or inappropriate) payment of  
22 claims, the Secretary shall establish further trans-  
23 action standards for the coordination of benefits be-  
24 tween health plans.

1           “(7) PROTECTION OF TRADE SECRETS.—Ex-  
2           cept as otherwise required by law, the standards  
3           adopted under this section shall not require disclo-  
4           sure of trade secrets or confidential commercial in-  
5           formation by an entity operating a medicare infor-  
6           mation network.

7           “(c) TIMETABLES FOR ADOPTION OF STANDARDS.—

8           “(1) INITIAL STANDARDS.—Not later than 18  
9           months after the date of the enactment of this sec-  
10          tion, the Secretary shall adopt standards relating to  
11          the information transactions, data elements of medi-  
12          care information and security described in sub-  
13          sections (a) and (b).

14          “(2) ADDITIONS AND MODIFICATIONS TO  
15          STANDARDS.—

16          “(A) IN GENERAL.—The Secretary shall  
17          review the standards adopted under this section  
18          and shall adopt additional or modified stand-  
19          ards, that have been developed or modified by  
20          a standard setting organization, as determined  
21          appropriate, but not more frequently than once  
22          every 12 months. Any addition or modification  
23          to such standards shall be completed in a man-  
24          ner which minimizes the disruption and cost of  
25          compliance.

1           “(B) ADDITIONS AND MODIFICATIONS TO  
2 CODE SETS.—

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

7           “(ii) ADDITIONAL RULES.—If a code  
8 set is modified under this paragraph, the  
9 modified code set shall include instructions  
10 on how data elements of medicare informa-  
11 tion that were encoded prior to the modi-  
12 fication may be converted or translated so  
13 as to preserve the informational value of  
14 the data elements that existed before the  
15 modification. Any modification to a code  
16 set under this paragraph shall be imple-  
17 mented in a manner that minimizes the  
18 disruption and cost of complying with such  
19 modification.

20           “(d) REQUIREMENTS FOR HEALTH PLANS.—

21           “(1) IN GENERAL.—If a person desires to con-  
22 duct any of the information transactions described  
23 in subsection (b)(1) with a health plan as a standard  
24 transaction, the health plan shall conduct such  
25 standard transaction in a timely manner and the in-

1       formation transmitted or received in connection with  
2       such transaction shall be in the form of standard  
3       data elements of medicare information.

4           “(2) SATISFACTION OF REQUIREMENTS.—A  
5       health plan may satisfy the requirement imposed on  
6       such plan under paragraph (1) by directly transmit-  
7       ting standard data elements of medicare information  
8       or submitting nonstandard data elements to a medi-  
9       care information network service for processing into  
10      standard data elements and transmission.

11          “(3) TIMETABLES FOR COMPLIANCE WITH RE-  
12      QUIREMENTS.—Not later than 24 months after the  
13      date on which standards are adopted under sub-  
14      sections (a) and (b) with respect to any type of in-  
15      formation transaction or data element of medicare  
16      information or with respect to security, a health plan  
17      shall comply with the requirements of this section  
18      with respect to such transaction or data element.

19          “(4) COMPLIANCE WITH MODIFIED STAND-  
20      ARDS.—If the Secretary adopts a modified standard  
21      under subsection (a) or (b), a health plan shall be  
22      required to comply with the modified standard at  
23      such time as the Secretary determines appropriate  
24      taking into account the time needed to comply due  
25      to the nature and extent of the modification. How-

1 ever, the time determined appropriate under the pre-  
2 ceding sentence shall be not earlier than the last day  
3 of the 180-day period beginning on the date such  
4 modified standard is adopted. The Secretary may ex-  
5 tend the time for compliance for small health plans,  
6 if the Secretary determines such extension is appro-  
7 priate.

8 “(e) GENERAL PENALTY FOR FAILURE TO COMPLY  
9 WITH REQUIREMENTS AND STANDARDS.—

10 “(1) GENERAL PENALTY.—

11 “(A) IN GENERAL.—Except as provided in  
12 paragraph (2), the Secretary shall impose on  
13 any person that violates a requirement or  
14 standard—

15 “(i) with respect to medicare informa-  
16 tion transactions, data elements of medi-  
17 care information, or security imposed  
18 under subsection (a) or (b); or

19 “(ii) with respect to health plans im-  
20 posed under subsection (d);

21 a penalty of not more than \$100 for each such  
22 violation of a specific standard or requirement,  
23 but the total amount imposed for all such viola-  
24 tions of a specific standard or requirement dur-  
25 ing the calendar year shall not exceed \$25,000.

1           “(B) PROCEDURES.—The provisions of  
2 section 1128A (other than subsections (a) and  
3 (b) and the second sentence of subsection (f))  
4 shall apply to the imposition of a civil money  
5 penalty under this paragraph in the same man-  
6 ner as such provisions apply to the imposition  
7 of a penalty under such section 1128A.

8           “(C) DENIAL OF PAYMENT.—Except as  
9 provided in paragraph (2), the Secretary may  
10 deny payment under this title for an item or  
11 service furnished by a person if the person fails  
12 to comply with an applicable requirement or  
13 standard for medicare information relating to  
14 that item or service.

15           “(2) LIMITATIONS.—

16           “(A) NONCOMPLIANCE NOT DISCOV-  
17 ERED.—A penalty may not be imposed under  
18 paragraph (1) if it is established to the satisfac-  
19 tion of the Secretary that the person liable for  
20 the penalty did not know, and by exercising rea-  
21 sonable diligence would not have known, that  
22 such person failed to comply with the require-  
23 ment or standard described in paragraph (1).

24           “(B) FAILURES DUE TO REASONABLE  
25 CAUSE.—

1           “(i) IN GENERAL.—Except as pro-  
2           vided in clause (ii), a penalty may not be  
3           imposed under paragraph (1) if—

4                   “(I) the failure to comply was  
5                   due to reasonable cause and not to  
6                   willful neglect; and

7                   “(II) the failure to comply is cor-  
8                   rected during the 30-day period begin-  
9                   ning on the first date the person liable  
10                  for the penalty knew, or by exercising  
11                  reasonable diligence would have  
12                  known, that the failure to comply oc-  
13                  curred.

14           “(ii) EXTENSION OF PERIOD.—

15                   “(I) NO PENALTY.—The period  
16                   referred to in clause (i)(II) may be ex-  
17                   tended as determined appropriate by  
18                   the Secretary based on the nature and  
19                   extent of the failure to comply.

20                   “(II) ASSISTANCE.—If the Sec-  
21                   retary determines that a health plan  
22                   failed to comply because such plan  
23                   was unable to comply, the Secretary  
24                   may provide technical assistance to  
25                   such plan during the period described

1 in clause (i)(II). Such assistance shall  
2 be provided in any manner determined  
3 appropriate by the Secretary.

4 “(C) REDUCTION.—In the case of a failure  
5 to comply which is due to reasonable cause and  
6 not to willful neglect, any penalty under para-  
7 graph (1) that is not entirely waived under sub-  
8 paragraph (B) may be waived to the extent that  
9 the payment of such penalty would be excessive  
10 relative to the compliance failure involved.

11 “(f) EFFECT ON STATE LAW.—

12 “(1) GENERAL EFFECT.—

13 “(A) GENERAL RULE.—Except as provided  
14 in subparagraph (B), a provision, requirement,  
15 or standard under this section shall supersede  
16 any contrary provision of State law, including a  
17 provision of State law that requires medical or  
18 health plan records (including billing informa-  
19 tion) to be maintained or transmitted in written  
20 rather than electronic form.

21 “(B) EXCEPTIONS.—A provision, require-  
22 ment, or standard under this section shall not  
23 supersede a contrary provision of State law, if  
24 the provision of State law—

1           “(i) provides requirements or stand-  
2           ards that are more stringent than the re-  
3           quirements or standards under this section  
4           with respect to the privacy of individually  
5           identifiable medicare information; or

6           “(ii) is a provision the Secretary de-  
7           termines is necessary to prevent fraud and  
8           abuse with respect to controlled sub-  
9           stances, or for other purposes.

10           “(2) PUBLIC HEALTH REPORTING.—Nothing in  
11           this section shall be construed to invalidate or limit  
12           the authority, power, or procedures established  
13           under any law providing for the reporting of disease  
14           or injury, child abuse, birth, or death, public health  
15           surveillance, or public health investigation or inter-  
16           vention.

17           “(g) MEDICARE INFORMATION ADVISORY COMMIT-  
18           TEE.—

19           “(1) ESTABLISHMENT.—There is established a  
20           committee to be known as the Medicare Information  
21           Advisory Committee (in this subsection referred to  
22           as the ‘committee’).

23           “(2) DUTIES.—The committee shall—

24           “(A) advise the Secretary in the develop-  
25           ment of standards under this section; and

1           “(B) be generally responsible for advising  
2 the Secretary and the Congress on the status  
3 and the future of the medicare information net-  
4 work.

5           “(3) MEMBERSHIP.—

6           “(A) IN GENERAL.—The committee shall  
7 consist of 9 members of whom—

8                   “(i) 3 shall be appointed by the Presi-  
9 dent;

10                   “(ii) 3 shall be appointed by the  
11 Speaker of the House of Representatives  
12 after consultation with the minority leader  
13 of the House of Representatives; and

14                   “(iii) 3 shall be appointed by the  
15 President pro tempore of the Senate after  
16 consultation with the minority leader of  
17 the Senate.

18           The appointments of the members shall be  
19 made not later than 60 days after the date of  
20 the enactment of this section. The President  
21 shall designate 1 member as the Chair.

22           “(B) EXPERTISE.—The membership of the  
23 committee shall consist of individuals who are  
24 of recognized standing and distinction in the  
25 areas of information systems, information

1 networking and integration, consumer health,  
2 or health care financial management, and who  
3 possess the demonstrated capacity to discharge  
4 the duties imposed on the committee.

5 “(C) TERMS.—Each member of the com-  
6 mittee shall be appointed for a term of 5 years,  
7 except that the members first appointed shall  
8 serve staggered terms such that the terms of  
9 not more than 3 members expire at one time.

10 “(D) INITIAL MEETING.—Not later than  
11 30 days after the date on which a majority of  
12 the members have been appointed, the commit-  
13 tee shall hold its first meeting.

14 “(4) REPORTS.—Not later than 1 year after the  
15 date of the enactment of this section, and annually  
16 thereafter, the committee shall submit to Congress  
17 and the Secretary a report regarding—

18 “(A) the extent to which entities using the  
19 medicare information network are meeting the  
20 standards adopted under this section and work-  
21 ing together to form an integrated network that  
22 meets the needs of its users;

23 “(B) the extent to which such entities are  
24 meeting the security standards established pur-  
25 suant to this section and the types of penalties

1           assessed for noncompliance with such stand-  
2           ards;

3           “(C) any problems that exist with respect  
4           to implementation of the medicare information  
5           network; and

6           “(D) the extent to which timetables under  
7           this section are being met.

8           Reports made under this subsection shall be made  
9           available to health care providers, health plans, and  
10          other entities that use the medicare information net-  
11          work to exchange medicare information.

12          “(h) DEFINITIONS.—For purposes of this section:

13           “(1) CODE SET.—The term ‘code set’ means  
14           any set of codes used for encoding data elements,  
15           such as tables of terms, enrollment information, and  
16           encounter data.

17           “(2) COORDINATION OF BENEFITS.—The term  
18           ‘coordination of benefits’ means determining and co-  
19           ordinating the financial obligations of health plans  
20           when health care benefits are payable under such a  
21           plan and under this title (including under a  
22           MedicarePlus product).

23           “(3) MEDICARE INFORMATION.—The term  
24           ‘medicare information’ means any information that  
25           relates to the enrollment of individuals under this

1 title (including information relating to elections of  
2 MedicarePlus products under section 1805) and the  
3 provision of health benefits (including benefits pro-  
4 vided under such products) under this title.

5 “(4) MEDICARE INFORMATION NETWORK.—The  
6 term ‘medicare information network’ means the  
7 medicare information system that is formed through  
8 the application of the requirements and standards  
9 established under this section.

10 “(5) MEDICARE INFORMATION NETWORK SERV-  
11 ICE.—The term ‘medicare information network serv-  
12 ice’ means a public or private entity that—

13 “(A) processes or facilitates the processing  
14 of nonstandard data elements of medicare infor-  
15 mation into standard data elements;

16 “(B) provides the means by which persons  
17 may meet the requirements of this section; or

18 “(C) provides specific information process-  
19 ing services.

20 “(6) HEALTH PLAN.—The term ‘health plan’  
21 means a plan which provides, or pays the cost of,  
22 health benefits. Such term includes the following, or  
23 any combination thereof:

24 “(A) Part A or part B of this title, and in-  
25 cludes a MedicarePlus product.

1           “(B) The medicaid program under title  
2           XIX and the MediGrant program under title  
3           XXI.

4           “(C) A medicare supplemental policy (as  
5           defined in section 1882(g)(1)).

6           “(D) Worker’s compensation or similar in-  
7           surance.

8           “(E) Automobile or automobile medical-  
9           payment insurance.

10           “(F) A long-term care policy, other than a  
11           fixed indemnity policy.

12           “(G) The Federal Employees Health Bene-  
13           fit Plan under chapter 89 of title 5, United  
14           States Code.

15           “(H) An employee welfare benefit plan, as  
16           defined in section 3(1) of the Employee Retire-  
17           ment Income Security Act of 1974 (29 U.S.C.  
18           1002(1)), but only to the extent the plan is es-  
19           tablished or maintained for the purpose of pro-  
20           viding health benefits.

21           “(7) INDIVIDUALLY IDENTIFIABLE MEDICARE  
22           INFORMATION.—The term ‘individually identifiable  
23           medicare information’ means medicare enrollment  
24           information, including demographic information col-  
25           lected from an individual, that—



1 cluding outpatient diagnostic imaging services) for which  
2 payment may be made under the program solely on the  
3 grounds that the device is not an approved device, if—

- 4 (1) the device is an investigational device; and
- 5 (2) the device is used instead of either an ap-  
6 proved device or a covered procedure.

7 (b) CLARIFICATION OF PAYMENT AMOUNT.—Not-  
8 withstanding any other provision of title XVIII of the So-  
9 cial Security Act, the amount of payment made under the  
10 medicare program for any item or service associated with  
11 the use of an investigational device in the furnishing of  
12 inpatient or outpatient hospital services (including out-  
13 patient diagnostic imaging services) for which payment  
14 may be made under the program may not exceed the  
15 amount of the payment which would have been made  
16 under the program for the item or service if the item or  
17 service were associated with the use of an approved device  
18 or a covered procedure.

19 (c) DEFINITIONS.—In this section—

- 20 (1) the term “approved device” means a medi-  
21 cal device (or devices) which has been approved for  
22 marketing under pre-market approval under the  
23 Federal Food, Drug, and Cosmetic Act or cleared  
24 for marketing under a 510(k) notice under such Act;  
25 and

1 (2) the term “investigational device” means—

2 (A) a medical device or devices (other than  
3 a device described in paragraph (1)) approved  
4 for investigational use under section 520(g) of  
5 the Federal Food, Drug, and Cosmetic Act, or

6 (B) an investigational combination product  
7 under section 503(g) of the Federal Food,  
8 Drug, and Cosmetic Act which includes a device  
9 (or devices) authorized for use under section  
10 505(i) of such Act.

11 **SEC. 15742. ADDITIONAL EXCLUSION FROM COVERAGE.**

12 (a) IN GENERAL.—Section 1862(a) (42 U.S.C.  
13 1395y(a)), as amended by section 15525(a)(2) and section  
14 15701(c)(2)(C), is amended—

15 (1) by striking “or” at the end of paragraph  
16 (16),

17 (2) by striking the period at the end of para-  
18 graph (17) and inserting “; or”, and

19 (3) by inserting after paragraph (17) the fol-  
20 lowing new paragraph:

21 “(18) where such expenses are for items or  
22 services, or to assist in the purchase, in whole or in  
23 part, of health benefit coverage that includes items  
24 or services, for the purpose of causing, or assisting

1 in causing, the death, suicide, euthanasia, or mercy  
2 killing of a person.”.

3 (b) EFFECTIVE DATE.—The amendments made by  
4 subsection (a) shall apply to payment for items and serv-  
5 ices furnished on or after the date of the enactment of  
6 this Act.

7 **Subtitle I—Clinical Laboratories**

8 **SEC. 15801. EXEMPTION OF PHYSICIAN OFFICE LABORA-**  
9 **TORIES.**

10 Section 353(d) of the Public Health Service Act (42  
11 U.S.C. 263a(d)) is amended—

12 (1) by redesignating paragraphs (2), (3), and  
13 (4) as paragraphs (3), (4), and (5) and by adding  
14 after paragraph (1) the following:

15 “(4) EXEMPTION OF PHYSICIAN OFFICE LAB-  
16 ORATORIES.—

17 “(A) IN GENERAL.—Except as provided in  
18 subparagraph (B), a clinical laboratory in a  
19 physician’s office (including an office of a group  
20 of physicians) which is directed by a physician  
21 and in which examinations and procedures are  
22 either performed by a physician or by individ-  
23 uals supervised by a physician solely as an ad-  
24 junct to other services provided by the physi-  
25 cian’s office is exempt from this section.

1           “(B) EXCEPTION.—A clinical laboratory  
 2           described in subparagraph (A) is not exempt  
 3           from this section when it performs a pap smear  
 4           (Papanicolaou Smear) analysis.

5           “(C) DEFINITION.—For purposes of sub-  
 6           paragraph (A), the term ‘physician’ has the  
 7           same meaning as is prescribed for such term by  
 8           section 1861(r) of the Social Security Act (42  
 9           U.S.C. 1395x(r)).”;

10           (2) in paragraph (3) (as so redesignated) by  
 11           striking “(3)” and inserting “(4)”; and

12           (3) in paragraphs (4) and (5) (as so redesign-  
 13           ated) by striking “(2)” and inserting “(3)”.



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